VIRGINIA MEDICAL ASSISTANCE

ELIGIBILITY MANUAL



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APPLICATION FOR MEDICAL ASSISTANCE

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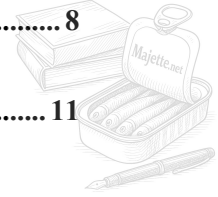
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M0110 General Information

M0110.100 Legal Base and Agency Responsibilities

A. Introduction

Virginia's two medical assistance programs are Medicaid and the Family Access to Medical Insurance Security Plan (FAMIS). Collectively, these programs are referred to as medical assistance (MA). The MA programs pay medical service providers for medical services rendered to eligible individuals. When an individual submits an application for MA, his eligibility is determined for Medicaid first. If he is not eligible for Medicaid due to excess income, his eligibility is determined for FAMIS.

The policies and procedures for determining Medicaid eligibility are contained in Chapters 1 through 18 of this manual; the policies and procedures for determining FAMIS eligibility for children and pregnant women (FAMIS MOMS) are contained in Chapters 21 and 22, respectively.

The MA eligibility determination consists of an evaluation of an individual's situation that compares each of the individual's circumstances to an established standard. Requests for Virginia MA must be made on an approved electronic or paper application form or telephonically through the Cover Virginia Call Center.

All activity of the agency in receiving and acting upon an application must be consistent with the objectives of the MA programs and be conducted in a manner which respects the personal dignity and privacy of the individual.

The local agency must provide timely, accurate, and fair service to all applicants and recipients. Each local agency must establish office procedures and operations that accommodate the needs of the populations it serves. The local agency must not establish any polices, regulations, or rules that create a barrier to accessing benefits. Populations with special needs include households with elderly or disabled members, homeless households, and households with members who work during normal office hours. The local agency must provide bilingual staff and interpreter services to households with limited English proficiency.

B. Legal Base

The Medicaid Program is established under Title XIX of the Federal Social Security Act and is financed by state and federal funds. The State Plan for Medical Assistance (State Plan) is the official body of regulations covering the operation of the Medicaid program in Virginia. The FAMIS program is established under Title XXI of the Social Security Act.

Virginia law provides that the MA programs be administered by the Department of Medical Assistance Services (DMAS). Determination of eligibility for medical assistance is the responsibility of local departments of social services under the supervision of the Virginia Department of Social Services (DSS).

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C. Agency Responsibilities

1. DMAS The administrative responsibilities of DMAS are:

- the development of the State Plan to cover eligibility criteria and scope of services, in conformity with federal law and regulation,
- the determination of medical care covered under the State Plan,
- oversight of the Cover Virginia Call Center, the Central Processing Uni (CPU), which handles telephonic applications for MA, *and the Cover Virginia Incarcerated Unit (CVIU).*
- the handling of appeals related to the MA programs,
- the approval of providers authorized to provide medical care and receive payments under the MA programs,
- the processing of claims and making payments to medical providers, and
- the recovery of MA expenditures in appropriate cases. Suspected applicant fraud is a combined responsibility of both DMAS and DSS.

2. DSS The responsibilities of DSS are:

- the determination of continuing eligibility for Medicaid and FAMIS,
- the referral of individuals with inappropriate MA payments to the DMAS Recipient Audit Unit, and
- the referral of certain individuals to the Health Insurance Marketplace.

3. DSS/Cover Virginia *Certain processes are handled at DSS or at Cover Virginia, with general responsibilities that may include:*

- the determination of initial eligibility for Medicaid and FAMIS, including applications referred from the Health Insurance Marketplace,
- the enrollment of eligible persons in the Medicaid or FAMIS programs,
- the maintenance of case records pertaining to the eligibility of MA enrollees for certain populations or aid categories.

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M0110.110 Confidentiality

A. **Confidentiality**

MA applicants and recipients are protected by federal and state confidentiality regulations, 42 CFR 431.300 and 12VAC30-20-90. These regulations were established to protect the rights of clients to confidentiality of their information.

B. **Release of Client Information**

Except as otherwise indicated, no person shall obtain, disclose or use, authorize, or permit the use of any client information that is directly or indirectly derived from the records, files or communications of the agency, except for purposes directly connected with the administration of the MA programs, which include but is not limited to:

- establishing eligibility,
- determining the amount of medical assistance,
- providing services for recipients, and
- conducting or assisting in an investigation, prosecution or a civil or criminal proceeding related to the administration of the program.

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C. Use of System Searches

Searches of online information systems, including but not limited to the State Online Query-Internet (SOLQ-I),the State Verification Exchange System (SVES), and the Federal Data Hub, are permitted **only** for applicants and family members whose income and/or resource information is required to determine eligibility for the applicant or patient pay for an enrollee. This includes spouses of applicants and parents of child applicants. Searches of the *Asset Verification System (AVS) are permitted only for applicants with a resource test.*

The Federal Data Hub *and AVS are* to be accessed only for information necessary to determine eligibility for MA cases processed in the Virginia Case Management System (VaCMS). *They* may not be used for other public assistance programs.

D. Release of Information to Medical Providers

Although certain individuals are authorized to receive information about an applicant's/recipient's case, only the minimum data necessary to respond to the request is to be released. Federal regulations stipulate that the disclosure of information about an applicant or recipient can only be for purposes related to administration of the Medicaid State Plan.

Information in the case record related to an individual's medical treatment, or method of reimbursement for services may be released to Virginia MA providers by DMAS without the applicant's/enrollee's consent. Enrollee consent is not needed for the DSS agency to provide confirmation of an individual's eligibility, the dates of eligibility, and any patient pay responsibility if the medical provider is unable to obtain that information from the member verification system or from DMAS staff. The provider **is not** entitled to specific information about an applicant's/recipient's income or resources because the provider does not need that information for medical treatment or payment.

Provider contractors, such as application assistance companies, operate under the authority of the provider. A patient's consent is not required for the agency to provide the contractor with information related to reimbursement for services rendered or medical treatment. Providers and their contractors **are not** entitled to receive detailed financial or income information contained in an applicant's or recipient's case record. Information should not be provided from case records unless the release of such information is for purposes directly related to the administration of the MA programs.

Local agencies may release MA enrollee identification numbers to medical providers by telephone if the provider cannot contact the DMAS provider/recipient verification telephone number. This procedure does not conflict with federal or State confidentiality regulations, if the local agency is satisfied that the number is being released to an identifiable provider.

E. Release to Authorized Representatives and Other Application Assistants

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1. Authorized Representatives

Individuals not determined to be incapacitated by a court can designate whomever they choose to be their authorized representatives, including a provider or a provider's contractor (such as an application assistance company). The designation must be in writing, with the applicant or recipient specifying the information to be released to the authorized representative.

It is not sufficient to indicate that any information in the case record may be released; the designation must state the specific information to be released (i.e. notices, the ability to make application or provide information necessary to determine eligibility, and what, if any, other information can be released to the authorized representative). The authorized representative designation is valid *until:*

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

The authorized representative can file an appeal on behalf of an individual whose application was denied or canceled. The DMAS Appeals Division will determine whether or not the authorized representative can represent the individual during the appeal.

2. Application Assisters

Application assisters are authorized under the Affordable Care Act (ACA) to provide assistance with completing the MA application and renewal, and with explaining and helping the individual to meet documentation requirements. They must be authorized by the individual *to provide assistance with completing the application and/or renewal.* There are two categories of application assisters:

a. Certified Application Counselors (CAC)

CAC are individuals authorized to assist individuals with obtaining health insurance coverage, including Medical Assistance. CAC are generally under the supervision of a non-profit organization and do not receive a fee for providing application counseling.

b. Navigators

Navigators receive federal funding to assist individuals with obtaining health insurance coverage, including Medical Assistance.

Application assisters **cannot** sign forms, receive notices or other communications or otherwise act on behalf of the individual *and* do not have the same CommonHelp system privileges as authorized representatives.

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Certified Application Counselors and Navigators are designated on the MA application and are deemed to have client consent to release information without an additional release of information form. The client may revoke his consent to the release of information at any time by notifying the LDSS verbally or in writing. The revocation of consent or statement is to be documented in the case record.

F. Safeguarding Client Information

All information associated with an applicant or recipient that could disclose the individual's identity is confidential and shall be safeguarded. Such information includes but is not limited to:

- name, address, and all types of identification numbers assigned to the client;
- medical services provided to the client;
- social and economic conditions or circumstances of the client;
- agency evaluation of the client's personal information;
- medical data about the client, including diagnoses and past histories of disease or disabilities;
- information received for verifying income, eligibility, and amount of medical assistance payments;
- information received in connection with identification of legally liable third party resources; and
- information received in connection with processing and rendering decisions of recipient appeals.

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G. Ownership of Records

All client information contained in the agency records is the property of the agency, and employees of the agency shall protect and preserve such information from dissemination except as indicated.

Original client records are not to be removed from the premises by individuals other than authorized staff of the agency, except by court order. The agency may destroy records pursuant to records retention schedules.

H. Release of Client Information with Consent

As part of the application process for MA, the client shall be informed of the need to consent to the release of information necessary for verifying eligibility. Whenever a person, agency or organization that is not performing one or more of the functions described in M0110.110 B above requests client information, the agency must obtain written permission to release the information from the client or the person legally responsible for the client whenever possible. A release for information obtained from the client by the requesting agency also satisfies this requirement.

Certified Application Counselors and Navigators are designated on the MA application and are deemed to have client consent to release information without an additional release of information. The client may revoke his consent to the release of information at any time by notifying the LDSS verbally or in writing. The revocation of consent is to be documented in the case record.

I. Release of Client Information without Consent

Information from the applicant/recipient's case record may not be released to other agencies, such as public housing agencies, legal services, private organizations, the U.S. Citizenship and Immigration Services (USCIS), Virginia Employment Commission (VEC), school lunch programs, health departments or elected officials *beyond what is specified in interagency agreements as described below* without the client's consent.

An exception applies to agencies with which there is an agreement for specific types of sharing of information, such as wage information from the VEC, Systematic Alien Verification for Entitlements (SAVE) with USCIS, the State Verification Exchange System (SVES) with the Social Security Administration, etc.

Client information may be disclosed without client consent in the following situations:

1. **Social Services Employees** — to employees of state and local departments of social services for the purpose of program administration;

2. **Program Staff in Other States** — to program staff in other states when a client moves or when there is a question of dual participation, or to verify the status of assistance in Virginia for applicants in another state;

3. **DMAS & LDSS Staff** — between state/local department of social services staff and DMAS for the purpose of supervision and reporting;

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4. Auditors to federal, state and local employees for the purposes of auditing, monitoring, and evaluation; and

5. For Recovery Purposes for the purpose of recovery of monies for which third parties are liable for payment of claims.

6. Law Enforcement Agencies *when the request is made under a court order, such as a search warrant or subpoena, and the release of information is not prohibited under state or federal law, including the Health Insurance Portability and Accountability Act (HIPAA). Local departments of social services are advised to consult with the agency's legal counsel prior to releasing information requested by law enforcement agencies.*

J. Client's Right of Access to Information Any client has the right to obtain personal information held by the agency. Upon written or verbal request, the client shall be permitted to review or obtain a copy of the information in his record with the following exceptions:

- Information that the agency is required to keep confidential from the client pursuant to §2.2-3704 and §2.2-3705, Code of Virginia, Virginia Freedom of Information Act, Public Records to be open to Inspection; and
- Information that would breach another individual's right to confidentiality

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

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

- All personal information about the client except as provided in §2.2-3704 and §2.2-3705,

The identity of all individuals and organizations not having regular access authority that request access to the client's personal information.

3. Client May Contest Information Pursuant to the Code of Virginia §2.2-3800, a client may contest the accuracy, completeness or relevancy of the information in his record. Correction of the contested information, but not the deletion of the original information if it is required to support receipt of state or federal financial participation, shall be inserted in the record when the agency concurs that such correction is justified.

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When the agency does not concur, the client shall be allowed to enter a statement in the record refuting such information. Corrections and statements shall be made a permanent part of the record and shall be disclosed to any entity that receives the disputed information.

M0110.120 Address Confidentiality Program (ACP)

A. Purpose

The Virginia Attorney General's Office's ACP was created to help a victim of domestic violence who has recently moved to a new location that is unknown to the abuser. The victim wants to keep the new address confidential. Effective July 1, 2011, this program was made available statewide.

B. All Mail Goes to Richmond P.O. Box Address

The ACP offers a substitute mailing address for the individual in a high risk situation. An individual participating in the ACP will have an ACP authorization card that can be used to verify participation in the program; a participant will use a post office box address in Richmond as his address. This address is to be accepted as a mailing address. No locality, FIPS code, or other geographic identification is included on the ACP authorization card.

The actual physical address of the participant **MUST NOT** be entered in into any of the VDSS automated systems. Only the mailing address (which is P.O. Box 1133, Richmond, Virginia, 23218) is entered into the computer systems as the participant's residence address; no separate mailing address is entered.

C. Accept Participant's Verbal Statement of Residency

Virginia state residency and locality residency is established by the participant's verbal statement that he is residing in the locality where he is applying for assistance.

D. Third Party Liability (TPL)

When an individual in the ACP is covered on the abuser's private health insurance plan (TPL), do not add the TPL coverage in the enrollment system. For an individual with TPL who is already receiving MA at the time of entry into the ACP, delete the TPL. Notify the DMAS TPL Unit by e-mail at tplunit@dmas.virginia.gov to ensure that the insurance is not billed or added back to the individual's case record upon a subsequent data match with the insurance company.

E. Refer to Local Domestic Violence Program

Please refer any victims of domestic violence to the local Domestic Violence Program for consideration of the ACP, for safety planning, and other services. Local domestic violence advocates are currently receiving training about the ACP. In most localities, the applications for the ACP program will be completed with the DV advocates as a part of in depth safety planning.

M0110.200 Definitions

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

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



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

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

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

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

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

The authorized representative can file an appeal on behalf of an individual whose application was denied or canceled. The DMAS Appeals Division will determine whether or not the authorized representative can represent the individual during the appeal.

The authorized representative of an incompetent or incapacitated individual is the individual's spouse, parent, attorney-in-fact (person who has the individual's power-of-attorney), legally appointed guardian, legally appointed conservator (committee), or family substitute representative. An individual's spouse is permitted to be an authorized representative for MA purposes as long as the spouse and applicant are living together, or lived together immediately before the applicant's institutionalization; no written designation is required.

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F. Child means an individual under age 21 years.

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

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

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

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

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

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

M. Incarcerated Individual *means an inmate or offender in a Department of Corrections (DOC), local/regional jail, or Department of Juvenile Justice (DJJ) facility.*

***N.* Medical Assistance** means any program administered by DMAS jointly with the Department of Social Services (DSS) that helps individuals or families pay for medical, dental and related health services. These programs are Medicaid, FAMIS and FAMIS MOMS.

M0110.300 Availability of Information

A. Information Required to be Given to the Applicant

1. Explanation of the Medical Assistance Programs The local agency must furnish the following information in written form, and orally as appropriate, to all applicants and enrollees, and to other individuals upon request:

- the eligibility requirements,
- services covered under the MA programs,

- the rights and responsibilities of applicants and enrollees, and
- the appeals process.

When the MA rights and responsibilities are explained verbally, the eligibility worker must document in the case record (electronic or hard copy) that they were explained and the applicant/enrollee's acknowledgement. The applicant/enrollee's failure to acknowledge receipt of the rights and responsibilities is not a condition for MA eligibility and cannot be used to deny, delay or terminate MA coverage.

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

- The brochure "Virginia Department of Social Services Division of Benefit Programs," form # B032-01-0002, contains information about the Medicaid Program and must be given to all applicants;

- The Division of Child Support Enforcement (DCSE)'s booklet "Child Support and You," form #032-01-945 must be given to applicants who are applying on behalf of a child who has an absent parent; and

- *The Medicaid and FAMIS Handbooks are available online at. https://coverva.org/en/member-handbooks. A printed copy of the handbook corresponding to the individual's enrollment or request must be given to anyone who requests a hard copy.*

Applicants may also be given MA Fact Sheets as appropriate.

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

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

3. Voter Registration

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

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

a. Exceptions to Offering Voter Registration

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



- the individual has previously indicated that he is currently registered to vote where he lives,
- there is a completed agency certification form in the individual's case record indicating the same, and
- the individual has not moved from the address where he stated that he was registered to vote.

b. Prohibitions

Local social services agencies and agency staff are prohibited from the following activities when providing voter registration application services:

- seeking to influence an individual's political preference;
- displaying any political preference or party affiliation;
- making any statement to the or taking any action the purpose or effect of which is to discourage the individual from applying to register to vote; or
- making any statement to an individual or taking any action the purpose of which is to lead the individual to believe that a decision to register or not register has any impact on the individual's eligibility for assistance or the benefit level that they may be entitled to receive.

c. Voter Registration Services

Each local social services agency must provide the following voter registration services:

- distribution of voter registration application forms;
- assistance to individuals in completing the registration application form, unless such assistance is refused, and ensuring that all spaces on the form are completed;
- ensuring that the certification statement on the application for benefits or statement of facts is completed; and
- acceptance of voter registration application forms for transmittal to the local general registrar.

1) Each completed registration application must be submitted to the local general registrar every Friday (if Friday is a holiday, the forms must be forwarded to the local registrar on the last working day before Friday.) Completed forms are to be forwarded to the local registrar in an envelope, notated with an "A" in the upper left-hand corner and listing the number of completed registration applications included in the envelope.

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1) For split/combined agencies, all voter registration applications are to be transmitted to the general registrar in the locality where the local social services agency is located.

2) If the individual chooses, he may take a voter registration application to be mailed to the State Board of Elections at his own cost.

d. Voter Registration Application

In Virginia, one voter registration application form will be used to serve a twofold purpose:

- the voter registration application will be completed by the individual with necessary assistance from local agency staff during the application/review process and left at the local agency for transmittal to the local general registrar; or

- for individuals who do not wish to complete the voter registration during the application process, they may take a voter registration form for mail-in registration.

e. **Individuals Required to be Offered Voter Registration Services**

In order to be offered voter registration services, an individual must:

- be a member of the *MA household or* family unit.

- be at least 18 years old by the next general election. General elections are held in all localities on the Tuesday after the first Monday in November or on the first Tuesday in May to fill offices regularly scheduled by law to be filled at those times.

  If any question arises as to whether the individual will turn 18 before the next general election, complete the registration application and the local registrar will determine if the individual may be registered.

- be present in the office at the time of the application or renewal interview if an interview takes place, or when a change of address is reported in person. If a change of address is not reported in person, a registration application will be sent to the individual upon request. Any change in the *household* composition that does not occur concurrent with an application, renewal or change of address will be handled at the next scheduled renewal.

Any individual accompanying the applicant/enrollee to the local agency who is not a member of the assistance unit (including payees and authorized representatives) will not be offered voter registration services by the local agency. However, a registration application is to be provided to the non-unit member upon request.

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Any request for a mail-in application for assistance must include a mail-in voter registration application. When an authorized representative is applying on another individual's behalf, the local agency is to offer a mail-in voter registration application. In both situations, the bottom of the certification form is to be completed accordingly.

f. **Voter Registration Application Sites**

Local social services agencies are required to offer voter registration application services at each local office (including satellite offices) for applicants/recipients of TANF, SNAP, and Medical Assistance. Voter registration application services are also offered by out-stationed staff taking MA applications at hospitals or local health departments and by Medicaid staff at the state's Department of Behavioral Health and Developmental Services' facilities.

B. Information Made Available to the Public in General

1. Availability of Manual

Federal regulations require copies of the State Plan and eligibility rules and policies to be available in agency offices and other designated locations. Policy manuals must be made available in agency offices and other designated locations to individuals who ask to see them.

Upon request, copies of program policy materials must be made available without charge or at a charge related to the cost of reproduction. Copies of manual pages may be made at the local departments of social services. The full *Medical Assistance* Eligibility Manual is available on the DMAS web site at *http://www.dmas.virginia.gov/#/assistance*.

2. MA Handbooks and Fact Sheets

Federal regulation 42 CFR 435.905 requires the state agency to publish bulletins or pamphlets describing eligibility in easy to understand language. The handbooks available for each MA program include basic information about the programs and provide a listing of rights and responsibilities. To supplement the MA handbooks, fact sheets that explain specific policy areas are available to local social services agencies from the state department of social services. A copy of the handbook corresponding to the program in which the individual was enrolled must be given to all recipients after enrollment and must be given to others upon request. The Medicaid handbooks are available on the internet at *http://www.dmas.virginia.gov/#/clientservices*. The FAMIS Handbook is available at http://www.coverva.org/programs_famis.cfm.

C. Inquiries

1. General Inquiries

The following information has been developed to give guidance to employees of the State and local departments of social services about how to respond to inquiries:

- Limit verbal and written information to explaining the written materials provided. Those written materials may include copies of manual pages, MA handbooks, or fact sheets. The individual may also be referred to the Virginia Department of Social Services website at *www.dss.virginia.gov* and the Virginia Department of Medical Assistance Services website at *www.dmas.virginia.gov* for additional information.

- Do not go beyond the scope of the written materials. Questions about hypothetical situations, such as (but not limited to) "what would happen if a certain value of resources were transferred?" or "what would be the effect on Medicaid if a trust were written in a certain way?" should not be answered.

Medicaid rules and policies are applied to the facts of a specific application after an application is received. Prior to receipt, do not give hypothetical advice or answers to hypothetical questions to applicants, their attorneys or anyone applying on behalf of the applicant. Answering hypothetical questions is inappropriate for two reasons:

- Until a complete application is received, the local agency cannot be sure it has all the relevant facts. An attempt to be helpful could be futile or lead to incorrect advice. In the event of a dispute, the applicant may then assert that the agency is bound by the incorrect advice. The applicant or other persons affected by the applicant's actions (such as those affected by a property transfer or those otherwise responsible for the care of the applicant) may attempt to hold the agency employee or employees involved individually liable for damages suffered as a result of alleged negligent advice.

- Providing responses to hypothetical questions may under some circumstances constitute the practice of law. The practice of law includes advising another for compensation, direct or indirect, in any matter involving the application of legal principles to facts or purposes or desires. Local agency workers, regional MA consultants, and central office MA employees, even if they are attorneys, are not functioning as legal counsel and must not give legal advice which may affect the rights of applicants, recipients, or others who may not be applying or eligible for MA.

All MA staff are bound by these guidelines for the dissemination of information. Do not refer inquiries from attorneys, applicants or others acting on behalf of the applicant to regional or state MA staff.

2. *Case Specific Inquiries*

Send questions that occur as a direct result of the receipt of an application to the regional MA consultant. Do not refer questions from attorneys (or legal questions in general) to the Office of the Attorney General. These attorneys are responsible for providing legal advice to the regional MA consultant and are not authorized to give legal advice to the public.

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M0110.400 Retention of Case Information

A. Introduction

The agency must maintain case records that contain information necessary to support the facts essential to the determination of initial and continuing eligibility as well as any basis for discontinuing or denying assistance. The case record shall consist of a hard (i.e. paper) record, an electronic record, or a combination of the two. To be stored electronically in the individual's case record in the Virginia Case Management System (VaCMS), a document is scanned into VaCMS using the Document Management Imaging System (DMIS).

Records of active cases must be maintained for as long as the client receives benefits. Closed records must be maintained for a minimum of three years from the date of closure.

B. Policy

Case records must contain the following elements:

- the date of application,
- the date of and basis for the disposition of the application,
- facts essential to the determination of initial and continuing eligibility,
- the provision of medical assistance (i.e. enrollment),
- the basis for discontinuing medical assistance,
- the disposition of income and eligibility verification information, and
- the name of the agency representative taking action on the case and the date of the action.

The agency must include in each applicant's case record documentation to support the agency's decision *on his application and the fact that the agency gave recipients timely and adequate notice of proposed action to terminate, discontinue or suspend their eligibility or to reduce or discontinue services they may receive under the medical assistance programs.* Types of documentation that support the agency's decision include evaluations of eligibility, case narratives, and permanent verifications. Verifications of earned and unearned income, *documentation of reasonable compatibility* and the current value of resources *(if applicable*) must be maintained in the record. Notes by the eligibility worker that the verifications were viewed are not sufficient; *income reasonable compatibility and electronic verification of income should be documented in case comments.*

The case record must contain a duplicate, either electronically or in writing, of all notices sent to the client. Copies of the documents used for verification of citizenship and identity, such as birth certificates, must also be maintained within the case record.

Active cases may be purged with the exception of documentation that supports the information shown in the paragraphs above. Agencies may wish to retain other information used in future eligibility determinations, such as resource assessments and burial contracts. Closed cases are required to be retained by the agency for a period of no less than three years from the date of closure.

The case record shall be organized as to enable audit and program integrity entities to properly discharge their respective responsibilities for reviewing the manner in which the MA programs are being administered.



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M0110.500 VIRGINIA DSS STRENGTHENING FAMILIES INITIATIVE PRACTICE MODEL

A. Introduction

The Virginia DSS Strengthening Families Initiative (SFI) Practice Model sets forth standards of professional practice and serves as a values framework to define relationships, guide thinking and decision-making, and structure beliefs about individuals, families, and communities. The Practice Model suggests a desired approach to working with and delivering services to Virginia's citizens.

B. Practice Model Principles

The principles of the Practice Model are:

1. All children, adults and communities deserve to be safe and stable.
2. All individuals deserve a safe, stable and healthy family that supports them through their lifespan.
3. Self-sufficiency and personal accountability are essential for individual and family well-being.
4. All individuals know themselves best and should be treated with dignity and respect.
5. When partnering with others to support individual and family success, we use an integrated service approach.
6. How we do our work has a direct impact on the well-being of the individuals, families, and communities we serve.

M0110, Appendix 1 contains the full SFI Practice Model.

C. Policy

Medicaid and other benefit programs are designed to provide supportive benefits to assist families who are unable to provide the necessities of life and maintain minimum standards of health and well-being through their own efforts. Gathering relevant information about a family's situation and evaluating that information against the eligibility criteria for the benefit programs are the basis for making the eligibility determinations.

The process of gathering relevant information also includes an assessment of need for service programs and other resources to assist the family. This process includes following the Practice Model described above. If other needs exist, the eligibility worker must refer the family for appropriate services or resources within the agency or community. Eligibility workers may consult with their supervisors and other agency staff as necessary to gather information to facilitate making such referrals.

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VIRGINIA DEPARTMENT OF SOCIAL SERVICES

Virginia Department of Social Services
Strengthening Families Initiative Practice Model

The Virginia Department of Social Services Practice Model sets forth our standards of professional practice and serves as a values framework that defines relationships, guides thinking and decision-making and structures our beliefs about individuals, families and communities. We approach our work every day based on various personal and professional experiences. While our experiences impact the choices we make, our Practice Model suggest s a desired approach to working with others and provides a clear model of practice, inclusive of all agency programs and services, that outlines how our system successfully practices. Central to our practice is the family. Guided by this model, we strive to continuously improve the ways in which we deliver programs and services to Virginia's citizens.

1. All children, adults and communities deserve to be safe and stable.

- Every child has the right to live in a safe home, attend a safe school and live in a safe community. Ensuring safety requires a collaborative effort among family, agency staff, and community partners and across all programs and services.
- Every adult has the right to live and work in a safe environment. We value all programs that address domestic and family violence and the abuse, neglect and exploitation of older or incapacitated adults.
- We value individual and family strengths, perspectives, goals and plans as central to creating and maintaining a safe environment. The meaningful engagement and participation of children, adults, extended fa mily and community stakeholders is a necessary component of assuring safety.
- When legal action is necessary to ensure the safety of a child and/or an adult, we use our authority with respect and sensitivity.
- Individuals are best served when services are person-centered, family-focused and community-based and aim to preserve the family unit and prevent family disruption.

2. All individuals deserve a safe, stable and healthy family that supports them through their lifespan.

- We believe mothers, fathers, and children thrive in safe, stable, healthy families. We value family structures that support the best interests of children; however, we believe that children do best when raised in intact, two-parent families.
- Both parents should be actively involved in the lives of their children, even if they are not the primary caregiver.

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- Healthy, lifelong family connections are crucial to the development of children, the stability of the family and the support of infirm, dependent or aging adults. Through the services we provide, we seek out, promote and preserve these healthy ties to family members and to others in the community to whom the family is connected or who may provide support.

3. Self-sufficiency and personal accountability are essential for individual and family well-being.

- Family members support each other in ways the social services system cannot. We value the intra-family resources and supports that are available within the context of any family as a pathway to self-sufficiency and personal accountability.

- We believe employment, training and education are keys to self-sufficiency. We believe in employment and training programs that remove barriers and create opportunities for individuals and families.

- Individuals and families face unique challenges that impact their ability to maintain self-sufficiency. We value all programs and services that assist individuals and families to regain and maintain self-sufficiency and achieve personal accountability.

- Both custodial and noncustodial parents should provide necessary financial resources to support their children.

- We believe that parents and caregivers serve as role models in teaching the importance of self-sufficiency and personal accountability.

- We support asset development strategies to help individuals and families weather short-term emergencies and improve long-term stability.

4. All individuals know themselves best and should be treated with dignity and respect.

- All programs and services should be culturally and linguistically sensitive to all individuals.

- Individuals and families are empowered when they have access to information and resources.

- We support programs for vulnerable populations including children, the elderly and individuals with disabilities.

- The measure of success differs with every individual. We strive to understand children, adults, and families wit hin the context of their own values, traditions, history and culture.

- The voices of children, individuals and families are heard, valued and included in decision-making processes related to programs and services.

5. When partnering with others to support individual and family success, we use an integrated service approach.

- Cooperation, coordination and collaboration within and outside of the social services system are essential to providing the most comprehensive services to families. We are committed to working across programs, divisions, agencies, stakeholder groups and communities to improve outcomes for the childre n, individuals, families and communities we serve.



- Through the development of policies, procedures, standards and agreements across systems, we will share infor mation, solve problems and overcome barriers.

- We value prevention networks that link effective public and private programs and community-based organizations that identify individuals and families before they need services.

- We believe in partnering across programs and systems in order to provide a full array of services along the continuum of care. We are committed to working within and outside of the social services system to identify and address service gaps.

6. How we do our work has a direct impact on the well-being of the individuals, families and communities we serve.

- Children, individuals and families deserve trained, skillful professionals to engage and assist them. We hire, de velop and maintain a workforce that aligns with our practice model.

- Clear expectations, effective supervision, leadership and proper resource supports are critical for the workforce to do their job effectively.

- We believe in creating and maintaining a supportive working and learning environment with accountability at all levels.

- We value the provision of high-quality, timely, efficient and effective services. We believe relationships and communication should be conducted with honesty, transparency, integrity, empathy and respect within and outside of our social services system.

- The collection and sharing of accurate, outcome-driven data and evidence-based information is a critical part of how we continually learn and improve. We use data to inform, manage, improve practice, measure effectiveness and guide decisions.

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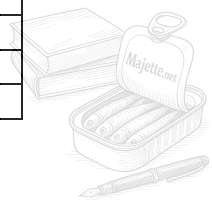
CHAPTER M01
APPLICATION *FOR* MEDICAL *ASSISTANCE*
SUBCHAPTER 20

MEDICAL ASSISTANCE *APPLICATION*

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M0120 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Page 17
TN #DMAS-36	10/1/25	M0120.100
TN #DMAS-35	7/1/25	Pages 2 and 5
TN #DMAS-30	1/1/24	Page 17
TN #DMAS-25	10/1/22	Page 7
TN #DMAS-23	4/1/22	Pages 9, 10, 16, 17, 19
TN #DMAS-18	1/1/21	Pages 11, 17 Page 12 is a runover page. Page 12a was added as a runover page.
TN #DMAS-17	7/1/20	Pages 2, 2a, 5, 7, 8, 13, 16 Page 6 is a runover page. Page 14 was removed. Pages 15-20 were renumbered.
TN #DMAS-14	10/1/2019	Pages 7, 10, 11, 18 Page 20a was deleted.
TN #DMAS-12	4/1/19	Pages 2, 12-13,15, 20a
TN #DMAS-10	10/1/18	Pages 2, 4, 15, 17-20 Page 20a was added as a runover page.
TN #DMAS-8	4/1/18	Page 12
TN #DMAS-6	10/1/17	Page 1
TN #DMAS-5	7/1/17	Page 2a
TN #DMAS-4	4/1/17	Pages 2a, 7, 10, 13
TN #DMAS-3	1/1/17	Page 15
TN #DMAS-2	9/1/16	Pages 2, 15 Page 2a is a runover page.
TN #DMAS-1	6/1/16	Pages 7, 10, 11, 16-20
TN #100	5/1/15	Table of Contents Pages 1, 2, 15, 20 Page 2a and 16 are runover pages.
UP #10	5/1/14	Table of Contents Pages 11, 16-18 Pages 11a and 11b were deleted. Pages 19 and 20 were added.
TN #99	1/1/14	Page 11 Pages 11a and b were added.
TN #98	10/1/13	Table of Contents Pages 1-17
UP #9	4/1/13	Page 13, 15, 16
UP #7	7/1/12	Pages 1, 10-12
TN #96	10/1/11	Table of Contents Pages 6-18
TN #95	3/1/11	Pages 1, 8, 8a, 14
TN #94	9/1/10	Pages 8, 8a
TN #93	1/1/10	Pages 1, 7, 9-16
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Appendices

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M0120.000 Medical Assistance Application

M0120.100 Applying for Medical Assistance

A. Right to Apply

An individual cannot be refused the right to complete an application for medical assistance (MA) for himself (the applicant) or any other individual for whom he is authorized to apply. Under no circumstances can an individual be discouraged from asking for assistance for themselves or any person for whom they are a legally responsible or authorized to represent. An applicant may be assisted with the application by an individual of their choice. A face-to-face *or telephone* interview is not required *but may be requested by the applicant or benefits worker*.

B. Signed Application Required

An application for MA must be signed to be valid. Paper forms must bear the *written (not typed)* signature of the applicant or an individual authorized to apply on *their* behalf. Applications submitted electronically or through the approved telephonic process *at Cover Virginia, the Enterprise Call Center or the Virginia Insurance Marketplace* meet the signature requirement.

1. Unsigned Application

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

2. Invalid Signature

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

If an electronic application does not bear a valid signature, the agency must obtain a valid signature from the applicant or his authorized representative for the case record. The signature page of a paper application form can be used.

M0120.150 When An Application Is Required

A. New Application Required

A new application is required when there is:

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

When an application is received because there is a new person in the family for whom medical assistance is requested, the annual renewal for the existing enrollees is done using the same application form. See subchapter M1520 for renewal policy and procedures.

B. Application NOT Required

A new application is not required when an individual is already an active Medicaid enrollee or is enrolled in another medical assistance program. An application is not needed for a child turning age one when the child was deemed to be eligible based on the mother's enrollment at the time of birth. A renewal following the procedures in M1520 must be completed when the child turns one. Act on the enrollment of a deemed newborn *within seven days* when the birth is reported to the local DSS office or to DMAS.

Changes in the enrollee's circumstances do not require a new application. Changes that do not require a new application include, but are not limited to,



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

A change in living arrangements may require a partial review of the individual's eligibility when the change results in a change to the assistance unit. Whenever the change requires verifications that can be used to complete a renewal, the annual renewal should be completed at the time the change is reported.

M0120.200 Who Can Sign the Application

A. Incarcerated Individuals

Offenders of any age who are being held in Department of Corrections (DOC) or Department of Juvenile Justice (DJJ) facilities may have applications submitted with the assistance of DOC or DJJ staff. *DJJ staff may sign the application and act as Authorized Representatives for individuals under age 18.*

Offenders of local and regional jails may submit applications for themselves, authorize facility staff to assist, or designate an authorized representative to assist in applying.

For new applications, send all notices and correspondence to the mailing address listed on the application (normally the facility address). For re-entry and pre-release applications, send all notices and correspondence to the post-release mailing address of the individual.

B. Applicants Age 18 or Older

The applicant must sign the application, even if the form is filled out by another person, unless the application is filed and signed by the applicant's legal guardian, conservator (known as the “committee” for persons declared incompetent prior to the 1997 changes in the guardianship section of the Code of Virginia), attorney in fact, or authorized representative. A spouse, aged 18 or older, may sign the application for his spouse when they are living together.

EXCEPTION: A parent can submit and sign an application for a child under age 21, when the child is living with the parent. The child does not need to authorize the parent to apply or conduct Medicaid business on his behalf.

If the applicant cannot sign his or her name on a paper application but can make a mark, the mark must be correctly designated (the individual's first and last name and the words "his mark" or "her mark" must be printed adjacent to the mark) and witnessed by one person as in the example below:

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

Witness's signature:_____

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Virginia Medical Assistance Eligibility	**M01**	**July 2020**
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M0120 MEDICAL ASSISTANCE APPLICATION	**M0120.200**	**2a**

1. Authorized Representative

An authorized representative is a person age 18 years or older who is authorized to conduct business for an individual. A competent individual age 18 years or older must designate the authorized representative in a written statement (which defines the representative's responsibilities). The individual may change or his authorized representative at any time by submitting a new authorized representative statement.

The authorized representative statement is valid while the application is being processed and for as long as the individual is covered, as well as during an appeal related to the denial, reduction of or cancellation of the individual's coverage.

An individual who reapplies after a period of non-coverage must sign another authorized representative statement to designate an authorized representative.

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

2. Family Substitute Representative

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

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

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3. No Individual authorized to sign

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

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

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

   If the verification is provided within the 10 day period, continue to pend the application until the guardian or conservator is appointed. If the application pends for 45 days, send written notice to the applicant to extend the pending application.

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

c. If guardianship/conservator procedures have not begun or have not been verified as being on the court docket, refer the applicant to Adult Protective Services (APS) in the local agency.

   If the report to APS meets all criteria for a valid report, an investigation will be conducted to learn whether protective services are needed and, if so, what services are needed. The protective services identified will be provided or arranged by APS.

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

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

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3. Procedure for Who Can Sign the Application

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

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

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

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

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

NO: Has the applicant signed a written statement authorizing a person (or staff of an organization) to apply for *MA* on his behalf? (*Note: a completed authorized representative section on a telephonic application is acceptable)*

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

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

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

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

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

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

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

C. Applicants Under Age 18

1. Child Applicant

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

- his parent (custodial or non-custodial)
- legal guardian,
- authorized representative *(including Department of Juvenile Justice staff for individuals under 18)*, or
- an adult related by blood or marriage with whom the child lives (documentation of the relationship is not required).

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

a. No Guardian or Legal Custody

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

b. Action Is Initiated To Appoint Guardian/Award Custody

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

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

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

If the court refuses to appoint a guardian or custodian and there is no adult who is legally able to sign an application for the child, deny the application as invalid.

c. Action Not Initiated – Refer to Child Welfare Services

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

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

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

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

2. Non-custodial Parent Applying for Child

Eligibility for a child is based on the income of the parent with whom the child lives. If a non-custodial parent applies for his child, he must give written permission for the eligibility worker to contact the custodial parent. The eligibility worker must obtain the custodial parent's income information, written permission to verify income using available online data sources, and other information necessary to verify and calculate countable income, including Social Security Number and residence address. If either the non-custodial parent or the custodial parent fail to give the necessary permission, the child's eligibility cannot be determined using the application filed by the non-custodial parent.

3. Minor Parent Applying for Child

Parent*(s)* under age 18 years may apply for MA for *their* own child because *they are* the parent of the child. *An undocumented minor can apply for FAMIS Prenatal Coverage since the coverage is considered to be for the unborn child. If the individual is eligible, the parent can then be enrolled for the duration of the pregnancy and the 60 day postpartum period. Any future applications filed for the minor prior to turning age 18 would need to be signed by someone who is legally authorized to sign on the individual's behalf.*

***4.* Foster Care Child**

a. IV-E

The Title IV-E Foster Care & Medicaid Application form, available at https://fusion.dss.virginia.gov/Portals/%5Bdfs%5D/Files/Copy%20of%20032-03-0636-06-eng.xlsx, is used for the IV-E Foster Care eligibility determination. A separate MA application is **not** required for a child who has been determined eligible for Title IV-E Foster Care. However, if there is a non-custodial agreement for the IV-E eligible child, the parent or legal guardian must sign an MA application for the child.

b. Non-IV-E

The Cover Virginia Application for Health Coverage & Help Paying Costs is used for the MA eligibility determination of a **non-IV-E** Foster Care child. Applications for non-IV-E Foster Care children may also be filed online. The MA application for a non-IV-E child who is in foster care must be signed by an authorized employee of the public or private agency that has custody of the child. Exception: If the child has been placed with and is living with a parent or care-taker relative, the parent or care-taker relative can sign the application.

If there is a non-custodial agreement, an MA application form must be filed and the parent or legal guardian must sign the application.



***5.* Adoption Assistance & Special Medical Needs Children**

a. IV-E

A separate MA application is not required for a child who has been determined eligible for Title IV-E Adoption Assistance, regardless of which state has the adoption assistance agreement with the adoptive parents. IV-E Adoption Assistance children who have been placed for adoption through the Interstate Compact for Adoption and Medical Assistance (ICAMA) should have an ICAMA form 6.01 which verifies their Title IV-E eligibility for Medicaid. The ICAMA form 6.01 serves as the MA application form.

b. Non-IV-E

Non-IV-E Adoption Assistance children include Non-IV-E Special Medical Needs children.

1) Placed by a Virginia agency

An MA application is required for all non-IV-E Adoption Assistance and Non-IV-E Special Medical Needs children whose parents have adoption assistance agreements with a Virginia public or private child-placing agency. The child's adoptive parent signs and files the application for the child.

2) Placed by another state

Non-IV-E Adoption Assistance children who have been placed for adoption through the Interstate Compact for Adoption and Medical Assistance (ICAMA) should have an ICAMA form 6.01 which verifies their adoption assistance status (IV-E or non-IV-E). The ICAMA form 6.01 serves as the MA application form and a separate application is not required when:

- the other state is an ICAMA member state, and
- the ICAMA member state **reciprocates** Medicaid coverage of Virginia Non-Title IV-E Adoption Assistance children.

All states and territories EXCEPT Vermont, Wyoming, Puerto Rico and Virgin Islands are members or associate members of ICAMA. A list of the ICAMA member states and whether they reciprocate Medicaid coverage for Non-IV-E Adoption Assistance children is in M0120, Appendix 3.

An MA application must be filed for Non-IV-E Adoption Assistance children from non-member states and ICAMA member or associate member states which do NOT reciprocate. The child's adoptive parent signs and files the MA application for the child.

D. Deceased Applicant

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

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

If the above conditions were met, an application may be made by any of the following:

- his guardian or conservator,
- attorney-in-fact,
- executor or administrator of his estate
- his surviving spouse, or
- his surviving family member, in this order of preference: adult child, parent, adult brother or sister, adult niece or nephew, or aunt or uncle.

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

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

Retroactive FAMIS coverage is available ONLY to an eligible child who was born within the 3 months prior to the FAMIS application month.

E. Enrollee Turns 18

When a child who is enrolled in MA Medicaid turns 18, it is not necessary to obtain a new application signed by the enrollee.

As long as the enrollee is under age 21, he does not need to authorize a parent with whom he lives for the parent to continue to conduct the enrollee's MA business.

M0120.300 Medical Assistance Application Forms

A. General Principle – Application Required

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

- IV-E Foster Care/Adoption Assistance children
- Auxiliary Grant (AG) applicants
- Newborn children under age 1 born *to women eligible for* Medicaid, FAMIS*, FAMIS MOMS, or FAMIS Prenatal Coverage.*

1. **Title IV-E Foster Care & Medicaid Application**

The Title IV-E Foster Care & Medicaid Application, available at https://fusion.dss.virginia.gov/Portals/%5Bdfs%5D/Files/Copy%20of%20032-03-0636-06-eng.xlsx, is used for foster care or adoption assistance children who are eligible under Title IV-E of the Social Security Act. If the child requires a resource evaluation for a medically needy spenddown, Appendix E can be used to collect the information. The Appendix must be signed by the applicant's guardian.

For a IV-E FC child whose custody is held by an LDSS or a private FC agency, or for a IV-E adoption assistance (AA) child, the Title IV-E Foster Care & Medicaid Application is used to determine if the child meets Medicaid IV-E eligibility requirements. This form is also used to determine Medicaid eligibility for IV-E AA children. This form is **not** used for children in non-custodial agreement cases or non-IV-E FC or AA.

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

For non-IV-E FC children, a separate Medicaid application must be submitted by either the custodial agency or a parent or caretaker relative with whom the child has been placed. When a child enters care through a non-custodial agreement, or when a child is a non-IV-E AA child, a separate Medicaid application must be submitted by the parent or guardian.

2. **Auxiliary Grant (AG)**

An application for AG is also an application for Medicaid. A separate MA application is not required.

3. **Exception for Certain Newborns**

A child born to a mother who was eligible for Medicaid, FAMIS, *FAMIS MOMS, or FAMIS Prenatal Coverage* at the time of the child's birth (including a child born to an emergency-services-only alien mother) is deemed to have applied and been found eligible for Medicaid on the date of the child's birth (see M0320.301). An application for the child is not required. The child's coverage is subject to renewal when he turns 1 year old.

If the child was born to a mother who was covered by Medicaid or the Children's Health Insurance Program outside Virginia at the time of the child's birth, verification of the mother's coverage must be provided or else an application must be filed for the child's eligibility to be determined in another covered group.

4. Forms that Protect the Application Date

a. Low Income Subsidy (LIS) Medicaid Application

The Medicare Patient and Provider Improvement Act (MIPPA) requires LIS application data submitted by the Social Security Administration (SSA) to states to be treated as an application for Medicaid, if the LIS applicant agrees. LIS application data is sent to LDSS via the SSA Referral Inbox in VaCMS. The LDSS must generate an LIS Medicaid application and cover sheet and mail them to the individual. The individual must return the application or apply for Medicaid online or by telephone in order for his Medicaid eligibility to be determined. If the individual submits the application, the date of LIS application with the SSA is treated as the date of the Medicaid application.

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b. Model Application for Medicare Premium Assistance Form

The Model Application for Medicare Premium Assistance Form was developed by the federal Centers for Medicare & Medicaid Services (CMS) that states can choose to use for the Medicare Savings Program applicants. The model application is **NOT** a prescribed Virginia Medicaid application form at this time.

Should a local department of social services (LDSS) receive a model application form, the agency is to send a valid Virginia MA application to the applicant with a request that it be completed, signed, and returned to the agency within 30 calendar days. The date of application on the model Application for Medicare Premium Assistance is to be preserved as the application date for purposes of Medicaid entitlement.

The processing time for the LDSS begins when the agency receives the Virginia application form back from the applicant. If the Virginia application form is not returned within 30 days, no further action is necessary on that application. The agency does not send a Notice of Action because no Virginia application was received. The model application date is not preserved beyond 30 calendar days. Should the person later submit a valid Virginia application, the date the Virginia application is received by the LDSS is the application date.

The model application form may be viewed on the SSA web site at: https://www.ssa.gov/forms/ssa-1020b-ocr-sm-inst.pdf.

B. Application Forms

Medical assistance must be requested using an application method or form approved by the Departments of Medical Assistance Services (DMAS) and Social Services (VDSS). Applications may be made electronically through CommonHelp or the Health Insurance Marketplace.

Applications may also be made telephonically through the Cover Virginia Call Center or with a paper application form.

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

1. Streamlined Applications

The following forms are used to apply for affordable health insurance, including qualified health plans with the Advance Premium Tax Credit (APTC), through the Health Insurance Marketplace or the local DSS:

- the Cover Virginia Application for Health Coverage & Help Paying Costs and all applicable appendices:
  - Appendix D, for applications submitted for aged, blind or disabled *(ABD)* applicants and ABD applicants who are requesting *long-term services and supports (LTSS)*
  - Appendix E, when a Families and Children (F&C) Medically Needy determination is requested
  - *Appendix F, for applicants in need of LTSS who are between the ages of 19 and 64 years and who are not eligible for or enrolled in Medicare;*

- the federal Application for Health Coverage & Help Paying Costs for multiple individuals and all applicable appendices; and

- the federal Application for Health Coverage & Help Paying Costs (Short Form) for individuals and all applicable appendices.

2. BCCPTA Medicaid Application

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

3. Replaced Application Forms

The following forms were replaced by the streamlined application forms effective October 1, 2013. While agencies should accept and process any of these forms if they are submitted, additional information, such as tax filing information, may need to be obtained (see M0120.300 B.4 below).

- Application for Benefits (#032-03-824)
- The Application/Redetermination for Medicaid for SSI Recipients (#032-03-091)
- The Medicaid Application/Redetermination for Medically Indigent Pregnant Women (#032-03-040)
- The Health Insurance for Children and Pregnant Women (#FAMIS-1)
- The Application for Adult Medical Assistance form (#032-03-0222)
- The Plan First Application (#DMAS-65E)

4. Renewal Forms Returned After Reconsideration Period

Renewal forms filed after the end of the 90-day reconsideration period are treated as reapplications. Accept the form and request any additional information needed to determine the individual's eligibility. See M1520.200 C for additional information.

5. If Additional Information is Required

Applicants may apply for MA on any valid application form. Regardless of which application form is used, if additional information is required to determine an applicant's eligibility, send the applicant the relevant page(s) of the Cover Virginia Application for Health Coverage & Help Paying Costs, and/or Appendices D or E, as appropriate, along with a checklist asking for the information. Give the applicant at least 10 business days to return the information and any required verifications to the agency.

M0120.400 Place of Application

A. Principle

The place of application may be the office of the local social services department serving the locality in which the applicant resides. Verification of locality residence is not required. MA applications are also accepted online, telephonically through Cover Virginia, or at designated hospitals and health clinics (Medicaid outstationed sites). If an applicant is homebound and needs assistance with completing the application, the agency, upon request, must arrange to have the application taken where he resides or is a patient.

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1. **Locality of Residence** Medical assistance applications that are approved are sent to the LDSS in the applicant's locality of residence or where the individual last lived outside of an institution.

2. **Joint Custody Situations** A child whose residence is divided between two custodial parents living in different localities is considered to reside in the locality in which he attends school. If the child is not enrolled in school, the parents must decide which locality is the child's residence for application/ enrollment purposes.

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B. Foster Care, Adoption Assistance, Department of Juvenile Justice

1. Foster Care

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

a. Title IV-E Foster Care

Children in the custody of a Virginia LDSS or private foster care agency who receive Title IV-E maintenance payments apply at the agency that holds custody. Title IV-E foster care children in the custody of another state's social services agency apply in the Virginia locality where they reside.

b. State/Local Foster Care

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

Children in the custody of another state's social services agency who have been placed with and are living with a parent or caretaker-relative apply at the LDSS where the child is residing. (see M0230).

2. Adoption Assistance

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

Children receiving adoption assistance through another state's social services agency apply at the LDSS where the child is residing.

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

When a child is in the custody of the Virginia Department of Juvenile Justice (DJJ) or is the responsibility of a court (corrections children), responsibility for processing the application and determining eligibility will be handled either centrally or by the LDSS in the locality in Virginia in which he last resided prior to going into the DJJ system. For a new applicant use the physical address where the person is located. For pre-release and re-entry individuals, use the address where the person will reside after release (post-release).

C. Institutionalized Individual (Not Incarcerated)

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

Exception: If the applicant is applying for or receives SNAP, responsibility for processing the MA application and determining MA eligibility rests with the LDSS in the locality in which the institution where he is receiving care is located.

If the individual did not reside in Virginia prior to entering an institution, responsibility for processing the application and determining eligibility rests with the LDSS in the locality in which the institution where he is receiving care is located.

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D. **Individuals In Virginia Veteran's Care Center**

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

E. **Incarcerated Individuals and DJJ Supervisees**

Inmates of state (DOC), regional and local correctional facilities, and individuals under the age of 21 under the supervision of DJJ (placed in a facility or receiving services from any court services unit or DJJ contractor) may apply for Medicaid. Responsibility for processing the application and determining eligibility will be handled through a centralized process or by the local department of social services (DSS) in the locality where the individual was living prior to incarceration or DJJ/court custody. Applications are not to be refused because an applicant is an inmate of a public institution at the time of application.

If the individual did not reside in Virginia prior to becoming incarcerated or committed to DJJ, responsibility for processing the application and determining eligibility will be handled through a centralized process or by DSS in the locality in which correctional facility is located.

The physical address on the application should be the address where the individual is currently placed.

The mailing address will be the facility address where the individual is currently placed. For pre-release or re-entry individuals, use the address the person provides where they will be located after release. If the individual was homeless prior to being incarcerated, use the physical address of the local DSS or an address the person provides.

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M0120.500 Receipt of Application

A. General Principle

An applicant or authorized representative may submit an application for medical assistance only or may apply for MA in addition to other programs.

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

B. Application Date

The application date is the earliest date the signed application for medical assistance is received by the local agency, an out-stationed site, or an entity contracted with DMAS to accept applications. The application must be on a form prescribed by DMAS and signed by the applicant or person acting on his behalf.

The application may be received by mail, fax, hand delivery, electronically or telephonically. The date of receipt by the agency must be recorded. If an application is received after the agency's business hours, the date of the application is the next business day. Exception: For CommonHelp applications, if the application is received after business hours and the next business day is in the following month, the date of the application is the actual date it was submitted.

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

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

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C. Hospital Presumptive Eligibility

The Affordable Care Act required states to allow approved hospitals to enroll patients who meet certain Families & Children covered groups in Medicaid for a limited time on the basis of their presumptive eligibility. The Department of Medical Assistance Services (DMAS) is responsible for coordinating the HPE Agreement with approved hospitals, providing training and technical assistance, and monitoring the appropriate use of the HPE enrollments. HPE is not available to individuals who are already actively enrolled in Medicaid or FAMIS. Local eligibility staff do not determine eligibility for HPE.

1. HPE Determination and Enrollment

To provide an individual HPE coverage, the hospital staff obtains basic demographic information about the individual, as well as the attestations from the individual regarding Virginia residency (including locality), U.S. citizenship or lawful presence, Social Security number, household size and income, and requirements related to a covered group. As the information is self attested, no verifications or additional proof is required.

Hospital staff determines eligibility and enters the approved individual's data into the HPE webpage located in the provider portal in the *Medicaid Enterprise System (MES—formerly the* Medicaid Management Information System [MMIS]). This information is electronically transferred to the Cover Virginia Central Processing Unit (CPU) which is responsible for enrolling the individual in the appropriate aid category (AC) in MMIS. The HPE enrollment **is not** entered in the Virginia Case Management System (VaCMS). HPE recipients are not entered into a managed care organization (MCO).

The hospital is responsible for providing immediate notification to the individual of his HPE coverage. They will request that he file a full MA application by the end of the following month so that continued eligibility for Medicaid can be evaluated without an interruption in coverage.

The HPE covered groups and the ACs are:

- Pregnant Women (AC 035)
- Child Under Age 19 (AC 064)
- Low Income Families with Children (LIFC) (AC 065)
- Former Foster Care Children Under Age 26 (AC 077)
- Breast & Cervical Cancer Prevention & Treatment Act (BCCPTA) (AC 067)
- Plan First (AC 084)
- MAGI Adults (AC 106) (effective January 1, 2019)

Individuals enrolled on the basis of HPE receive a closed period of coverage beginning with the date of the HPE determination through the last day of the following month or the date MA eligibility is determined, whichever comes first. Enrollment in HPE is not based on the date of the hospital admission nor the first day of the month.

While enrolled as HPE, individuals in the Child Under Age 19 years, LIFC, Former Foster Care Children Under Age 26, BCCPTA, and MAGI Adults covered groups receive full Medicaid benefits. HPE pregnant women coverage



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(AC 035) is limited to outpatient prenatal services; labor and delivery are not covered under HPE for AC 035. HPE coverage for Plan First enrollees AC084 is limited to family planning services only. Transportation to receive covered medical services is covered for all HPE enrollees.

Enrollment as HPE is limited to one HPE period per calendar year for all individuals other than pregnant women. For pregnant women, enrollment is limited to one HPE eligibility period per pregnancy. Children's 12 month continuous eligibility does not apply to children enrolled as HPE.

There are no appeal rights for an HPE determination.

2. Eligibility Procedures – Post HPE Enrollment

a) MA Application Not Submitted

If the person does not submit an MA application prior to the end of the HPE coverage period, no further worker action or additional notice not required because the enrollment was for a closed period of coverage.

b) MA Application Submitted

For MA coverage to continue beyond the initial HPE coverage period, the individual must submit a full MA application. MA applications submitted by HPE enrollees are subject to the standard eligibility and entitlement policies. The 7-calendar day processing standard applies to MA applications submitted by pregnant women. The 10-work day requirement applies to applications submitted by BCCPTA individuals enrolled in HPE.

While the LDSS does not determine eligibility for HPE, if an MA application is received and pended in VaCMS, the individual's coverage in the HPE AC may need to be extended or reinstated (if HPE coverage will end during the application processing period) while the application is processed. If HPE coverage needs to be extended/reinstated, alert a VDSS Regional Consultant or *submit a* Coverage Correction Request *through the Coverage Correction Portal (CCP) on the MES website.*, *Home | MES*. *To access the CCP and User Guides, LDSS, VDSS, CoverVA, and DMAS staff must sign into the MES using their current credentials and then sign into the MMIS with their eCode. The enrollment mailbox has been disabled.*

Example 1: Mary Smith is enrolled in HPE coverage in AC 065 (LIFC) for the period of 3-5-18 through 4-30-18. On 4-20-18, she submits an MA application; however, the 45th processing day will fall after the HPE end date of 4-30-18. Therefore, the worker must have the HPE coverage reinstated in MES under the same aid category (AC 065), using the MA application date. The effective date of the reinstatement is 5-1-18, the day after the HPE coverage ends. Once the application has been processed. the worker must act to cancel the HPE coverage, and if the individual remains eligible reinstate coverage in the appropriate AC.

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c) Applicant Determined Eligible for MA Coverage

If the individual is determined eligible for MA coverage, coverage under the appropriate MA aid category will includes any day(s) to which he is entitled and not covered by HPE.

If the individual submits a MA application and it is approved in the **same month** HPE coverage began and HPE began the first day of the month, MA coverage begins the first day of that application month.

If the MA application is approved and HPE began on any day other than the first day of the month, the worker will enroll MA coverage beginning with the first day of the month and end on the day before the HPE begin date. Ongoing coverage will then begin the day after the HPE coverage ends. An exception to this process will be for an approved pregnant woman or Plan First application.

Example 2: Tony is an adult enrolled in HPE coverage (AC106) for the period of 9-6-18 through 10-31-18. He submits an MA application on 9-8-18 and is approved as a MAGI Adults AC103 on 9-28-18. He did not request retroactive coverage so the AC103 coverage will be for the period 9-1 thru 9-5 and ongoing AC103 coverage will begin on 11-1-18 (after the HPE coverage ended).

If an individual submits an MA application in the month a full-benefit HPE coverage is to end, and is determined eligible for ongoing MA coverage, the ongoing coverage is entered in the appropriate MA AC beginning the first day of the month after the effective date of the HPE coverage cancellation. An exception to this process will be for an approved pregnant woman application.

Example 3: Billy is a child enrolled in HPE coverage (AC 064) for the period of 2-14-18 through 3-31-18. His parent submits an MA application on 3-18-18 and there is no indication of any medical services in a retro period. Billy is determined eligible for Medicaid coverage in AC 092 on 3-26-18.

The Medicaid entitlement begins after the HPE coverage ends. The worker enrolls the child into AC 092 with ongoing coverage beginning 4-1-18.

d) Applicant Determined Eligible as Pregnant Woman (PW) or for Plan First

The HPE process for a pregnant woman (AC 035) or Plan First (AC 084) follows the same policy as other HPE categories. The exception is for enrollment if an MA application is submitted and approved for a pregnant woman (AC 091 or AC 005) or for Plan First. In those cases, coverage will begin on the first day of the month the MA application was received. Request that HPE coverage be cancelled retroactively. Reinstate in full coverage for the ongoing coverage.



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Example 4 : Jane was enrolled in HPE AC 035 (pregnant women) for the period of 4-13-18 through 5-30-18. She files an MA application on 4-28-18 and is approved for AC 091 coverage. Jane would have coverage as AC 091 for the period beginning 4-1-18. However, based on her expected delivery date found on the application, Jane was pregnant during the months prior to her HPE determination. The worker determines and approves retro coverage. The worker ensures Jane has coverage for AC 091 with a begin date of 1-1-18. In *MES*, this transaction would be a retro cancel reinstate using Cancel Reason 024.

e) Retroactive Coverage

An individual cannot receive retroactive HPE coverage.

An individual's eligibility for retroactive coverage for the three months prior to the month of the MA application is determined when the individual had a medical service within the three months prior to the month of the **full** MA application or when MA began. If the individual had full coverage while enrolled as HPE, only enroll him for the portion of the retroactive period that he was not enrolled as HPE.

f) Applicant Determined Not Eligible for ongoing MA coverage

If the applicant is determined to not be eligible for ongoing MA coverage, his entitlement to HPE coverage ends. Unless the HPE coverage was extended, no further action is required by the worker. If cancellation of HPE coverage is needed, request that the effective cancel date be the current date (i.e. day of the eligibility determination), using Cancel Reason 008.

Send a Notice of Action indicating that the individual's MA application was denied and that his HPE coverage was cancelled with the effective date. Because the individual receives notice of the HPE coverage period from the hospital at the time of the HPE enrollment, advance notice of the HPE cancellation is not required. There are no appeal rights for HPE.

The individual's HPE coverage is valid regardless of whether or not the individual is eligible for ongoing coverage; do not refer the case to the DMAS Recipient Audit Unit.

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Commonwealth of Virginia
Department of Social Services

NOTICE REGARDING MEDICAID APPLICATION REQUIREMENTS

A Medicaid application has been filed on the behalf of _____ (name of applicant). However, the application is not valid and cannot be processed because the application must be signed by one of the following persons:

- the parent of a person under age 18,
- the adult who is the legal guardian or has legal custody of a person under age 18,
- any adult related by blood or marriage with whom a person under age 18 lives,
- the person for whom Medicaid is requested if the person is over age 18 or an emancipated minor,
- the authorized representative for the person who is requesting assistance, who may be
  - any person to whom he/she has legally given power of attorney, or
  - any person who he/she has designated by a signed written statement to apply on his/her behalf for Medicaid or public benefits, or
- the guardian, conservator, or committee of a person over age 18 who has been judged legally incapacitated by a court of law.

Please return the signed application and the authorized representative statement (if needed) by _____ so that the application may be processed. Thank you.
(date)

_____ _____
Signature Date

_____
Title

_____
Agency Name

_____
Phone Number

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COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application

AGENCY USE ONLY

DATE RECEIVED:

CASE NAME/NUMBER:

LOCALITY: WORKER

Please complete all sections. If you need assistance, please contact an eligibility worker at your local Department of Social Services.

1. IDENTIFYING INFORMATION

LAST NAME: FIRST NAME: MI: SOCIAL SECURITY NUMBER:

ADDRESS: CITY: STATE: ZIP: STATE OF RESIDENCE:

MAILING ADDRESS (If different): CITY: STATE: ZIP: HOME PHONE #: DAYTIME PHONE #:

2. ADDITIONAL INFORMATION

RACE: ☐ WHITE ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ BLACK ☐ ASIAN/PACIFIC ISLANDER ☐ HISPANIC ☐ OTHER

MARITAL STATUS: ☐ NEVER MARRIED ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

DATE OF BIRTH: _____ PLACE OF BIRTH: _____

U. S. CITIZEN? YES ☐ NO ☐ IF NO, ALIEN NUMBER:

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

DO YOU HAVE HEALTH INSURANCE? YES ☐ NO ☐ IF YES, COMPANY NAME: _____

POLICY #: _____ EFFECTIVE DATE: _____ TYPE OF COVERAGE: _____

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

3. BCCPTA CERTIFICATION

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

SCREENING DATE: _____ DIAGNOSIS DATE: _____ FACILITY/SERVICE SITE: _____ PHONE #: _____

SIGNATURE OF BCCEDP CASE MANAGER : _____ DATE: _____

032-03-384/1

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YOUR RIGHTS AND RESPONSIBILITIES

By signing below, I agree to the following:
I have the right to:

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

I have the responsibility to:

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

I further understand and agree that:

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

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

_____ _____
Signature or Mark **Date**

_____ _____
Witness/Authorized Representative **Date**

VOTER REGISTRATION

Check one of the following:

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

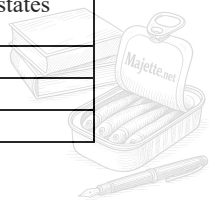
Applying to register or declining to register to vote will not affect the assistance or services that you will be provided by this agency. A decision not to apply to register to vote will remain confidential. A decision to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right in applying to register to vote, you may file a complaint with: Secretary of Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497. The phone number is (804) 786-6551.

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Interstate Compact on Adoption and Medical Assistance (ICAMA) Member States and Reciprocity

STATE	COBRA OPTION*	RECIPROCITY**	COMMENT
Alabama	Yes	Yes	Reciprocity with ICAMA member states only
Alaska	Yes	Yes	Reciprocity with all states
Arizona	Yes	Yes	Reciprocity with all states
Arkansas	Yes	Yes	Reciprocity with all states
California	Yes	Yes	Reciprocity with all states
Colorado	Yes	Yes	Reciprocity with all states
Connecticut	Yes	Yes	Reciprocity with ICAMA member states only
Delaware	Yes	Yes	Reciprocity with all states
District of Columbia	Yes	**No**	
Florida	Yes	Yes	Reciprocity with ICAMA member states only
Georgia	Yes	Yes	Reciprocity with all states
Hawaii	Yes	**No**	
Idaho	Yes	Yes	Reciprocity with all states
Illinois	Yes	**No**	
Indiana	Yes	Yes	Reciprocity with all states
Iowa	Yes	**No**	
Kansas	Yes	Yes	Reciprocity with all states
Kentucky	Yes	Yes	Reciprocity with ICAMA member states only
Louisiana	Yes	Yes	Reciprocity with all states
Maine	Yes	Yes	Reciprocity with all states
Maryland	Yes	Yes	Reciprocity with all states
Massachusetts	Yes	Yes	Reciprocity with all states
Michigan	Yes	Yes	Reciprocity with all states
Minnesota	Yes	Yes	Reciprocity with all states
Mississippi	Yes	Yes	Reciprocity with all states
Missouri	Yes	Yes	Reciprocity with all states
Montana	Yes	Yes	Reciprocity with ICAMA member states only
Nebraska	Yes	**No**	
Nevada	Yes	**No**	
New Hampshire	Yes	**No**	
New Jersey	Yes	Yes	Reciprocity with ICAMA member states only
New Mexico	No	**No**	
New York ***	Yes	**No**	
North Carolina	Yes	Yes	Reciprocity with ICAMA member states only
North Dakota	Yes	Yes	Reciprocity with ICAMA member states only
Ohio	Yes	Yes	Reciprocity with all states
Oklahoma	Yes	Yes	Reciprocity with all states
Oregon	Yes	Yes	Reciprocity with all states



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STATE	COBRA OPTION*	RECIPROCITY**	COMMENT
Pennsylvania	Yes	Yes	Reciprocity with all states
Rhode Island	Yes	Yes	Reciprocity with ICAMA member states only
South Carolina	Yes	Yes	Reciprocity with all states
South Dakota	Yes	Yes	Reciprocity with all states
Tennessee	Yes	Yes	Reciprocity with all states
Texas	Yes	Yes	Reciprocity with all states
Utah	Yes	Yes	Reciprocity with ICAMA member states only
Vermont			
Virginia	Yes	Yes	Reciprocity with ICAMA member states only
Washington	Yes	Yes	Reciprocity with all states
West Virginia	Yes	Yes	Reciprocity with all states
Wisconsin	Yes	Yes	Reciprocity with all states
Wyoming			

* *per COBRA 1985 law, the ICAMA member state's Medicaid program covers its own Non-IV-E (state-local) Adoption Assistance [AA] children).*

** *the ICAMA member state's Medicaid program covers Non-IV-E AA children who have adoption assistance agreements with another state and move to the state.*

**** ICAMA Associate Member State*
ICAMA Non-Member State (Vermont, Wyoming)

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CHAPTER M01
APPLICATION *FOR* MEDICAL *ASSISTANCE*
SUBCHAPTER 30

APPLICATION PROCESSING

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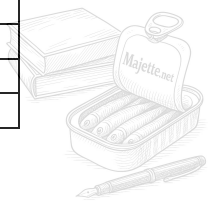
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Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Page 12
TN #DMAS-36	10/1/25	M0130.500
TN #DMAS-35	7/1/25	Pages 1, 9, 10 and 15
TN #DMAS-34	1/1/25	Page 9
TN #DMAS-33	10/1/24	TOC, Pages 1, 6, 6a, 12-14 Page 15 is added.
TN #DMAS-32	7/1/24	Pages 9 and 10
TN #DMAS-29	10/1/23	Page 12
TN #DMAS-27	4/1/23	Page 6a
TN #DMAS-25	10/1/22	Pages 9,10
TN #DMAS-23	4/1/22	Pages 5, 12
TN #DMAS-21	10/1/21	Page 14
TN #DMAS-20	7/1/21	Page 2 Page 2a is a runover page.
TN #DMAS-18	1/1/21	Pages 4, 8, 13

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TN #DMAS-17	7/1/20	Pages 2, 6, 10 Page 6a was added as a runover page.
TN #DMAS-15	1/1/20	Pages 9, 10
TN #DMAS-14	10/1/19	Pages 9, 10
TN #DMAS-11	1/1/19	Page 1
TN #DMAS-10	10/1/18	Table of Contents Pages 1, 2-2b, 9-12 Pages 2c-2e were added as runover pages.
TN #DMAS-9	7/1/18	Page 2b
TN #DMAS-8	4/1/18	Page 13
TN #DMAS-7	1/1/18	Pages 1, 9
TN #DMAS-5	7/1/17	Pages 1, 10
TN #DMAS-4	4/1/17	Page 6
TN #DMAS-3	1/1/17	Pages 5, 7, 11
TN #DMAS-2	10/1/16	Table of Contents Pages 2. 4, 5, 7-10, 12, 13 Page 2a is a runover page. Page 14 was added as a runover page.
TN #DMAS-1	6/1/16	Table of Contents Pages 4, 6, 10, 12 Page 11 is a runover page. Page 13 was added as a runover page.
TN #100	5/1/15	Pages 1, 2-2b, 5, 11 Pages 3, 6 and 2c are runover Pages.
UP #10	5/1/14	Table of Contents Pages 8-12 Page 13 was added.
TN #99	1/1/14	Pages 10-12 Page 13 was added.
TN #98	10/1/13	Table of Contents Pages 1-12
UP #9	4/1/13	Page 3, 5
UP #7	7/1/12	Pages 4, 5
TN #96	10/1/11	Pages 6-8
TN #95	3/1/11	Page 8
TN #94	9/1/10	Pages 2-6, 8
TN #93	1/1/10	Pages 4-6, 8
Update (UP) #2	8/24/09	Pages 8, 9



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M0130.001 Medical Assistance Application Processing Principles

A. Introduction

Under the Affordable Care Act (ACA), the Medicaid and FAMIS medical assistance (MA) programs are part of a continuum of health insurance options available to Virginia residents. MA application processing is based on several principles that are prescribed by the ACA.

B. Principles

1. Single Application

Applications for affordable health insurance, including qualified health plans with Advance Premium Tax Credit (APTC) assistance and MA, are made on a single, streamlined application. The application gathers information needed to determine eligibility for both APTC and MA.

2. No Wrong Door

Individuals may apply for MA through their local department of social services (LDSS), the Virginia Health Insurance Marketplace (VIM), at the CommonHelp website, or the Cover Virginia Call Center. Applications may be routed to either the LDSS or Cover Virginia for processing.

Effective 11/1/2018, applications made through the VIM that require MAGI eligibility determinations will have the eligibility determination made by the VIM. If an application is approved, the case will be routed to either the CPU or LDSS, where it should be accepted and enrolled without delay. ABD applications received by the VIM will be routed to the local agencies for processing.

3. Use of Electronic Data Source Verification

The eligibility determination process for MA is based on electronic data source verification (EDSV) to the fullest extent possible. The Federally-managed Data Services Hub (the Hub) provides verification of a number of elements related to eligibility for MA applications processed in the Virginia Case Management System (VaCMS). Data from on-line sources including the Virginia Employment Commission (VEC), the Work Number, *Asset Verification System (AVS) and the Virginia Department of Motor Vehicles (DMV)* are also acceptable for both initial applications and renewals. *Electronic sources should be automatically inquired prior to worker evaluation. Information available electronically is considered agency knowledge.*

Eligibility workers are to request information from the applicant or authorized representative(s) only when it is not available through an approved data source or the information is inconsistent with agency records.

Searches of online information systems, including but not limited to the Hub, State Online Query-Internet (SOLQ-I) and the State Verification Exchange System (SVES) are permitted **only** for applicants and family members whose income and/or resource information is required to determine eligibility for the applicant or patient pay for an enrollee. This includes spouses of applicants and parents of child applicants.

4. Processing Time

Agencies are required by the State Plan to adhere to prescribed standards for the processing of MA applications, including applications processed using the self-directed functionality in VaCMS. The amount of time allowed to process an application is based on the availability of required information and verifications, as well as the covered group under which the application must be evaluated.



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5. Delayed Verifications *If requested verifications or other information needed to process the case are delayed in the postal system due to no fault of the applicant's, accept the documentation, reopen the case if necessary, and complete application processing.*

M0130.100 Processing Time Standards

A. Processing Time Standards

1. Expedited Application Requirements

a. Pregnant Women

Applications for pregnant women must be processed within **seven (7) calendar days** of the agency's receipt of the signed application.

If the pregnant woman also applies for other children or other persons in her family and the agency cannot determine the other persons' eligibility within 7 calendar days, the agency must determine just the MA eligibility of the pregnant woman within the 7 calendar days.

The agency must have all necessary verifications within the 7 calendar days in order to determine eligibility. If the agency does not receive the verifications within the 7 calendar days, the worker must send the applicant written notice on the 7th day. The notice must state why action on the application was not taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 days by which to submit the documentation.

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

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

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

BCCPTA Medicaid applications filed by individuals who do not meet the description of an individual in the Low-income Families with Children (LIFC), Medicaid pregnant women, or SSI recipients covered groups must be processed within 10 working days of the agency's receipt of the signed application.

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BCCPTA Medicaid applications filed by individuals who meet the description of an individual in the LIFC, pregnant women, or the SSI recipients covered groups must be processed as soon as possible, but no later than 45 days of the agency's receipt of the signed application.

If the BCCPTA Medicaid application is the only application required and no additional information is required, the eligibility decision must be made immediately and the applicant must be notified of the decision within 10 working days of the agency's receipt of the application.

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

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

2. 45/90 Day Requirement

Applications for which information in addition to that provided on the application is required, including requests for retroactive coverage, must be processed within 45 calendar days for all applicants other than pregnant women, women in the BCCPTA covered group, or individuals needing a disability determination.

For individuals who require a disability determination to meet the covered group requirement, the time standard for processing an application is 90 calendar days. Other non-financial requirements, however, must be met and verified by the 45th calendar day, or the application must be denied and DDS must be notified to stop action on the disability determination (see M0310.112 *G.3*).

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

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

3. Early Denial Before Deadline Date

When the 45-day processing deadline date falls on a weekend or a holiday, the LDSS may deny an individual's application on the last business day before the deadline date if all necessary verifications have not been received. If the early denial action is taken, however, the LDSS must re-open the application if the individual provides the necessary information on or before the 45th day deadline.

If the individual's application is re-opened and he is determined eligible, the LDSS must enroll the individual and send a notice to the individual notifying him of the approval and the begin date of coverage.

4. Processing Priority

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

5. Time Standard Exceptions

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

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

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If action is not taken within the time standard, the case record must show the cause for the delay and the applicant must be notified in writing of the status of his application, the reason for the delay, and his right of appeal.

When an application is delayed after 90 days because of a disability decision and the agency has determined that excess resources exist at the time the delay notice is sent, the NOA must inform the applicant that he/she has excess resources and the amount. The notice must also state that:

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

B. Application for Retroactive Coverage

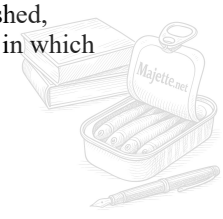
The retroactive period is based on the month in which the application is filed with the agency. The retroactive period is the three months prior to the application month.

Retroactive Medicaid eligibility must be determined when an applicant for medical assistance indicates on the application that he, or anyone for whom he requests assistance, received a covered medical service within the retroactive period. The covered service may be listed by the applicant as an actual medical service on the application, or information on the application may indicate that a service was received, such as the birth of a child or Medicare coverage during the retroactive period.

An individual may request retroactive coverage at any time subsequent to an application even if the application was denied or the applicant signed a statement saying he did not want retroactive coverage. The retroactive period is based on the application month regardless of whether the application was denied or approved. **There is no administrative finality on determining retroactive eligibility if eligibility for the months in the retroactive period has not been determined.**

If the application was denied, the application is reopened for determination of eligibility in the entire retroactive period – all three months prior to the application month – even if a covered medical service was received in only one retroactive month. The applicant must provide all verifications necessary to determine eligibility during the retroactive period.

If the applicant is found eligible for retroactive coverage and a Medicaid-covered medical service was received over one year prior to the date the retroactive eligibility is determined, the applicant must be given an "Eligibility Delay" letter to give to the medical provider so that Medicaid will pay the claim (see the sample letter on the intranet at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*. Once retroactive eligibility is established, Medicaid coverage begins the first day of the earliest retroactive month in which retroactive eligibility exists.



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M0130.200 Required Information and Verifications

A. Identifying Information

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

1. Name

The name entered in the official case record and computer enrollment systems for an applicant must match the applicant's name on his Social Security card or Social Security Administration (SSA) records verification. This is important because of the Medicare Buy-in and other computer matches the *Medicaid Enterprise System (MES—formerly the* Medicaid Management Information System [MMIS]) performs with SSA. At the time of the initial MA application, verify the SSA record of the individual's name.

The Federally managed Data Services Hub verifies the individual's name and SSN with the SSA for cases processed in VaCMS (see M0130.200 B.1 below). For an individual whose name and SSN cannot be verified in VaCMS and for all individuals whose cases are not processed in VaCMS, either SVES or the State Online Query-Internet system (SOLQ-I) SSA Title II and Title XVI results may be used.

If the individual says his name is different from the name on his Social Security card, he must first notify SSA and have his name changed on SSA records. When SSA changes his name and SSA verification of the name change is received, the worker can change his name in the case record and on the eligibility and *MES* computer systems.

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

2. SSN

The SSN of an individual for whom medical assistance is requested and for whom having an SSN or proof of application for one is an eligibility requirement, must be provided by the applicant and verified by the worker through SSA. The Hub or SOLQ-I may be used to verify the individual's SSN. See M0240.001.

B. Required Verifications

1. The Federally-managed Data Services Hub

The Hub is a data center that links the following federal systems:

- Social Security Administration
- Internal Revenue Service (IRS)
- Systematic Alien Verification for Entitlements (SAVE).

Income verification by the Hub is acceptable for retroactive eligibility determinations provided that reasonable compatibility is met (see M0420.100 B.9).

Information from other sources, such as the Work Number, may become available via the Hub in the future.

2. Other Verification Sources

An individual must provide verifications of certain MA eligibility requirements when they cannot be verified through EDSV. Before taking action on the application, the applicant must be notified in writing of the required information. The verification request (checklist) must be sent to the authorized representative, if one has been designated.



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The eligibility worker must allow at least 10 calendar days for receipt of the necessary verifications, but additional time may be allowed depending on the type of information requested. The specific information requested and the deadline for receipt of the verifications must be documented in the case record. If the applicant reports to the EW that he needs help to obtain certain verifications, the EW must attempt to assist the applicant. If the verification cannot be obtained, the application must be denied.

3. Copy or Scan Verification Documents

Legal documents and documents that may be needed for future eligibility determinations or audits must be copied or scanned into VaCMS using the Document Management Imaging System (DMIS) and preserved for the record. These include citizenship and identity documents, alien status documentation, verification of legal presence, trusts, annuities, contracts, wills, life insurance policies, **the current value of all other countable resources, and verifications of earned and unearned income**. **Notes by the eligibility worker that the verifications were viewed are not sufficient.**

4. Non-custodial Parent Applying for Child

Eligibility for a child is based on the income of the parent with whom the child lives. If a non-custodial parent applies for his child, he must give written permission for the eligibility worker to contact the custodial parent. The eligibility worker must obtain the custodial parent's income information, written permission to verify income using available online data sources, and other information necessary to verify and calculate countable income, including Social Security Number and residence address. If the either the non-custodial parent or the custodial parent fails to give the necessary permission, the child's eligibility cannot be determined using the application filed by the non-custodial parent.

5. Information Not Provided

If information necessary to make an eligibility determination is requested but not provided by the applicant and cannot be obtained from any other source, the application must be denied (or the coverage cancelled) due to the inability to determine eligibility. Individuals whose applications are denied due to the inability to determine eligibility are not referred to the *V*IM. See M0130.300 D.2. *If the Verification Checklist or other mail is returned to the agency, follow the steps in M0130.500 Returned Mail prior to taking negative action.*

When the deadline date falls on a weekend or holiday, LDSS may choose to deny the application (or cancel coverage) before the deadline date. However, if the early denial or cancel action is taken, LDSS must re-open the application if the individual provides the necessary information on or before the original deadline date. If the individual's application is re-opened and he/she is determined eligible, the LDSS must send a notice to the individual notifying *them* of the changed action.

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C. Verification of Nonfinancial Eligibility Requirements

1. Verification Not Required

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

- Virginia state residency;
- pregnancy.

2. Verification Required

The following information must be verified:

- citizenship and identity;
- Social Security number (see section D below);
- legal presence in the U.S. of applicants;
- age of applicants age 65 and older; and
- disability and blindness.

The worker must attempt to verify all information using Electronic Verification sources prior to requesting proof from the applicant.

3. Verification Required for a Case Change of Gender

An individual's gender is not a factor used to process a determination of Medicaid eligibility and does not have to be verified. The individual's request to a change the gender listed on the case cannot be accepted verbally and verification of a change is required. Acceptable verification could include a Social Security Administration record, a state driver license, state identification card, or other official document.

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See M0130.200 E below for instructions on the verification of legal presence. See subchapter M0220 for instructions on the verification of identity and citizenship. See subchapter M0310 for instructions on the verification of age and disability.

D. Social Security Numbers

Applicants must provide the SSN of any person for whom they request Medicaid, if an SSN is required for that individual's eligibility. An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

1. SSN Verification

The Federal Hub, SVES or SOLQ-I may be used to verify the individual's SSN.

2. Exceptions to SSN Requirements

The SSN requirement does not apply to:

- *an alien who is eligible only for Medicaid payment of emergency services, as defined in subchapter M0220,*
- *a non-citizen who is only eligible to receive an SSN for a valid non-work reason,*
- *a child under age one born to a Medicaid-eligible or FAMIS- covered mother (see M0330.301 B. 2 and M2220.100.), or*
- *an individual who refuses to obtain an SSN because of well-established religious objections.*

See M0240 for additional information and verification requirements.

3. SSN Not Yet Issued

If an SSN has not been issued, the applicant must cooperate by applying for a number with the local Social Security Administration (SSA) office. Instruct the applicant to submit form SS-5, the Application for Social Security Number, to the SSA and to obtain a receipt from the SSA verifying that the application was submitted. The SS-5 is available online at: https://www.ssa.gov/forms/ss-5.pdf. The applicant must provide the SSN to the local social services department as soon as it is received and the number must be entered in the eligibility and enrollment system. Applicants who refuse to furnish an SSN or to show proof of application for a number will be ineligible for medical assistance.

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

When entering the individual in the eligibility/enrollment system, use the date the individual applied for an SSN, or the individual's date of birth, preceded by "999" as the individual's SSN. For example, an individual applied for an SSN on October 13, 2006, enter "999101306" as the individual's SSN.

E. Legal Presence (Effective January 1, 2006)

Effective January 1, 2006, Section 63.2-503.1 of the Code of Virginia requires most applicants for or recipients of public assistance who are age 19 or older to provide proof of citizenship or legal presence in the U.S. Applicants or recipients age 19 or older for whom medical assistance is requested must prove their citizenship or legal presence.



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Individuals who, on June 30, 1997, were Medicaid-eligible and were residing in long-term care facilities or participating in home and community-based waivers, and who continue to maintain that status (eligible for Medicaid and reside in long-term care facilities or participate in home and community-based waivers) are exempt from this requirement.

Non-citizens applying for Medicaid payment limited to emergency services are not subject to the legal presence requirement. An individual who is applying on behalf of another and is not requesting assistance for himself is not subject to the legal presence requirement.

2. Documents That Demonstrate Legal Presence

An applicant may demonstrate legal presence by presenting one of the following documents:

- valid evidence of U.S. citizenship;
- valid evidence of legal permanent resident status;
- valid evidence of conditional resident alien status;
- a valid SSN verified by SSA;
- a U.S. non-immigrant visa;
- a pending or approved application for legal asylum;
- a refugee or temporary protected status document; or
- a pending application for an adjustment of residence status.

3. Failure to Provide Proof of Legal Presence

An applicant who cannot provide documentation that he is a citizen or legally present at the time of application must sign an affidavit under oath attesting that he is a U.S. citizen or legally present in the U.S. in order to meet the requirement for proof of legal presence for either:

- a period of 90 days or until it is determined that he is not legally present in the U.S., whichever is earlier; or

- indefinitely if the applicant provides a copy of a completed application for a birth certificate that has been filed and is pending and being actively pursued in accordance with federal or state law. Such extension shall terminate upon the applicant's receipt of a birth certificate or determination that a birth certificate does not exist because the applicant is not a U.S. citizen.

The affidavit form is on the intranet at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*.

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

4. Relationship to Other Medicaid Requirements

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

F. Third Party Liability (TPL)

Applicants must be asked to provide information about any health insurance they may have. Verification of health insurance information is not required.



If the client is eligible for benefits to be used exclusively for the payment of medical expenses (i.e. an insurance settlement), but there is no TPL code for that benefit, the worker must email the information to the DMAS TPL Unit at TPLUnit@dmas.virginia.gov, or send the information to:

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

G. Health Insurance Premium Payment (HIPP) Program

The HIPP program is a cost-savings program for individuals enrolled in Medicaid which may reimburse some or all of the employee portion of the employer group health insurance premium. Eligibility for HIPP is determined by the HIPP Unit at DMAS. Participation in HIPP is voluntary.

The local DSS agency must give each applicant or enrollee who reports that he or someone in his family is employed more than 30 hours each week and is eligible for health insurance coverage under an employer's group health plan must be given a HIPP Fact Sheet, which provides a brief description of the program and the contact information for the HIPP Unit at DMAS. The HIPP Fact Sheet is available at https://fusion.dss.virginia.gov/Portals/[bp]/Medicaid/Resources%20and%20Job%20Aids/MA%20Fact%20Sheets/HIPP%20Fact%20Sheet%2024_d032_03_0842-04-eng_.doc?ver=2024-07-15-082927-803. Enrollees and other members of the public may contact the HIPP Unit for additional information at hippcustomerservice@dmas.virginia.gov.

If the health insurance policy holder lives outside of the home, a HIPP Consent Form must be completed by both the policy holder and the parent/authorized representative so the DMAS HIPP Unit can process the HIPP application. If the form is required, the DMAS HIPP Unit will send it to the applicant for completion.

H. Verification of Financial Eligibility Requirements

The eligibility worker must verify the following financial eligibility requirements:

- the value of all countable, non-excluded resources, if the reported values of the resources are not both reasonably compatible with electronic sources AND below the resource limit. In all situations the sources of the resources do not have to match. If the member attests to having resources below the limit and values received from electronic sources are above the limit, additional verification should be requested. Reasonable compatibility for resource evaluation is effective for all case actions as of June 3, 2024.
- asset transfer information for individuals in need of long-term care services, including the date of transfer, asset value, and compensation received.
- earned and unearned income. For all case actions effective August 26, 2022, if the income attested to by the applicant is within 20% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required.

If the attested income is under the income limit and the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return. If the applicant meets a Medically Needy (MN) covered group, verification of income **is required** to determine spenddown liability.

If the attested income is over the income limit and the individual does not meet a Medically Needy (MN) covered group, deny the application.

The agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information, and

information from SSA through SVES or SOLQ-I. Verification of income is valid if the information is less than *6* months old. The agency must include in each applicant's case record facts to support the agency's decision on the case.

1. **Resources** The value of all countable, non-excluded resources must be verified. If an applicant's attested resources are over the resource limit, the applicant or authorized representative must be given the opportunity to provide verification of the resources. All available resource verification system(s) must be searched prior to requesting information from the applicant.

2. **Use of Federal Income Tax Data** The Hub provides verification of income reported to the IRS. Income information reported to the IRS may be used for eligibility determinations for Families and Children (F&C), MAGI Adults, and ABD covered groups when IRS information is available. The income reported on the application is compared to the data obtained from the Hub for reasonable compatibility per M0420.100. When IRS verification is used for an ABD individual, reasonable compatibility is acceptable as verification of earned (i.e. taxable) income.

3. **SSA Data** Social Security and/or Supplemental Security Income must be verified through SSA. The Federal Hub links to SSA data. SOLQ-I may also be used. The State Data Exchange (SDX) system should only be used as an alternate method when the Hub or SOLQ-I is not available.

4. **Income** For all case actions effective August 26, 2022, the applicant's attested income, including when the applicant attests to having zero ($0.00) income, is considered the verified income if the income attested to by the applicant is within *2*0% of the income reported by electronic data sources OR both sources are below the applicable income limit.

   If the attested income is under the income limit and the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return. If the applicant meets a MN covered group, verification of income **is required** to determine spenddown liability based on actual income received.

   For individuals requesting long-term services and supports (LTSS), verification of income is required to calculate the patient pay. See M1470.

   If the attested income is over the income limit and the individual does not meet a Medically Needy (MN) covered group, deny the application.

   If the individual agrees that the discovered countable income was received, determine if the on-line information can be used to evaluate current/ongoing eligibility. If the discovered information is not sufficient to evaluate eligibility, send a written request for needed verifications and allow at least ten calendar days for the return of the verifications.

   If the individual reports the income has stopped, ask when the income stopped to ensure all income needed to correctly determine prospective and retroactive eligibility (if appropriate) is evaluated. Note the date of termination of income (last pay received) in the record. If the income stopped during a month that is being evaluated for eligibility, the individual must provide verification of the termination of income.

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M0130.300 Eligibility Determination Process

A. Evaluation of Eligibility Requirements

When an MA application is received the worker must determine through a "file clearance" search of the eligibility and enrollment systems whether or not the individual already has Medicaid or FAMIS coverage.

With the exception of individuals enrolled on the basis of presumptive eligibility (PE), applications for MA submitted by individuals who already have an application recorded or who are currently active are denied as duplicate applications. *See M0130.400.D*

Applications submitted by individuals currently enrolled as HPE or as Newborn Children are not duplicate applications because they were initially enrolled without filing a full MA application. See M0120.300 A.5 for more information.

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

It is crucial that individuals reviewing a case, including auditors, be able to follow the eligibility determination process in VaCMS. Changes and any questionable information must be appropriately documented as comments in the VaCMS case record.

The evaluation of eligibility requirements must be documented in writing for cases not processed in VaCMS. The Evaluation of Eligibility (form #032-03-823) may be used. The form is available online at the DSS Fusion website.

Agency or CPU created evaluation forms are also acceptable as long as all information needed to determine eligibility is documented on the evaluation form.

Eligibility decisions are made following a prescribed sequence:

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

Subchapter M0210 contains the Medicaid non-financial requirements.

B. Hierarchy of Covered Group

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

C. Applicant's Choice of Covered Group

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



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D. Application Disposition

1. General Principle

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

If an applicant dies during the application process, his eligibility can only be established for the period during which he was alive.

If an applicant (other than a Medicare beneficiary, HPE, or deceased individual) is ineligible for MA for any reason other than the inability to determine eligibility, a referral to the VIM must be made so that his eligibility for the APTC in conjunction with a Qualified Health Plan (QHP) can be determined. Individuals who have Medicare, who are incarcerated, who are enrolled as HPE, and deceased individuals and are not referred to the *V*IM.

2. Entitlement and Enrollment

a. Entitlement

Entitlement to medical assistance is based on the application month. However, entitlement cannot begin prior to an individual's date of birth, and cannot continue after an individual's date of death. See section M1510.100 for detailed entitlement policy and examples.

If applicants indicate that they have been receiving MA (Medicaid or Children's Health Insurance Program) coverage in another state prior to moving to Virginia, instruct them to contact the eligibility worker there and request that the coverage be cancelled, if they have not already done so. Individuals are no longer considered residents of the other state once they have moved to and intend to reside in Virginia and are not entitled to receive services paid for by the other state's MA program. Enrollment may begin with the month of application or the earliest month in the application's retroactive period that they met the residency requirement per M0230.

b. Enrollment

MA enrollees must be enrolled in the MES, either through the system interface with the eligibility determination system or by submitting a coverage correction *request through the Coverage Correction Portal (CCP) on the MES website., Home | MES.*

Note: The MES was implemented in April 2022. Prior to April 2022, the Medicaid Management Information System (MMIS) was used for enrollment and claims processing. References to MMIS in the Medical Assistance Eligibility Manual will be updated as other policy revisions are made.

When an individual who does not have Medicare is eligible for only limited MA benefits, such as Plan First, a referral to the *V*IM must be made so that eligibility for the APTC in conjunction with a QHP can be determined.

3. Notification to Applicant

Either a Notice of Action generated by the eligibility determination system or the equivalent form #032-03-006 (available at the DSS Fusion website) must be used to notify the applicant of the specific action taken on the application. The notice must be sent to the authorized representative, if one has been designated.



a. Approvals

As applicable, the notice must state that:

- the application has been approved, including the effective date(s) of coverage and the date of the next annual renewal;
- retroactive Medicaid coverage was approved, including the effective dates.
- For approvals of limited coverage, the notice or a separate system-generated notice must state that the application has been referred to the *V*IM for determination of eligibility for the APTC.

b. Denials

As applicable, the notice must state that:

- the application has been denied, including the specific reason for denial cited from policy;
- retroactive Medicaid coverage was denied, including the specific reason for denial cited from policy.
- When the applicant (other than a Medicare beneficiary or deceased individual) is ineligible for MA for any reason other than the inability to determine eligibility, either the notice or a separate system-generated notice must state that the application has been referred to the *V*IM for determination of eligibility for the APTC.

c. Delays

The notice must state that there is a delay in processing the application, including the reason.

d. Other Actions

Other actions for which a notice must be sent include when a request for re-evaluation of an application in spenddown status has been completed.

e. Advance Health Care Directive

An Advance Health Care Directive insert is required to be included with an initial notice of eligibility. The insert (available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, must be included with the initial approval or denial Notice of Action. This insert is not required when adding a person to an existing case, at redetermination, when a change is reported or when coverage is cancelled.



E. Notification for Retroactive Entitlement Only

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

M0130.400 Applications Denied Under Special Circumstances

A. General Principle

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

B. Withdrawal

An applicant may withdraw his application at any time. The request can be verbal or written. An applicant may voluntarily withdraw only his application for retroactive coverage by signing a statement or by a verbal statement specifically indicating the wish to withdraw the retroactive coverage part of the application.

A written withdrawal request must be placed in the case record. A verbal request for withdrawal can be accepted only from the applicant or case head, or *the* authorized representative. A verbal request must be documented in the case record with the date and time the withdrawal request was received, the name of the person who made the withdrawal request, and the *name* and title of the agency staff person who took the call.

When the applicant withdraws an application, the eligibility worker must send a notice of action on MA to the applicant.

C. Inability to Locate

If mail is returned, the worker must follow the returned mail policy in M0130.500. The agency must *attempt to contact the applicant by at least two methods in addition to* send*ing* a letter to the last known address informing the applicant of the agency's attempt to locate *them* and asking that *they* contact the office. For applicants who are documented as homeless *and do not provide a mailing address*, maintain all correspondence at the local agency. If the applicant does not respond *or contact the agency* within 45 days of the date of application, deny the application.

D. Duplicate Applications

The worker will review a duplicate application to verify there are no changes in circumstances, request(s) for coverage, or other actions that need to be acted on. Applications received requesting MA for individuals who already have an application recorded (i.e. pending) or who are currently active and receiving coverage will be denied due to duplication of request. *Document current coverage on the notice*.

For duplicate applications submitted by individuals currently enrolled in coverage, the denial notice must include the member's coverage status, as appropriate:

- the application has been approved for a new level or type of coverage; or
- the application has been denied for new services, but the member remains enrolled in their current level or type of coverage; or
- the requested coverage was denied and the member's existing coverage is being terminated.

*Do **NOT** deny an application for "overlapping coverage" without adding an explanation to the Notice of Action on Medicaid.*



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M0130.500 Returned Mail

A. General Principle

This policy pertains to all information mailed to the applicant at intake, changes or renewals. Generally, there are three types of recipient mail that could be returned to the Medicaid agency:
(1) mail with an in-state forwarding address;
(2) mail with an out-of-state forwarding address; and
(3) mail that does not include a forwarding address.

Workers must confirm whether the address information on the piece of returned mail is complete and consistent with the address information the agency has on file. The front of the returned mail should be scanned into the case record and all actions to contact the client must be documented.

B. Returned Mail With Complete Information

Compare the address provided to existing records. If an error is discovered (i.e., missing or incorrect apartment number, etc.), make any necessary corrections and resend the information. If the subsequent mailing to the correct address is not returned, no additional contact is required. The address should be updated in VaCMS and no other action is required. If the subsequent mailing is returned, proceed as indicated below based on whether the returned mail has a forwarding address.

C. Returned Mail with no Forwarding Addres

The worker must attempt to contact the recipient through two other methods, including phone, text, email, or alternate addresses [including attempting to contact the Authorized representative (AR)]. If only one other method is available, a contact attempt must be made. If no other methods are available, the condition will be met if it has satisfied the up-to-date contact information.

D. Returned Mail with Forwarding Address

Sending the VCL or other mail to the new address will represent one contact method. One other method of contact, if available, is required to satisfy the returned mail condition. If mail is not returned from the forwarding address, the returned mail condition no longer applies because the original mailing has been completed and is no longer considered to be returned. The address should be updated in VaCMS and no other action is required.

E. Mail Returned from Authorized Representative

Returned mail from the AR should be *investigated*. If the address appears correct and no other methods (phone, text, email or alternate addresses) are *available*, the client should be informed.

***F.* Lack of Alternative Contact Information**

If after complying with the conditions described above, the only contact information available is the address in the individual's case record, and the LDSS does not have or cannot find a phone number, email address or other means to contact the individual, no further efforts to contact the individual are necessary.
If the applicant does not respond or contact the agency within 45 days of the date of application (30 days for a change) to update their information, deny the application or close the case. See M0130.400 and M1520.200.

***G.* Documentation**

The case narrative must contain documentation of all methods used for contact attempts. To ensure applicants are able to complete the application process, the worker should ensure that if they successfully contact an individual after receiving returned mail, the recipient receives any necessary verification requests at their correct address and has sufficient time to return the information and complete the application process.



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CHAPTER M01

APPLICATION FOR MEDICAL ASSISTANCE
SUBCHAPTER 40

INCARCERATED INDIVIDUALS

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M0140 Changes

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TN #DMAS-34	1/1/25	Page 2
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M0140.000 Incarcerated Individuals General Information

A. Introduction

An incarcerated individual, or offender, is an inmate of a public institution. Inmates include those under the authority of the Virginia Department of Corrections (DOC), held in a regional or local jail, those on work release, and inmates of a Virginia Department of Juvenile Justice (DJJ) facility.

For juveniles not in a facility but within the authority of DJJ, see section M0280.300 D. See section M0280.301 regarding an individual who is not considered to be an inmate of a public institution.

An individual released from jail under a court probation order due to a medical emergency is NOT an inmate of a public institution because he is no longer incarcerated.

B. Policy Principles

An individual is not eligible for full benefit Medicaid coverage while incarcerated. These individuals may apply for medical assistance and (if approved) receive coverage limited to inpatient hospitalization services. Inpatient hospitalization may include long-term inpatient services, such as admission to a rehabilitation facility. *Children under 19 are eligible for 12 months of continuous in-patient hospitalization coverage.*

The offender must meet eligibility requirements for a full-benefit covered group. Medicaid non-financial eligibility requirements include

- Virginia residency requirements (see M0230)
- Citizenship or immigration status (see M0220)
- A Social Security Number (SSN) or proof of application for an SSN (see M0240)
- Institutional status requirement of being an inmate in a public institution (see M0280)

Medicaid financial eligibility requirements for the individuals covered group include

- Resources (if applicable) within resource limit (Chapter M06 for F&C; Chapter S11 for ABD)
- Income within income limit (Chapter M04 & M07 for F&C covered groups; Chapter S08 for ABD covered groups)

C. Covered Group

The individual is evaluated for eligibility in the covered group in which they would otherwise be eligible except for being incarcerated. The primary covered groups an offender may meet include:

- MAGI Adults (M0330.250)
- Pregnant Women (M0330.400)
- Child Under Age 19 (M0330.300)
- Aged, Blind or Disabled (M0320.300)
- Former Foster Care Child Under Age 26 Years (M0330.109)

D. Immigration Status Requirements

An incarcerated person must meet immigration requirements (see M0220). A non-citizen who meets all Medicaid eligibility requirements except for immigration status and has received an inpatient hospitalization may be evaluated for coverage as an Emergency Services Alien see M0140.200.C.3

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M0140.100 COMMUNICATION

A. Introduction

Direct communication between an offender and staff at the Cover Virginia Incarcerated Unit (CVIU) or LDSS may be limited or prohibited depending on the facility. Staff employed by the facility or DOC may assist in coordinating the application process and communicating information to the offender, or to CVIU/LDSS.

B. Policy

The facility may designate staff who are permitted to assist with applications. Communication with facility staff is limited only to information related to the case or application. Access to case information by facility staff is terminated when the offender is released and/or no longer incarcerated.

Case assistance for offenders held by the DOC will be coordinated by the Department of Corrections, Medicaid Program Unit, *5511-B Biggs Road, Richmond, Virginia 23224.*

Case assistance for offenders in regional and local jails is handled in coordination with the facility, their staff, and any authorized representative(s) (see M0110.110).

Send all notices and other correspondence to the mailing address or via secure email as indicated on the application. If the applicant has designated an authorized representative to act on his behalf and receive notices, send a copy of the correspondence and notices to the authorized representative.

M0140.200 APPLICATION GUIDELINES

A. Introduction

Any application, renewal, or case review for an offender will be processed in the required time standards following applicable Medicaid eligibility policy (see M0130.100).

B. Policy

Offenders may file their own applications. An authorized representative may assist in applying or renewing coverage. An offender may add or change an authorized representative at any time.

An authorized representative designation is valid for the life of the application (see M0110.110.E) unless a written statement indicates such designation will cease when incarceration ends.

See Broadcast in Fusion dated 3/8/2019 Cover Virginia Incarcerated Unit (CVIU) and 5/19/2019 Updates to Cover Virginia Incarcerated Unit (CVIU) Procedures (https://fusion.dss.virginia.gov/broadcasts) for instructions explaining how to send offender applications received by the local agency to Cover Virginia for processing.

If the offender is approved, the Commonwealth of Virginia (COV) Medicaid Card is suppressed (not mailed).



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C. Offender Application Processing

An application is not to be refused or denied because an applicant is incarcerated. A person is not required to have had an inpatient hospitalization in order to apply for Medicaid. The agency must evaluate the eligibility of all MA enrollees, with respect to circumstances that may change, at least every 12 months unless the enrollee is pregnant (see M1520.200 p.9).

1. New Application

An offender who does not have active Medicaid coverage may apply while incarcerated. Coverage is based on the month of application and can include up to three months of coverage (if requested) prior to the month of application, provided eligibility requirements are met.

Ongoing coverage in AC 108 or AC 109 is effective the first day of the month of application or the date when incarceration begins, whichever is later.

2. Re-entry Process

A medical assistance application for an offender with no active Medicaid coverage and an anticipated release date within 45 days is handled as part of a "Re-Entry" process *and will follow the same procedure as a New Application (ref M0140.200.C.1). If the offender is approved the case will have a redetermination conducted for ongoing Medicaid coverage*. This is a new application and an eligibility determination for Medicaid coverage will be made based on the information as reported or known at the time of release from the facility.

If the person is approved but is unable to or does not provide a post-release address where he will reside (e.g. reports as homeless or moving to a temporary shelter) the case will be transferred to the LDSS of his pre-incarceration, if known. If there is no known address, or the individual lived outside of Virginia prior to incarceration and intends to remain in the state, transfer the case to the LDSS where the correctional facility is physically located.

If the application is approved the worker will confirm that a new Commonwealth of Virginia Medicaid Card has been generated and a copy of the Notice of Action sent to the anticipated post-release address.

3. Emergency Services

A non-citizen who meets all Medicaid eligibility requirements except for immigration status, and has received an inpatient hospitalization, may qualify for coverage of emergency medical care. This care must have been provided in a hospital emergency room or as an inpatient in a hospital. Determine eligibility for emergency services using policy in *M0220.400* and enroll eligible individuals using the procedures in *M0220.600 D*.

For cases processed at the Cover Virginia Incarcerated Unit (CVIU) the individual will be enrolled in the appropriate AC 112 or AC 113 and the case will be retained at the CVIU for ongoing case maintenance.

Emergency Services coverage in AC 112 or AC 113 is effective the first day of the month of application, the first day of the retroactive period, or the date when incarceration begins, whichever is earliest



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M0140.300 CASE MAINTENANCE

A. Ongoing Case Maintenance

Case maintenance may include updates such as when the inmate is moved to another facility, change of an authorized representative, updates to demographics, or other changes affecting Medicaid eligibility or coverage.

Update to an offender's case are handled by the CVIU. Facilities will use a CVIU Communication Form to report changes. Local agencies will use the LDSS to Cover Virginia Communication Form #032-03-0458-00-eng to report changes.

B. Partial Reviews

If a change occurs it may be necessary to re-evaluate the offender's Medicaid coverage. This may include release from incarceration, change of anticipated release date, death, an inmate turning age 65 years old, becoming eligible for Medicare, or end of a pregnancy (see M0140.001 G).

The eligibility worker will handle such changes within 30 days and re-evaluate the offender for continued coverage.

For an offender case that involves a spenddown, see M1350.850.

C. Redetermination

An offender with ongoing approved Medicaid coverage is subject to an annual (every 12 months) redetermination of coverage. The CVIU processes redeterminations of incarcerated individuals (see M1520.200 A).

Do not initiate a renewal for an individual under 19 before their 12th month of eligibility unless they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased. Do not initiate a renewal of eligibility of a pregnant woman during her pregnancy. Eligibility as a pregnant woman ends effective the last day of the 12th month following the month in which her pregnancy ends. When eligibility as a pregnant woman ends, prior to the cancellation of her coverage, determine if the woman meets the definition for another Medicaid covered group (see M0310.002). If the woman meets the definition of a full-benefit covered group, determine if an ex parte renewal can be completed or if a renewal form is required and take appropriate action.

Follow Ex Parte Renewal procedure as found in M1520.200 B. 1 if applicable. If unable to process an Ex Parte renewal, see M1520.200 B. 2 and 3 for procedures.

D. Pre-Release Review

An offender with active Medicaid coverage and a reported release date of 45 days or less requires a "Pre-Release" partial review. Eligibility will be evaluated for ongoing Medicaid coverage and processed based on the information as reported or known at the time of release.

If the offender is approved and remains eligible for ongoing Medicaid coverage, the worker will cancel the existing aid category (AC108 or AC109) on the day prior to the actual release date and enter coverage in the new AC as of the date of release. *Children under 19 should be given a new 12 month period of continuous eligibility at renewal.*

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The worker will confirm a new Commonwealth of Virginia Medicaid Card has been generated and copy of the Notice of Action sent to the post-release address.

If eligibility for ongoing Medicaid is denied, cancel existing Medicaid coverage the day prior to actual date of release.

An offender with active Medicaid coverage (AC108/109) and released to the community before a Pre-Release Review can be conducted by the CVIU will transfer the offender's case to the locality for review. The CVIU will send a CPU to LDSS Communication Form to alert the locality for the need to review the member for ongoing Medicaid coverage and any other requested benefits.

1. Release to a Community Living Arrangement

An offender entering a household with existing benefits after incarceration may affect Medicaid eligibility for those in the household.

The CVIU will process Pre-Release Reviews if approved, the case will be assigned to the locality where the ex-offender plans to reside.

If the person is approved but cannot or will not provide an address where he will reside (e.g. reports as homeless or moving to a temporary shelter), the case will be transferred to the LDSS of his pre-incarceration, if known. If there is no known address or the individual lived outside of Virginia prior to incarceration and intends to remain in the state, transfer the case to the LDSS where the correctional facility is physically located.

2. Release to an Institutional Placement, LTSS, or HCBS

When an offender is being released and needs to be placed in an institution or receive home and community-based services (HCBS), the CVIU will collaborate with LDSS in the locality where the individual will be residing for processing the application to ensure the eligible individual can receive necessary medical support/services when released.

E. Split Cases

For case maintenance, an offender with active Medicaid coverage in aid category 108 or 109 should be placed in his own case in VaCMS and assigned to the CVIU. If the incarcerated individual is the case name and other household members with active coverage are on the case, the local agency will be responsible for removing any other member(s), setting up a new case, and transferring the offender's case to the CVIU.

CHAPTER M02

NONFINANCIAL ELIGIBILITY REQUIREMENTS

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TN #DMAS-10	10/1/18	Page ii
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SUBCHAPTER 10

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M0210.000 GENERAL RULES & PROCEDURES

M0210.001 PRINCIPLES OF MEDICAID ELIGIBILITY DETERMINATION

A. Introduction

Medicaid is an assistance program which pays medical service providers for services rendered to eligible needy individuals. An individual's need for medical care, the state of his health, or his coverage by private health insurance, have no effect on his Medicaid eligibility.

The eligibility determination consists of an evaluation of an individual's situation which compares each of the individual's circumstances to an established standard or definition. The evaluation provides a structured decision-making process. An individual must be evaluated for eligibility in all covered groups for which he meets the definition, and the applicant/enrollee shall be informed of all known factors that affect eligibility.

B. Eligibility Requirements

Although all the requirements that follow may not be applicable in a particular individual's situation, they must be looked at and evaluated.

1. Nonfinancial Eligibility Requirements

The Medicaid nonfinancial eligibility requirements are:

a. Legal presence in the U.S., effective January 1, 2006 (M0210.150).
b. Citizenship/alien status (M0220).
c. Virginia residency (M0230).
d. Social Security number (SSN) provision/application requirements (M0240).
Assignment of rights to medical benefits and pursuit of support from the absent parent requirements (M0250).
f. Institutional status requirements (M0280).
g. Covered group requirements (M03).

2. Financial Eligibility Requirements

The Medicaid financial eligibility requirements are:

a. Asset transfer for individuals who need long-term care (subchapter M1450).

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

c. Income within income limit appropriate to the individual's covered group. (Chapters M04 and M07 for F&C covered groups; Chapter S08 for ABD covered groups).

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3. Example

EXAMPLE: On January 5, 2006, Mr. H applies for Medicaid. He is in a nursing facility in Virginia, and has been there since July 5, 2005. When evaluating his application, the worker finds that he:

- is a U.S. citizen,
- is currently a Virginia resident residing in a medical institution in Virginia,
- provided his SSN,
- refused to provide third party liability and medical support information,
- has applied for all benefits to which he is entitled,
- meets the institutional status requirements,
- is age 67 years and meets a covered group requirement.

He currently has $5,000 in the bank. His income is $600 per month Social Security (SS). Since he refused to provide third party liability and medical support information, he does not meet the assignment of right requirements and his application must be denied. He is also informed of the resource limit and that he is ineligible for Medicaid because his resources exceed the limit.

M0210.100 INELIGIBLE PERSONS

A. Introduction

The individuals listed in this section are not eligible for Medicaid. However, their income and resources may be considered in determining the eligibility of others in the household who have applied for Medicaid.

B. Certain Recipients of General Relief (GR)

A recipient of General Relief (GR) maintenance who does not meet a Medicaid covered group is not eligible for Medicaid.

An applicant for Medicaid and Supplemental Security Income (SSI) who receives GR from the interim assistance component may become eligible for Medicaid following the establishment of SSI eligibility. Eligibility for an SSI payment is effective the month **following** the SSI application month. When the Medicaid application is dated in the same month as the SSI application, Medicaid eligibility can be effective the month of application if the applicant meets all Medicaid eligibility requirements and another covered group requirement in the application month.

C. Essential Spouse of an ABD Individual

An essential spouse of an aged, blind, or disabled person who does not himself/herself meet a covered group is not eligible for Medicaid.

D. Individual Who Refuses to Assign Rights

By signing the application for medical assistance, an applicant assigns his rights to third party payments. Should the individual for any reason subsequently refuse to assign rights to third-party payments or support for himself or anyone for whom he can legally assign rights, he is not eligible for Medicaid. Failure to assign rights for another person will not affect the eligibility of that other person.



E. Individual Who Refuses to Pursue Support From an Absent Parent

An individual applying for Medicaid for himself and on behalf of a child meets the requirement to cooperate with the pursuit of medical support from an absent parent for the child by signing the application. If DMAS requires the individual, other than a categorically needy pregnant woman, to take further action to cooperate with the pursuit of medical support, the individual must cooperate to continue to be eligible for Medicaid. If the individual refuses to cooperate in the pursuit of medical support, he is not eligible for Medicaid. Eligibility could exist if the individual meets a covered group and the individual chooses not to apply for the child.

F. Individual Found Guilty of Medicaid Fraud

An individual found guilty by a court of Medicaid fraud is not eligible for Medicaid. Ineligibility will last for a period of 12 months beginning with the month of conviction.

G. Individual Who Refuses to Supply or Apply For an SSN

Any individual, except a child under age 1 born to a Medicaid or FAMIS eligible mother, or an illegal alien, who does not apply for an SSN account number or who fails or refuses to furnish all SSNs to the Department of Social Services is not eligible for medical assistance coverage.

M0210.150 LEGAL PRESENCE

A. Legal Presence (Effective January 1, 2006)

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

An individual who is applying on behalf of another and is not requesting assistance for himself is not subject to the legal presence requirement.

B. Documents That Demonstrate Legal Presence

An applicant may demonstrate legal presence by presenting one of the following documents:

- valid evidence of U.S. citizenship;
- valid evidence of legal permanent resident status;
- valid evidence of conditional resident alien status;
- a valid SSN verified by the Social Security Administration (SSA);
- a U.S. non-immigrant visa;
- a Resident Alien Card, form I-551, showing lawful permanent residence (green card);
- a pending or approved application for legal asylum;

- a refugee or temporary protected status document; or
- a pending application for an adjustment of residence status.

C. Failure to Provide Proof of Legal Presence

At the time of application, an applicant who cannot provide documentation that he is a citizen or legally present must sign an affidavit under oath attesting that he is a U.S. citizen or legally present in the United States in order to meet the requirement for proof of legal presence for either:

- a period of 90 days or until it is determined that he is not legally present in the U.S., whichever is earlier; or

- indefinitely if the applicant provides a copy of a completed application for a birth certificate within the United States or its territories that has been filed and is pending. The affidavit's validity shall terminate upon the applicant's receipt of a birth certificate or determination that a birth certificate does not exist because the applicant is not a citizen of the United States.

The Affidavit Of United States Citizenship Or Legal Presence In The United States is available at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*.

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

D. Relationship to Other Medicaid Requirements

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

M0210.200 COVERED GROUPS

A. Introduction

An individual who meets the nonfinancial eligibility requirements must also meet the definition for a Medicaid covered group. Covered groups include individuals who are age 65 or older, blind, disabled, under age 19, pregnant women, and the parent(s) or caretaker-relative of a dependent child. Medicaid financial eligibility requirements vary depending upon the covered group for which eligibility is being determined.

See chapter M03 for the covered groups' definitions, policy and procedures.

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CHAPTER M02
NONFINANCIAL ELIGIBILITY REQUIREMENTS
SUBCHAPTER 20

CITIZENSHIP & ALIEN REQUIREMENTS

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Changed With	Effective Date	Pages Changed
TN #DMAS-36	10/1/25	Appendix 2, pages 1 and 2
TN #DMAS-35	7/1/25	Pages 4, 4a, 4b and 20
TN #DMAS-33	10/1/24	Pages 14e, 22
TN #DMAS-32	7/1/24	Pages 1, 4-5, 6a; Appendix 1, page 5 Appendix 4, page 2 Appendix 5, page 1
TN #DMAS-30	1/1/24	Page 3; Appendix 4, page 1
TN #DMAS-27	4/1/23	Page 17 Appendix 4, page 1 Appendix 5, page 1
TN #DMAS-25	10/1/22	Table of Contents, Page 14d. Page 22 Appendix 4 added page 2.
TN #DMAS-24	7/1/22	Table of Contents Pages 1, 4a, 4b, 5, 6a, 8, 14d, 14e, 15, 17, 18, 21, 22, 23 Page 6b was added as a runover page. Appendix 9 was added. Pages 22a and 24-25 were removed.

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TN #DMAS-22	1/1/22	Table of Contents Pages 7, 12, 14a, 14b, 14d, 14e, 16, 22, 22a, 24 Appendix 5, pages 1, 3 Appendix 8, pages 1, 3 Appendix 4 was added.
TN #DMAS-20	7/1/21	Pages 14c, 15, 18, 21, 22a Appendix 5, page 3 Appendix 8, page 3 Page 15 is a runover page.
TN #DMAS-19	4/1/21	Table of Contents Pages 7, 14a-14d, 16, 22a, 24 Appendix 3, page 1 Appendix 5, page 1 Appendix 8, pages 1, 3 Page 8 is a runover page. Pages 8a and 14e were added as runover pages.
TN #DMAS-18	1/1/21	Page 21
TN #DMAS-17	7/1/20	Table of Contents Page 21
TN #DMAS-14	10/1/19	Table of Contents Pages 3, 4, 23, 24 Page 25 was added as a runover page. Appendix 8 was added.
TN #DMAS-13	7/1/19	Page 21
TN #DMAS-12	4/1/19	Pages 20, 21, 23
TN #DMAS-10	10/1/18	Page 1
TN #DMAS-9	7/1/17	Page 1, 2, 14c
TN #DMAS-6	10/1/17	Page 15 Appendix 1, page 4
TN #DMAS-5	7/1/17	Pages 18, 19, 23, 24
TN #DMAS-3	1/1/17	Table of Contents Page 22a Appendix 1, page 1
TN #DMAS-2	10/1/16	Pages 13, 19-22, 23, 24
TN #DMAS-1	6/1/16	Pages 4, 4b, 5, 23
TN #100	5/1/15	Table of Contents Pages 4b, 12, 17, 18 Appendix 5, page 3 Page 4 was renumbered for clarity. Page 4a is a runover page.
TN #99	1/1/14	Table of Contents Pages19, 23, 24 Appendix 4 was removed.



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TN #98	10/1/13	Pages 2-3b Appendix 1 Pages 1-5 Pages 6-18 were removed.
UP #9	4/1/13	Page 3 Appendix 1, pages 3, 17 Appendix 3, pages 3, 4
UP #8	10/1/12	Table of Contents Pages 4, 7-8, 12, 14d-20 Page 17a was deleted. Appendix 5 , page 3 Appendix 7 pages 1-5
UP #7	7/1/12	Table of Contents Pages 14d, 16-19 Appendix 5 , page 3
TN #96	10/1/11	Table of Contents Pages 2, 3, 7, 8, 14d, 18-22a, 23 Appendix 5, page 3
TN #95	3/1/11	Table of Contents Pages 3, 3a, 4-6a, 14a-14c, 17, 19, 20 Pages 22a, 23, 24 Appendices 1-2a removed. Appendix 3 and Appendices 5-8 reordered and renumbered.
TN #94	9/1/10	Pages 3-3b, 7-9, 14a-14d, 18, 21, 22a, 23 Appendix 1 Appendix 3, page 3
Update (UP) #3	3/1/10	Pages 1-3a
TN #93	1/1/10	Table of Contents Pages 7-8, 14a, 14c-14d, 15-20, 22a Appendix 1 Appendix 3, page 3 Appendix 4, pages 1 and 2 Appendix 6, page 2
TN #92	5/22/09	Table of Contents Pages 1-6a Appendix 8 (18 pages) Pages 4a-4t were removed and not replaced.
TN #91	5/15/09	Page 7 Pages 14a, 14b Page 18 Page 20 Appendix 3, page 3



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M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS

M0220.001 GENERAL PRINCIPLES

A. Introduction

This subchapter explains in detail how to determine if an individual is a citizen or alien eligible for full Medicaid benefits (referred to as "full benefit aliens") or emergency services only (referred to as "emergency services aliens"). The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) made major changes to the Medicaid eligibility of non-citizens of the United States. These changes eliminated the "permanently residing under color of law" (PRUCOL) category of aliens. The Medicaid benefits for which an alien is eligible are based upon whether or not the alien is a "qualified" alien as well as the alien's date of entry into the United States.

With some exceptions, the Deficit Reduction Act of 2005 (DRA) required applicants for Medicaid and Medicaid recipients to verify their United States citizenship and identity to be able to qualify for Medicaid benefits. The citizenship and identity (C&I) verification requirements became effective July 1, 2006. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) allows additional exemptions from the C&I verification requirements and provides states with the option to verify C&I through the use of an electronic data match with the Social Security Administration (SSA). It also requires states to enroll otherwise eligible individuals prior to providing C&I verification or immigration status, and grant them *one or more* "reasonable opportunity" period*s* after enrollment to provide documentation, if necessary.

The policy and procedures for determining whether an individual is a citizen or a "full-benefit" or "emergency services" *noncitizens* are contained in the following sections:

M0220.100 Citizenship & Naturalization;
M0220.200 Alien Immigration Status
M0220.300 Full Benefit Aliens
M0220.400 Emergency Services Aliens
M0220.500 Aliens Eligibility Requirements
M0220.600 Aliens Entitlement & Enrollment
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B. Declaration of Citizenship/Alien Status

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

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

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



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M0220.100 CITIZENSHIP AND NATURALIZATION

A. Introduction

A citizen or naturalized citizen of the United States meets the citizenship requirement for medical assistance *(MA)* eligibility, and is eligible for all *MA* services if he meets all other eligibility requirements.

B. Citizenship Determination

1. Individual Born in the United States

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

A child born in the United States to non-citizen parents who are in the United States as employees of a foreign country's government may not meet the United States citizen requirement. When a child born in the United States to non-citizen parents is a United States citizen by birth, the child may not meet the Virginia residency requirements in M0230.201 because of the parents' temporary stay in the United States.

2. Individual Born Outside the U.S.

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

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

b. Individual Born to Naturalized Parents

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

c. Naturalized Individual

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

C. Verification

1. Requirements

The DRA requires that satisfactory documentation of citizenship and identity must be obtained for all enrollees who claim to be U.S. citizens. Enrollees who claim U.S. citizenship must have a declaration of citizenship AND documentary evidence of citizenship and identity in their case records.

2. Exceptions to Verification Requirements

The following groups of individuals are NOT required to provide verification of C&I. Document in the case record why an individual is exempt from verifying C&I:



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a. All foster care children and IV-E Adoption Assistance children;

b. Individuals born to mothers who were eligible for MA in any state on the date of the individuals' birth;

c. Individuals entitled to or enrolled in Medicare, individuals receiving Social Security benefits on the basis of a disability and SSI recipients currently entitled to SSI payments. Former SSI recipients are not included in the exemption. The local department of social services (LDSS) must have verification from the Social Security Administration (such as a SVES response) of an individual's Medicare enrollment, benefits entitlement or current SSI recipient status.

When an individual loses an exception status and his C&I has not previously been verified, the individual must be given a reasonable opportunity to provide C&I.

NOTE: A parent or caretaker who is applying for a child, but who is NOT applying for MA for himself, is NOT required to verify his or her C&I.

3. Verification Required One Time

Once verification of C&I has been provided, it is not necessary to obtain verification again. Documentary evidence may be accepted without requiring the individual to appear in person. C&I documentation must be stored in the case record.

4. Enroll Under Good Faith Effort

If an individual meets all other eligibility requirements and declares that he is a citizen, he is to be enrolled under a good faith effort. **Do not request verification of C&I from the applicant, and do not delay or deny application processing for proof of C&I.**

If the applicant meets all other eligibility requirements:

- Approve the application and enroll the applicant in MA, AND
- Specify on the Notice that the individual may have to provide documentation of C&I if it cannot be obtained by other means, OR
- Include the Reasonable Opportunity Insert, available at https://fusion.dss.virginia.gov/Portals/[bp]/Files/Medical%20Assistance%20Guidance/medicaid_reasonable_opportunity_insertrev_03-09-10.pdf?ver=2019-06-04-151050-230 with the Notice.

The individual remains eligible for MA while the agency attempts to verify C&I through the data matching process described in M0220.100 D below, or if necessary, requests verification from the individual. The same good faith effort requirements apply should an individual lose his exemption from providing C&I verification. ***Children enrolled under good faith effort are not eligible for 12 months of continuous eligibility***.

D. Procedures for Documenting C&I

CHIPRA allows the option for verification of C&I for individuals newly enrolled in Medicaid or Family Access to Medical Insurance Security Plan (FAMIS) using a data match with SSA to confirm the consistency of a declaration of citizenship with SSA records in lieu of presentation of original documentation. This option, implemented in March 2010, allows for a monthly exchange of data between the Medicaid Management Information System

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(MMIS) and SSA for the documentation of C&I for individuals enrolled in the Medicaid and FAMIS programs. In order for this process to be used to verify citizenship and identity, the individual's SSN must be verified by SSA (see M0240).

For eligibility determinations processed through VaCMS, the Social Security data match takes place when the individual's information is sent through the Hub. For cases not processed in VaCMS, the SSA data match will take place after the individual has been enrolled in MMIS.

1. MMIS Data Matches SSA

If the information in the MMIS matches the information contained in the SSA files, the MMIS will be updated to reflect the verification of C&I. No further action is needed on the part of the eligibility worker, and the enrollee will not be required to provide any additional documentation, if the SSA match code in MMIS shows that SSA verified the individual's C&I.

2. MMIS Data Does Not Match SSA

If the information in the MMIS does not match the information in the SSA files, a discrepancy report will be generated monthly listing the inconsistent information. Eligibility staff is expected to review the report to see if the report lists any enrollees who were rejected because SSA could not verify the enrollee's citizenship and identity.

a. SSA Cannot Verify C&I

If the SSA data match result does not verify the individual's C&I, eligibility workers must review the information in the system to determine if a typographical or other clerical error occurred. If it is determined that the discrepancy was the result of an error, steps must be taken to correct the information in the system so that SSA can verify C&I when a new data match with SSA occurs in the future.

If the inconsistency is not the result of a typographical or other clerical error, the individual must be given a reasonable opportunity period of 90 days to either resolve the issue with SSA or provide verification of C&I. The eligibility worker must send a written notification to the enrollee that informs the enrollee of the discrepancy and gives him 90 calendar days from the date of the notice to either resolve the discrepancy with the SSA and to provide written verification of the correction, OR provide acceptable documentation of C&I to the LDSS.

The notice must specify the date of the 90th day, and must state that, if the requested information is not provided by the 90th day, the individual's Medicaid coverage will be canceled. Include with the notice the "Birth Certificates and Proof of Citizenship for Medicaid" Fact Sheet available on at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/References. Acceptable forms of documentation for C&I are also included in Appendix 1 to this subchapter.

b. Individual Does Not Provide Verification in 90 Days

If the individual does not respond to the request and does not provide the information necessary to meet the C&I documentation requirements by the 90th day, coverage may be canceled. Send an advance notice and cancel coverage at the end of the month in which the 90th day occurs. If the individual provides part of the information or is in the process of getting the information, a new reasonable opportunity period shall be provided. *The new reasonable opportunity period begins the day after the first period ended. No more than two reasonable opportunity periods should be granted within a certification period since the case cannot be successfully redetermined without the C&I documentation.*

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c. Discrepancy Resolved With SSA Within 90 Days

If written verification is received that corrects the SSA discrepancy within the 90 days, update the system accordingly so that the enrollee's information will be included in a future data match for C&I verification. The individual continues to remain enrolled pending the results of the subsequent data match.

If this subsequent data match with SSA results in verified C&I, MMIS will automatically enter code "CV" in the Cit Lvl and Identity fields in the individual's MMIS record. No further match will be done with the SSA files for C&I verification.

d. Verification of C&I Provided Within 90 Days

If the individual provides acceptable verification of his C&I within the 90 days, update the appropriate demographic fields in MMIS with the appropriate codes. No further match will be done with the SSA files for C&I verification.

3. Subsequent Applications

If the individual who lost coverage for failure to provide C&I documentation files a subsequent application, *but still does not provide C&I documentation,* a new *90 day* reasonable opportunity period should be granted.

M0220.200 ALIEN IMMIGRATION STATUS

A. Introduction

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

B. Procedure

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

If the alien is an emergency services alien who is eligible for Medicaid, use the policy and procedures in section M0220.600 D to enroll an eligible emergency services alien in Medicaid for emergency services only.

C. Changes in Immigration Status

If a "full benefit" alien who was admitted to the U.S with immigration status in one of the "seven-year" alien groups listed in M0220.313.A becomes a Lawful Permanent Resident, he is considered to have full benefit status for the purposes of Medicaid eligibility for the first seven years of residency in the U.S.

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M0220.201 IMMIGRATION STATUS VERIFICATION

A. Verification Procedures

An alien's immigration status is verified by the official document issued by the United States Citizenship and Immigration Services (USCIS) and a comparison with the Systematic Alien Verification for Entitlements (SAVE) system. SAVE interfaces with the Federal Hub for applications processed in VaCMS. The EW does not need to obtain the alien status document when immigration status is verified through the Hub. If immigration status cannot be verified through the Hub, the EW must see the original document or a photocopy; submission of just an alien number is NOT sufficient verification.

If the alien has an alien number but no USCIS document, or has no alien number and no USCIS document, use the **secondary verification** SAVE procedure in M0220.202 below if the alien provides verification of his or her identity.

If the agency cannot promptly verify immigration status of an individual in the Hub/SAVE, the agency must provide a 90-calendar-day reasonable opportunity period for the individual's immigration status to be verified and may not delay, deny, reduce or terminate benefits for an individual whom the agency determines to be otherwise eligible for Medicaid during such reasonable the opportunity period.

If the individual does not respond to the request and does not provide the information necessary to meet the C&I documentation requirements by the 90th day, coverage may be canceled. Send an advance notice and cancel coverage at the end of the month in which the 90th day occurs. If the individual provides part of the information or is in the process of getting the information, a new reasonable opportunity period should be provided. *The new reasonable opportunity period begins the day after the first period ended. No more than two reasonable opportunity periods should be granted within a certification period since the case cannot be successfully redetermined without the C&I documentation.*

NOTE: If a noncitizen attests that they do not have a valid immigration status, do not use the verification procedures in this section or the SAVE procedures. Go to section M0220.400 below to determine the noncitizen's eligibility.

B. Documents That Verify Status

Appendix 7 to this subchapter contains a list of typical immigration documents used by lawfully present noncitizens.

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

Verify lawful admission by a Resident Alien Card (issued from August 1989 until December 1997) or Permanent Resident Card (Form I-551); a Re-entry Permit; or a Form I-688B with a provision of law section 274A.12(A)(1). Afghan and Iraqi immigrants admitted to the U.S. under a Special Immigrant Visa will have either (1) a Form I-551 or (2) a passport or I-94 form indicating categories SI1, SI2, SI3, SQ1, SQ2, or SQ3 and bearing the Department of Homeland Security stamp or notation.

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



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C. Letters that Verify Status

The USCIS and the Office of Refugee Resettlement (ORR) issue letters that are used in lieu of or in conjunction with USCIS forms to identify alien status. If the letter is the only document provided, it is necessary to verify the status of the alien. For USCIS letters, contact the USCIS at 1-800-375-5283 for assistance in identifying the alien's status. For ORR letters, contact the toll-free ORR Trafficking Verification Line at 866-401-5510 (see Appendix 2 of this subchapter). Do not verify ORR letters via the SAVE system.

D. Local USCIS Office Documents

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

E. Expired or Absent Documentation

If an applicant presents an expired USCIS document or is unable to present any document showing his immigration status, refer the individual to the USCIS district office to obtain evidence of status **unless** he provides an alien registration number. Allow the individual a 90-calendar-day reasonable opportunity period to provide the documentation.

If the individual meets all other Medicaid eligibility requirements, do not delay, deny, reduce or terminate the individual's eligibility for Medicaid **on the basis of *immigration* status**. If the individual does not *respond to the request and does not* provide the information necessary to meet the C&I documentation requirements by the 90th day, coverage *may* be canceled. Send an advance notice, and cancel coverage at the end of the month in which the 90th day occurs. *If the individual provides part of the information or is in the process of getting the information, a new reasonable opportunity period should be provided.*

If the applicant provides an alien registration number with supporting verification of his identity, use the SAVE procedures in M0220.202 below to verify immigration status.

If an applicant presents an expired I-551 or I-151, follow procedures for initiating a primary verification. If the alien presents any expired document other than an expired I-551 or I-151, follow procedures for initiating a secondary verification.

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

M0220.202 SYSTEMATIC ALIEN VERIFICATION FOR ENTITLEMENTS (SAVE)

A. SAVE

Aliens must submit documentation of immigration status before eligibility for the full package of Medicaid benefits can be determined. SAVE interfaces with the Federal Hub for applications processed in VaCMS. The following procedures are applicable when immigration status cannot fully be verified by the Hub.

If the documentation provided appears valid and meets requirements, eligibility is determined based on the documentation provided AND a comparison of the documentation provided with immigration records maintained by the USCIS. The comparison is made by using the SAVE system established by Section 121 of the Immigration Reform and Control Act of 1986 (IRCA).

1. Primary Verification

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

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

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

A primary verification document must be **initiated prior to case approval.** The primary verification document must be filed in the case record.

2. Secondary Verification

Secondary verification is required in the following situations:

a. The alien has an alien number but no USCIS document, or the alien has no alien number and no USCIS document.

b. Primary verification generates the message "Institute Secondary Verification" or "No File Found."

c. Discrepancies are revealed when comparing primary verification to the original immigration document.

d. Immigration documents have no Alien Registration Number (A-Number).

e. Documents contain an A-Number in the A60 000 000 or A80 000 000 series.

f. The document presented is an USCIS Fee Receipt.

g. The document presented is Form I-181 or I-94 in a foreign passport that is endorsed "Processed for I-551, Temporary Evidence of Lawful Permanent Residence," and the I-181 or I-94 is more than one year old.

When secondary verification is required, the agency must complete the top portion of a Document Verification Request (Form G-845) or initiate an on-line request for a secondary verification through SAVE. The G-845 is *available at http://www.uscis.gov. Click on "Forms."*

B. Document Verification Request (Form G-845)

If the alien has filed an USCIS application for or received a change in status, the application for or change in status in itself is not sufficient basis for determining immigration status. Likewise, any document which raises a question of whether USCIS contemplates enforcing departure is not sufficient basis for determining the alien's status. In such situations, verify the alien's status with USCIS using the Document Verification Request (Form G-845). For an alien who entered the U.S. before 8-22-96 and whose status is adjusted to a qualified status after he entered the U.S. use the Form G-845 Supplement to request the period of continuous presence in the U.S. The G-845 Supplement (S) is *available at http://www.uscis.gov. Click on "Forms."*

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



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

Once the requirement to obtain secondary verification is determined, the agency must initiate the request within ten work days. The USCIS mailing address is subject to frequent changes. Obtain the current mailing address from the SAVE web site at http://www.uscis.gov. Click on "Direct Filing Addresses for Form G-845."

A photocopy of the completed G-845 form must be filed in the record as evidence that the form has been forwarded to USCIS.

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

Acceptable documentation includes:

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

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

C. Agency Action

When the primary verification response requires the eligibility worker to initiate a secondary verification from USCIS, do not delay, deny, reduce or terminate the individual's eligibility for Medicaid **on the basis of alien status**. If the applicant meets all other Medicaid eligibility requirements, approve the application and enroll the applicant in Medicaid. Allow 90 calendar days for the secondary verification to be received. If the secondary verification or the individual do not provide the information necessary to meet the documentation requirements by the 90th day, coverage *may* be canceled. Send an advance notice and cancel coverage at the end of the month in which the 90th day occurs. *If the individual provides part of the information or is in the process of getting the information, a new reasonable opportunity period should be provided.*

Upon receipt of the G-845 or response to the on-line query, compare the information with the case record. Timely notice must be given to the individual when Medicaid benefits are denied or reduced.

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Note: When a secondary verification is requested for an alien with an expired I-551, the G-845 or response to the on-line SAVE query should indicate that the person continues to have lawful permanent resident status. When a secondary verification is requested for an alien with an expired I-151, the G-845 or response to the on-line SAVE query will indicate that the documentation is expired; however, do not delay, deny, reduce or terminate an individual's eligibility for Medicaid on the basis of an expired I-151.

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

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M0220.300 FULL BENEFIT ALIENS

A. Policy

A "full benefit" alien is

- an alien who receives SSI (M0220.305);
- an American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (INA) apply, or a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)) (M0220.306);
- a "qualified" alien (defined in M0220.310 below) who entered the U.S. before 8-22-96;
- a qualified alien refugee; asylee; deportee; Amerasian; Cuban or Haitian entrant; victim of a severe form of trafficking; or a qualified Afghan or Iraqi immigrant admitted to the U.S. on a Special Immigrant Visa *or an Afghan special immigrant who meets the criteria in M0220, Appendix 4*; who entered the U.S. on or after 8-22-96, but only for the first **7** years of residence in the U.S. (M0220.313.C) *unless the criteria in M0220 Appendix 4 are applicable.*
- effective 12-27-20, *a qualified alien who is a Compact of Free Association (COFA) migrant (also referred to as compact citizens). COFA is a compact between the United States and the three Pacific Island sovereign states of Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau—known as the Freely Associated States.*
- before 4-1-21, a qualified LPR who entered the U.S. on or after 8-22-96 who has at least 40 qualifying quarters of work, but only **AFTER** 5 years of residence in the U.S. (M0220.313 B). Effective 4-1-21, a qualified LPR who entered the U.S. on or after 8-22-96 and who has resided in the U.S. for at least five years is no longer required to have any qualifying quarters of work to receive full Medicaid benefits;
- *the following qualified aliens, but only **AFTER** 5 years of residence in the U.S.:*
  - *a parolee under section 212(d)(5) of the Immigration and Nationality Act for a period of at least 1 year;*
  - *an alien who is granted conditional entry pursuant to section 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980;*
  - *an alien, and/or an alien parent of battered children and/or an alien child of a battered parent who is battered or subjected to extreme cruelty while in the U.S.*
- a qualified alien who meets the veteran or active duty military requirements in M0220.311 below; or
- a lawfully residing non-citizen child under age 19 or pregnant woman who meets the requirements in M0220.314 below.

A full benefit alien is eligible for full Medicaid benefits if he/she meets all other Medicaid eligibility requirements.

Aliens who are not "full benefit" aliens are "emergency services" aliens and may be eligible for emergency Medicaid services only if they meet all other Medicaid eligibility requirements. See section M0220.400 for emergency services aliens.

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B. Procedure

1. Step 1 First, determine if the alien receives SSI. Section M0220.305 describes this group of aliens who receive SSI.

If the alien does NOT receive SSI, go to Step 2.

If the alien receives SSI, go to Step 6.

2. Step 2 Second, determine if the alien is an American Indian born in Canada or a member of an Indian tribe as defined in section 4(e) of the Indian Self- Determination and Education Assistance Act (25 U.S.C. 450b(e)). Section M0220.306 describes this group of aliens.

If NO, go to Step 3. If YES, go to Step 6.

3. Step 3 Third, determine if the alien is a "qualified" alien eligible for full benefits (a full benefit qualified alien).

- Section M0220.310 defines "qualified" aliens.
- Section M0220.311 defines qualified veteran or active duty military aliens.
- Section M0220.312 describes qualified aliens who entered the U.S. before 8-22-96.
- Section M0220.313 describes qualified aliens who entered the U.S. on or after 8-22-96.

If the alien is NOT a qualified alien eligible for full benefits, go to step 4.

If the alien is a qualified alien eligible for full benefits, go to step 6.

4. Step 4 Fourth, determine if the alien is a lawfully residing non-citizen child under age 19 or pregnant woman. See section M0220.314.

If the alien is NOT a lawfully residing non-citizen under age 19 or pregnant woman, go to Step 5.

If the alien is a lawfully residing non-citizen child under age 19 or pregnant woman, go to Step 6.

5. Step 5 The alien is an "**emergency services**" alien. Go to Section M0220.400 which defines emergency services aliens, then to M0220.500 which contains the eligibility requirements applicable to all aliens, then to *M0220.600 D*, which contains the entitlement and enrollment policy and procedures for emergency services aliens.

6. Step 6 Use Section M0220.500, which contains the Medicaid eligibility requirements applicable to all aliens, to determine the alien's Medicaid eligibility. Then use Section M0220.600, which contains the entitlement and enrollment procedures for **full benefit** aliens, to enroll an eligible full benefit alien.



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M0220.305 ALIENS RECEIVING SSI

A. Policy

An SSI recipient meets the Medicaid full benefit alien status requirements. Some SSI recipients who are aliens would have lost SSI and Medicaid eligibility. The Balanced Budget Act of 1997 restored SSI eligibility for certain groups of aliens:

- a legal alien who was receiving SSI on August 22, 1996, may continue to receive SSI if he/she meets all other SSI eligibility requirements.
- an alien who was blind or disabled on August 22, 1996, and who is residing legally in the U.S. may receive SSI in the future if he/she meets all other SSI eligibility requirements.
- a legal alien who is receiving SSI for months after July 1996 on the basis of an SSI application filed before January 1, 1979, is exempted from the SSI legal alien requirements, and is eligible for SSI if he/she meets all other SSI eligibility requirements.

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B. ***SSI Extension for Elderly and Disabled Refugees Act***

The SSI Extension for Elderly and Disabled Refugees Act (P.L. 110-328), enacted on September 30, 2008, allows elderly or disabled aliens subject to the seven-year time limit for receiving SSI to receive up to two additional years of SSI benefits. Although the Social Security Administration makes the determination of eligibility for the SSI extension, the categories of seven-year aliens to which the SSI extension may apply are listed in M0220.313 A.1 through A.4.

Individuals receiving SSI benefits on the basis of the SSI extension also meet the alien status requirement for full-benefit Medicaid eligibility.

C. **Procedure**

Verify the alien's SSI current payment status on the SDX or through SVES. If the alien currently receives SSI, and/or received SSI during the period for which Medicaid coverage is requested, the alien meets the alien status requirements for Medicaid with no further development.

Determine the alien SSI recipient's Medicaid eligibility using the policy and procedures for full benefit aliens in section M0220.600 below.

M0220.306 CERTAIN AMERICAN INDIANS

A. Policy

An alien who is

- an American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (INA) apply, or
- a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)),

meets the Medicaid full benefit alien status requirements.

B. Procedure

Verify the status of an American Indian born in Canada from *USCIS* documents that the individual presents, or via the SAVE system.

Verify the status of a member of an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e) from official documents that the individual presents.

M0220.310 QUALIFIED ALIENS DEFINED

A. Qualified Aliens Defined

A qualified alien is an alien who, at the time he applies for, receives or attempts to receive Medicaid is:

1. Lawful Permanent Resident

an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act.

2. Refugee

an alien who is admitted to the U.S. under the Immigration and Nationality Act as a **refugee under section 207 of the INA**, or an alien

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who is admitted to the U.S. as **an Amerasian immigrant** pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act 1988 (as contained in section 101(e) of Public Law 100-202 and amended by the 9th proviso under MIGRATION AND REFUGEE ASSISTANCE in title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1989, Public Law 100-461, as amended).

The refugee will have a Form I-94 identifying him/her as a refugee under section 207 of the INA. The Amerasian immigrant will have an I-94 coded AM1, AM2, or AM3, or an I-551 coded AM6, AM7, or AM8.

3. Conditional Entrant — an alien who is granted conditional entry pursuant to section 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980.

Aliens admitted to the United States as conditional entrants pursuant to 203(a)(7) of the Immigration and Nationality Act (INA) (8 USC 1153(a)(7)) have an *USCIS* Form I-94 bearing the stamped legend "Refugee - Conditional Entry" and a citation of the INA section.

NOTE: Section 203(a)(7) of the INA was made obsolete by the Refugee Act of 1980 (P.L.96-212) and replaced by section 207 of the INA effective April 1, 1980.

4. Asylee — an alien who is granted asylum under section 208 of the Immigration and Nationality Act. Aliens granted asylum will have a Form I-94 and a letter.

5. Parolee — an alien who is paroled into the U.S. under section 212(d)(5) of the Immigration and Nationality Act for a period of at least 1 year. Aliens in this group will have a Form I-94 indicating that the bearer has been paroled pursuant to section 212(d)(5) of the INA.

6. Deportee--Deportation Withheld — an alien whose deportation is being withheld under section 243(h) of the INA (as in effect immediately before the effective date of section 307 of division C of Public Law 104-208) or section 241(b)(3) of the INA (as amended by section 305(a)of division C of Public Law 104-208) . These aliens will have an order from an immigration judge showing that deportation has been withheld under section 243(h) or section 241(b)(3) of the INA and/or a Form I-94.

7. Cuban or Haitian Entrant — an alien who is a Cuban and Haitian entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980. A Cuban or Haitian Entrant is a person from Cuba or Haiti who

- has been granted parole by *USCIS* for humanitarian or public interest reasons, unless a final order of deportation or exclusion has been issued;
- has an application for asylum pending with *USCIS*, unless a final order of deportation or exclusion has been issued;

- is subject to *USCIS* exclusion or deportation proceedings, unless a final order of deportation or exclusion has been issued.

a. Humanitarian, Public Interest, Application for Asylum

To meet the humanitarian, public interest or application for asylum status, the Cuban or Haitian entrant must be from Cuba or Haiti and must have an I-94 with one or more of the following notations:

- humanitarian parole;
- public interest parole;
- section 212(d)(5);
- parole; or
- Form I-589 filed.

Contact *USCIS* if there is reason to believe that a final order of exclusion or deportation has been issued.

b. Subject to Exclusion or Deportation

To be subject to exclusion or deportation proceedings, the Cuban or Haitian entrant must be from Cuba or Haiti and must have letters or notices which indicate ongoing exclusion or deportation proceedings that apply to the individual. Contact *USCIS* if there is reason to believe that a final order of exclusion or deportation has been issued.

8. Battered Alien an alien, and/or an alien parent of battered children and/or an alien child of a battered parent who is battered or subjected to extreme cruelty while in the U.S. who meets the following requirements:

a. the perpetrator is a spouse, parent or other household member of the spouse or parent's family who was residing in the home at the time of the incident but is no longer in the home. The alien must not now be residing in the same household as the individual responsible for the battery or extreme cruelty, and

- the alien was battered or subjected to extreme cruelty while in the U.S. by a spouse or a parent, or by a member of the spouse or parent's family residing in the same household as the alien, and the spouse or parent consented to or acquiesced in such battery or cruelty;

- the alien's child was battered or subjected to extreme cruelty while in the U.S. by a spouse or a parent of the alien (without the active participation of the alien in the battery or cruelty), or by a member of the spouse or parent's family residing in the same household as the alien, and the spouse or parent consented or acquiesced to such battery or cruelty and the alien did not actively participate in such battery or cruelty; or

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- the alien child resides in the same household as a parent who has been battered or subjected to extreme cruelty while in the U.S. by that parent's spouse, or by a member of the spouse's family residing in the same household as the parent and the spouse consented or acquiesced to such battery or cruelty.

b. the agency providing benefits determines (according to the guidelines to be issued by the U.S. Attorney General) that there is a substantial connection between the battery or cruelty and the need for benefits; and

c. the alien has a petition approved by or pending with USCIS for one of the following:

- status as an immediate relative (spouse or child) of a U.S. citizen;
- classification changed to immigrant;
- status as the spouse or child of a lawful permanent resident alien (LPR); or
- suspension of deportation and adjustment to LPR status based on battery or extreme cruelty by a spouse or parent who is a U.S. citizen or LPR alien.

9. Afghan or Iraqi Special Immigrant an alien who is lawfully admitted into the U.S. on a Special Immigrant Visa (SIV) for permanent residency *or an Afghan special immigrant who meets the criteria in M0220, Appendix 4*;. Aliens in this group include the principal SIV holder, his spouse, and his children under age 21 living in the home. Afghan and Iraqi Special Immigrants will have either (1) a Form I-551 or (2) a passport or I-94 form indicating categories SI1, SI2, SI3, SQ1, SQ2, or SQ3 and bearing the Department of Homeland Security stamp or notation. *Other qualified Afghan special immigrants will have one of the documents listed in M0220, Appendix 4.*

10. Victims of Trafficking an alien who has been granted nonimmigrant status under section 101(a)(15)(T) or who has a pending application that sets forth a prima facie (has sufficient evidence) case for eligibility for such status.

M0220.311 VETERAN & ACTIVE DUTY MILITARY ALIENS

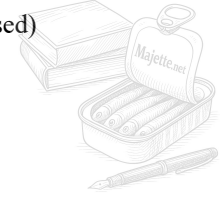
A. Veterans or Active Duty Military Aliens An alien lawfully residing in the state (not here illegally) is always eligible for full Medicaid benefits (if he/she meets all other Medicaid eligibility requirements) **regardless of the date of entry into the U. S.**, if he or she meets one of the following conditions:

1. he/she is a qualified alien and is a veteran discharged honorably not on account of alienage, and who fulfills the minimum active-duty service requirements of section 5303A(d) of title 38, United States Code;

2. he/she is a qualified alien and is on active duty (other than active duty for training) in the Armed Forces of the United States (not in the Armed Forces Reserves),

3. he/she is the

   a) spouse or the unmarried dependent child of a living (not deceased) qualified alien who meets the conditions of 1. or 2. above, or



b) the unremarried surviving spouse of an individual described in 1. or 2. above who is deceased, if the spouse was married to the veteran

- before the expiration of fifteen years after the termination of the period of service in which the injury or disease causing the death of the veteran was incurred or aggravated; or
- for one year or more; or
- for any period of time if a child was born of the marriage or was born to them before the marriage.

A divorced person is not a spouse.

A "dependent child" for this section's purposes is one whom the Veterans Administration (VA) has determined to meet the VA definition of "dependent child." According to the VA, a dependent child is an unmarried child under age 18, an unmarried child between ages 18 and 23 who is attending a VA-approved school, or a "helpless" child who became disabled before attaining age 18.

B. Verification

Acceptable verification of honorable discharge or active duty status include the following documents:

1. Discharge Status

For discharge status, an original or notarized copy of the veteran's discharge papers (DD 214) issued by the branch of service in which the alien was a member verifies whether he/she was honorably discharged for a reason other than alien status.

Other documentation which is acceptable under the Department of Defense (DOD) or VA guidelines can be substituted for the DD 214 form.

A self declaration under penalty of perjury may be accepted pending receipt of acceptable documentation.

2. Active Duty Status

For active duty military status, an original or notarized copy of the alien's current orders showing the individual is on full-time duty in the U.S. Army, Navy, Air Force, Marine Corps, or Coast Guard (full-time National Guard duty is NOT active military status), or a military identification card (DD Form 2 (active)) verifies whether the alien is in active duty military status.

Other documentation which is acceptable under the Department of Defense (DOD) or VA guidelines can be substituted for the current orders or military ID card.

A self declaration under penalty of perjury may be accepted pending receipt of acceptable documentation.

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C. Services Available To Eligibles

A qualified alien who meets the veteran or active duty military requirements above and who meets all other Medicaid eligibility requirements is eligible for the full package of Medicaid covered services available to the alien's covered group.

D. Entitlement & Enrollment of Eligibles

The Medicaid entitlement policy and enrollment procedures for eligible veteran/active duty military aliens are found in section M0220.600 below.

M0220.312 QUALIFIED ALIENS WHO ENTERED U.S. BEFORE 8-22-96

A. Qualified Aliens-- Entered U.S. Before 8-22-96

Qualified aliens (as defined in M0220.310 above) who were living in the U.S. prior to 8-22-96 and who meet all other Medicaid eligibility requirements are eligible for the full package of Medicaid benefits available to the covered group they meet.

1. Full Benefit Qualified Aliens

These "full benefit" qualified aliens who entered the U.S. before 8-22-96 are:

- Lawful Permanent Residents,
- Refugees under section 207, and Amerasian immigrants,
- Conditional Entrants under section 203(a)(7),
- Asylees under section 208,
- Parolees under section 212(d)(5),
- Deportees whose deportation is withheld under section 243(h) or 241(b)(3),
- Cuban or Haitian Entrants, and
- Battered aliens, alien parents of battered children, and/or alien children of battered parents.

NOTE: If the qualified alien is a veteran or in active duty military status, or is the spouse or the unmarried dependent child of a qualified alien who meets the conditions in M0220.311 above, the alien is a full benefit alien.

2. Adjusted Status

When an alien entered the U.S. before 8-22-96 with an unqualified alien status and the alien's status is adjusted to a qualified status after the alien entered the U.S., the alien's qualified status is considered to be effective back to the date he/she entered the U.S. if:

- the alien was physically present in the U.S. before 8-22-96, and
- the alien remained physically present in the U.S. from the date of entry to the status adjustment date.

The date of entry will be the first day of the verified period of continuous presence in the U.S. (see M0220.202).

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B. Services Available To Eligibles A qualified alien who entered the U.S. before 8-22-96 and who meets all other Medicaid eligibility requirements is eligible for the full package of Medicaid covered services available to the alien's covered group.

C. Entitlement & Enrollment of Eligibles The Medicaid entitlement policy and enrollment procedures for eligible qualified aliens who entered the U.S. before 8-22-96 are found in section M0220.600 below.

M0220.313 QUALIFIED ALIENS WHO ENTERED U.S. ON OR AFTER 8-22-96

A. No Limit on Residency in the U.S. Effective 12-27-20, *qualified aliens who are Compact of Free Association (COFA) migrants (also referred to as compact citizens) are full benefit aliens. COFA is a compact between the United States and the three Pacific Island sovereign states of Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau—known as the Freely Associated States.*

B. First 7 Years of Residence in U.S. During the first seven years of residence in the U.S., six (6) groups of qualified aliens (as defined in M0220.310 above) who entered the U.S. on or after 8-22-96 are eligible for the full package of Medicaid benefits available to the covered group they meet (if they meet all other Medicaid eligibility requirements), even if their status is adjusted later to LPR.. These 6 groups of qualified aliens who entered the U.S. on or after 8-22-96 are:

1. Refugees Refugees under section 207 and Amerasian immigrants are full benefit aliens for 7 years from the date of entry into the U.S. Once 7 years have passed from the date the refugee entered the U.S., the refugee becomes an "emergency services" alien.

2. Asylees Asylees under section 208 are full benefit aliens for 7 years from the date asylum in the U.S. is granted. Once 7 years have passed from the date the alien is granted asylum in the U.S., the asylee becomes an "emergency services" alien.

3. Deportees Deportees whose deportation is withheld under section 243(h) or section 241(b)(3) are full benefit aliens for 7 years from the date withholding is granted. After 7 years have passed from the date the withholding was granted, the deportee becomes an "emergency services" alien.

NOTE: If the qualified alien is a veteran or in active duty military status, or is the spouse or the unmarried dependent child of a qualified alien who meets the conditions in M0220.313 above, the alien is a full benefit alien.

4. Cuban or Haitian Entrants Cuban and Haitian entrants as defined in section 501(e) of the Refugee Education Assistance Act of 1980 are full benefit aliens for 7 years from the date they enter the U.S. After 7 years have passed from the date they entered the U.S., a Cuban or Haitian entrant becomes an "emergency services" alien.

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5. Victims of a Severe Form of Trafficking

Victims of a severe form of trafficking as defined by the Trafficking Victims Protection Act of 2000, P.L. 106-386 are full benefit aliens for 7 years **from the date they are certified or determined eligible** by the Office of Refugee Resettlement (ORR). Victims of a severe form of trafficking are identified by either a letter of certification (for adults) or a letter of eligibility (for children under age 18 years) issued by the ORR (see Appendix 5 of this subchapter). **The date of certification/eligibility specified in the letter is the date of entry for a victim of a severe form of trafficking.** After 7 years have passed from the certification/eligibility date, a victim of a severe form of trafficking becomes an "emergency services" alien unless his status is adjusted.

6. Afghan or Iraqi Immigrant Admitted to the U.S. on a Special Immigrant Visa

The Department of Defense Appropriations Act of 2010, enacted on December 19, 2009, provides that Iraqi and Afghan Special Immigrants are eligible for Medicaid benefits to the same extent and for the same time period as refugees. The legislation supersedes prior legislative authority that limited Special Immigrants to benefits for an 8-month time period. Provided that all other eligibility requirements are met, Iraqi and Afghan Special Immigrants are eligible for Medicaid benefits for the first seven years after entry into the United States (U.S.).

For Afghan special immigrants who do not hold a Special Immigrant Visa, see M0220, Appendix 4.

7. After 7 Years Residence in U.S.

After seven years of residence in the U.S., the qualified refugee, Amerasian, asylee, deportee, Cuban or Haitian entrant, victim of a severe form of trafficking, or Afghan or Iraqi Special Immigrant (as defined in M0220.310 above) who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an "emergency services" alien.

***C.* AFTER 5 Years of Residence in U.S.**

The following qualified aliens who entered the U.S. **on or after 8-22-96** are eligible for the full package of Medicaid benefits available to the covered group they meet (if they meet all other Medicaid eligibility requirements) after 5 years of residence in the U.S.:

- *a parolee under section 212(d)(5) of the Immigration and Nationality Act for a period of at least 1 year;*
- *an alien who is granted conditional entry pursuant to section 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980;*
- *an alien, and/or an alien parent of battered children and/or an alien child of a battered parent who is battered or subjected to extreme cruelty while in the U.S.*
- LPRs (as defined in M0220.310 above). *For eligibility determinations for months prior to April 2021, an LPR who entered the U.S. on or after 8-22-96 and who has resided in the U.S. for five years must also have at least 40 qualifying quarters of work. Effective 4-1-21, a qualified lawful permanent resident who entered the U.S. on or after 8-22-96 and who has resided in the U.S. for at least five years is no longer required to have any qualifying quarters of work to receive full Medicaid benefits.*

1. LPR

When an LPR entered the U.S. on or after 8-22-96, the LPR is an **"emergency services" alien during the first 5 years** the LPR is in the U.S., regardless of work quarters.



Note: If the LPR had prior immigration status in one of the "seven-year" alien groups listed in M0220.313.A, he is considered to have "seven-year" status for the purposes of Medicaid eligibility for the first seven years of residency in the U.S. To determine former status of a LPR, check the coding on the I-551 for codes RE-6, RE-7, RE-8, or RE-9. Contact the USCIS at 1-800-375-5283 for assistance in identifying the former status for other seven year aliens.

Effective 4-1-21, **AFTER** 5 years have passed from the date of entry into the U.S., LPRs are "full benefit" aliens. *For eligibility determinations for months prior to April 2021,* LPRs who DO NOT have at least 40 qualifying quarters of work remain emergency services aliens after 5 years have passed from the date of entry into the U.S.

2. Qualifying Quarter

- A qualifying quarter of work means a quarter of coverage as defined under Title II of the Social Security Act which is worked by the alien and/or
- all the qualifying quarters worked by the spouse of such alien during their marriage and the alien remains married to such spouse or such spouse is deceased, and all of the qualifying quarters worked by a parent of such alien while the alien was under age 18 years.

See Appendix 3 to this subchapter for procedures for verifying quarters of coverage under Title II of the Social Security Act.

Any quarter of coverage, beginning after December 31, 1996, in which the alien, spouse or parent of the alien applicant received any federal means-tested public benefit (such as SSI, TANF, Supplemental Nutrition Assistance Program [SNAP] and **full-benefit** Medicaid) **cannot** be credited to the alien for purposes of meeting the 40 quarter requirement. Medicaid coverage for **emergency services** does not impact the 40 quarter requirement.

D. **Services Available To Eligibles**

1. Refugee, Amerasian, Asylee, Deportee, Cuban or Haitian Entrant, Victim of a Severe Form of Trafficking; Afghan or Iraqi Special Immigrant

The following immigrants:

- qualified refugee,
- Amerasian,
- asylee,
- deportee,
- Cuban or Haitian entrant,
- victim of a severe form of trafficking, or

- Afghan or Iraqi Special Immigrant (as defined in M0220.310 above *and in M0220, Appendix 4)*,

- *Ukraine Humanitarian Parolees (see Appendix 4)*

who entered the U.S. on or after 8-22-96 and who meets all other Medicaid eligibility requirements is eligible for the full package of Medicaid covered services available to the alien's covered group during the first 7 years of residence in the U.S. After 7 years of residence in the U.S., the refugee, Amerasian, asylee, deportee, Cuban or Haitian entrant, victim of a severe form of trafficking, or Afghan or Iraqi Special Immigrant who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and is eligible for emergency services only.

2. LPR

Effective 4-1-21, after five years of residence in the U.S., an LPR who entered the U.S. on or after 8-22-96 is eligible for the **full package of Medicaid benefits** available to the covered group he/she meets if he/she meets all other Medicaid eligibility requirements.

For eligibility determinations for months prior to April 2021, LPRs who DO NOT have at least 40 qualifying quarters of work remain emergency services aliens after 5 years have passed from the date of entry into the U.S.

***E.* Entitlement & Enrollment *for those* Eligible**

The Medicaid entitlement policy and enrollment procedures for full benefit qualified aliens who entered the U.S. on or after 8-22-96 are found in section M0220.600 below.

The Medicaid entitlement policy and enrollment procedures for emergency services qualified aliens who entered the U.S. on or after 8-22-96 are found in section M0220.700 below.

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Virginia Medical Assistance Eligibility	**M02**	**October 2024**
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M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS	**M0220.314**	**14e**

M0220.314 LAWFULLY RESIDING NON-CITIZEN CHILDREN UNDER AGE 19 AND PREGNANT WOMEN

A. Policy

Section 214 of CHIPRA of 2009 gives states the option to provide Medicaid and FAMIS/FAMIS MOMS coverage to certain individuals who are lawfully residing in the United States and are otherwise eligible for assistance. Virginia has elected to cover children under the age of 19 and pregnant women who are lawfully residing in the U.S.

Noncitizens are lawfully residing in the U.S. if they have been admitted lawfully into the U.S. and have not overstayed the period for which they were admitted, or they have current permission to stay or live in the U.S.

This policy does **not** apply to individuals who receive temporary relief from removal under the Deferred Action for Childhood Arrivals (DACA) process announced by the U.S. Department of Homeland Security on June 15, 2012.

Children born in the U.S. to foreign diplomat parents (i.e. neither parent is a U.S. citizen) must have their own lawful status. They may apply for immediate LPR status.

Children under age 19 and pregnant women who are in one of the lawfully residing non-citizen alien groups described below must have their immigration status verified at the time of the initial eligibility determination and at each annual renewal of eligibility to ensure that they are lawfully residing in the U.S. and that their immigration status has not changed.

NOTE: All aliens who meet the alien status eligibility requirements for Medicaid and FAMIS/FAMIS MOMS must also meet the Virginia state residency requirements to be eligible for coverage under the programs.

For a pregnant woman who is not lawfully residing in the U.S., *or has the immigration status of DACA,* use Chapter M23 to evaluate her eligibility for FAMIS Prenatal Coverage. If she is not eligible for FAMIS Prenatal Coverage, evaluate her eligibility for the coverage of emergency services using M0220.500.

B. Eligible Alien Groups

Lawfully residing children under age 19 and pregnant women meet Medicaid and FAMIS/FAMIS MOMS alien requirements without regard to their date of arrival or length of time in the U.S. Children under 19 or pregnant women are lawfully residing aliens if they are:

1. a qualified alien as defined in section 431 of PRWORA (8 U.S.C § 1641). See M0220.310;

2. an alien in a nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission . This group includes individuals with valid visas;

3. an alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and nationality Act (INA) (8 U.S.C § 1182 (d)(5)) for less than I year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;

4. an alien who belongs to one of the following classes:
   a. aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C.§§ 1160 or 1255a, respectively),



b. aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. § 1254a), and pending applicants for TPS who have been granted employment authorization,

c. aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24),

d. Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended,

e. aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President,

f. aliens currently in deferred action status, except for individuals receiving deferred status as a result of the Deferred Action for Childhood Arrivals (DACA) process, announced by the U.S. Department of Homeland Security on June 15, 2012, or

g. aliens whose visa petition has been approved and who have a pending application for adjustment of status.

5. a pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158), or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231), or under the Convention Against Torture who has been granted employment authorization, or such an applicant under the age of 19 who has had an application pending for at least 180 days;

6. an alien who has been granted withholding of removal under the Convention Against Torture;

7. a child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J);

8. an alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806 (e); or

9. an alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

M0220.400 EMERGENCY SERVICES ALIENS

A. Policy

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

B. Procedure

- Section M0220.410 describes the qualified aliens who entered the U.S. on or after 8-22-96 who are emergency services aliens.
- Section M0220.411 defines "unqualified" aliens.
- Section M0220.500 contains the Medicaid eligibility requirements applicable to full benefit and emergency services aliens.
- Section *M0220.600 D* contains the entitlement and enrollment procedures for emergency services aliens.

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Subchapter Subject	Page ending with	Page
M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS	**M0220.410**	**16**

M0220.410 EMERGENCY-SERVICES-ONLY QUALIFIED ALIENS WHO ENTERED U.S. ON OR AFTER 8-22-96

A. First 5 Years of Residence in U.S.

During the first five years of residence in the U.S., four groups of qualified aliens (as defined in M0220.310 above) who entered the U.S. on or after 8-22-96 are eligible for **emergency Medicaid services only** provided they meet all other Medicaid eligibility requirements.

1. Lawful Permanent Residents (LPRs)

An LPR who enters the U.S. on or after 8-22-96 is an "emergency services" alien during the first 5 years the LPR is in the U.S., regardless of work quarters.

Note: If the LPR had prior Refugee status, he may be considered to have Refugee status for the purposes of Medicaid eligibility. To determine former Refugee status of a Lawful Permanent Resident, check the coding on the I-551 for codes RE-6, RE-7, RE-8, or RE-9. Refer to M0220.313.A.1.

2. Conditional Entrants

A qualified Conditional Entrant who enters the U.S. on or after 8-22-96 is an "emergency services" alien *during the first 5 years the Conditional Entrant is in the U.S.*

3. Parolees

A qualified parolee who enters the U.S. on or after 8-22-96 is an "emergency services" alien during the first 5 years the parolee is in the U.S.

4. Battered Aliens

A qualified battered alien who enters the U.S. on or after 8-22-96 is an "emergency services" alien during the first 5 years the battered alien is in the U.S.

B. AFTER 5 Years of Residence in U.S.

1. Lawful Permanent Residents Without 40 Work Quarters

For months prior to 4-1-21, Lawful Permanent Residents who DO NOT have at least 40 qualifying quarters of work remain emergency services aliens after residing in the U.S. for 5 years. Effective 4-1-21, Lawful Permanent Residents become full benefit aliens after 5 years of residing in the U.S. with no work requirement.

2. Conditional Entrants

A qualified Conditional Entrant who enters the U.S. on or after 8-22-96 *and has resided in the U.S. for at least 5 years is a full benefit alien.*

3. Parolees

A qualified parolee who enters the U.S. on or after 8-22-96 *and has resided in the U.S. for at least 5 years is a full benefit alien.*

4. Battered Aliens

A qualified battered alien who enters the U.S. on or after 8-22-96 *and has resided in the U.S. for at least 5 years is a full benefit alien.*

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C. AFTER 7 Years of Residence in U.S.

1. Refugees — After 7 years of residence in the U.S., a refugee or Amerasian immigrant who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an "emergency services" alien.

2. Asylees — After 7 years have passed since asylum was granted, an asylee who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an "emergency services" alien.

3. Deportees — After 7 years have passed since deportation was withheld, a deportee who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an "emergency services" alien.

4. Cuban or Haitian Entrants — After 7 years of residence in the U.S., a Cuban or Haitian Entrant who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an "emergency services" alien.

5. Afghan and Iraqi Special Immigrants — Medicaid coverage for Afghan and Iraqi Special Immigrants who are eligible in a Medicaid covered group cannot begin earlier than December 26, 2007. After 7 years of residence in the U.S., Afghan and Iraqi Special Immigrants are no longer eligible for full Medicaid benefits and become "emergency services" aliens.

After the applicable limited time period expires, individuals become "emergency services" aliens unless the requirements in M0220.313 B or M0220.314 are met.

D. Services Available To Eligibles — An emergency services alien who meets all Medicaid eligibility requirements is eligible for Medicaid coverage of emergency services only.

E. Entitlement & Enrollment of Eligibles — The Medicaid entitlement policy and enrollment procedures for emergency services aliens are found in section *M0220.600 D* below.

F. Public Charge Immigrants — *Effective December 23, 2022, DHS implemented a final rule in regards to immigrants who may become a public charge. USCIS issued policy guidance under section 212(a)(4) of the Immigration and Nationality Act (INA).*

The eligibility worker will use results from a SAVE system inquiry which will indicate a status if the applicant is inadmissible under the public charge policy. Such an indication would define the individual as an unqualified alien (see M0220.441).

M0220.411 UNQUALIFIED ALIENS

A. Unqualified Aliens

Aliens who do not meet the qualified alien definition M0220.310 above and who are **NOT** lawfully residing non-citizen children under age 19 or pregnant women per M0220.314 above are "unqualified" aliens. Unqualified aliens, with the exception of pregnant women who are eligible for FAMIS Prenatal Coverage, are eligible for emergency services only if they meet all other Medicaid eligibility requirements. Unqualified aliens include illegal and non-immigrant aliens.

For a pregnant woman who is not lawfully residing in the U.S. per M0220.314, use Chapter M23 to evaluate her eligibility for FAMIS Prenatal Coverage. If she is not eligible for FAMIS Prenatal Coverage, evaluate her eligibility for the coverage of emergency services using *M0220.400 and M220.600 D*.

B. Illegal aliens

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

C. Non-immigrant Aliens

Aliens who are lawfully admitted to the U.S. for a temporary or limited period of time, and the limited period has **not** expired, are non-immigrant aliens. Regardless of the individual's immigration status, accept declaration of Virginia residency on the application as verification of residency unless the individual resides on the grounds of a foreign embassy. Do **NOT** require individuals who have been admitted into the U.S. on non-immigrant visas to sign a statement of intended residency.

Non-immigrants have the following types of USCIS documentation:

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

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

Non-immigrants include:

1. **Visitors** visitors for business or pleasure, including exchange visitors;
2. **Foreign Government Representative** foreign government representatives on official business and their families and servants. Note: if the foreign government representative resides on the grounds of a foreign embassy, he does not meet the Virginia residency requirement;
3. **Travel Status** aliens in travel status while traveling directly through the U.S.;
4. **Crewmen** Crewmen on shore leave;
5. **Treaty Traders** treaty traders and investors and their families;
6. **Travel Status** aliens in travel status while traveling directly through the U.S.;

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7. **Foreign Students**	foreign students;
8. International Organization	international organization representatives and personnel, and their families and servants;
9. Temporary Workers	temporary workers including some agricultural contract workers;
10. Foreign Press	members of foreign press, radio, film, or other information media and their families.

M0220.500 ALIENS ELIGIBILITY REQUIREMENTS

A. Policy

An alien must meet all other Medicaid eligibility requirements to be eligible for any Medicaid services. The eligibility requirements are:

1. Residency

the Virginia residency requirements (M0230);

Regardless of the individual's immigration status *or whether or not his documentation (e.g. visa) has expired,* accept declaration of Virginia residency on the application as verification of residency. Do **NOT** require individuals who have been admitted into the U.S. on non-immigrant visas and other non-immigrants to sign a statement of intended residency.

2. Social Security Number (SSN)

the SSN provision/application requirements (M0240);

An alien eligible only for Medicaid payment of emergency services *is not required* to apply for or provide an SSN. This includes emergency services only aliens as defined in M0220.410 and unqualified aliens as defined in M0220. 411.

Any non-citizen who is only eligible to receive an SSN for a valid non-work reason is not required to provide or apply for an SSN. These individuals include, but are not limited to, non-citizens admitted to the U.S. on non-immigrant visas and individuals who do not intend to work in the U.S. and would only have needed an SSN for the purposes of receiving public assistance.

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3.	**Assignment of Rights and Pursuit of Support from Absent Parents**	the assignment of rights to medical benefits requirements (M0250);
4.	**Institutional Status**	the institutional status requirements (M0280);
5.	**Covered Group**	the covered group requirements (chapter M03). Individuals who are eligible for Medicaid payment of emergency services are enrolled into the emergency services aid categories, 112 and 113, to ensure proper benefit package assignment; emergency services are not covered for individuals in Plan First or the Medicare Savings Programs (Qualified Medicare Beneficiaries, Special Low Income Medicare Beneficiaries, Qualified Individuals).

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7. Financial Eligibility

the asset transfer requirements (see subchapter M1450) apply.

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

Income must be within the income limit appropriate to the individual's covered group (Chapter M04 for Modified Adjusted Gross Income [MAGI] covered groups; Chapter M07 for F&C Medically Needy covered groups, and Chapter S08 for ABD covered groups). Spenddown provisions apply to individuals who meet a Medically Needy covered group. All medical expenses count toward meeting the spenddown, but once an entitlement date is determined after the individual meets the spenddown, only emergency services rendered on or after the entitlement date are covered for emergency services aliens.

M0220.600 ENTITLEMENT & ENROLLMENT

A. Policy

An alien who is determined eligible for full Medicaid benefits and who meets all Medicaid eligibility requirements (including covered group requirements) is eligible for all Medicaid-covered services available to the recipient's covered group.

B. Application & Entitlement

1. Application Processing

The eligibility worker must take the application and develop it in the same manner as any other individual's application. All eligibility requirements, including covered group requirements must be met.

2. Entitlement

If the applicant is found eligible for Medicaid, ongoing eligibility may exist unless the recipient is on a spenddown.

3. Spenddown

Spenddown provisions apply to medically needy individuals who have excess income.

4. Notice

Appropriate notice must be sent to the applicant of the status of his application and of his Medicaid eligibility.

C. Enrollment Procedures

Once a full benefit alien is found eligible for Medicaid, he must be enrolled in VaCMS using the following data:

1. Country

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

2. Cit Status

In this field, Citizenship Status, enter the Citizenship code that applies to the alien. Below, next to the Citizenship code, is the corresponding Alien Code from the Alien Code Chart in Appendix 5 to this subchapter. Eligible alien codes are:

R = refugee (Alien Chart codes F1, F2, G1, G2); also used for Afghan and Iraqi Special Immigrants (Alien Chart Code Z1).
E = entrant (Alien Chart code D1).
P = full benefit qualified aliens (Alien Chart codes A1, A2, A3, B1, B3, C1, CC1, D1, D3, E1, E3, H1, H2, I1, *I3*, J1, J2, K1);
I = legal immigrant children under age 19 only (Alien Chart codes Y1, Y2, Y3)



3. Entry Date THIS FIELD MUST BE ENTERED. Enter the date on which the alien entered the U.S., except for asylees and deportees. For asylees, enter the date asylum was granted. For deportees, enter the date deportation withholding was granted.

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

5. Coverage Begin Date In this field, Coverage Begin Date, enter the date the alien's Medicaid entitlement begins.

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

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

D. Emergency Services Only Aliens

Unqualified aliens, and qualified aliens eligible for emergency services only are eligible for Medicaid coverage of emergency medical care only. This care must be provided in a hospital emergency room or as an inpatient in a hospital.

Effective July 1, 2022, an emergency services only alien who meets all other Medicaid eligibility requirements is enrolled in Medicaid with *retroactive and/or* ongoing coverage. Emergency services are no longer certified by the LDSS or DMAS, and the LDSS does not obtain an emergency services certification.

Applications received prior to July 1, 2022, are subject to the policies and procedures in M0220, Appendix 9. For an individual whose certification period begins prior to July 1, 2022 and expires on or after July 1, 2022, re-evaluate the individual's eligibility for ongoing coverage.

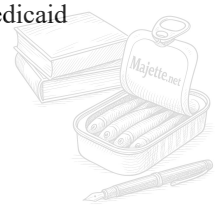
An emergency services alien will be assigned to one of the following Aid Categories (AC) by VaCMS:

- AC 112 for adults in Modified Adjusted Gross Income (MAGI) based covered groups
- AC 113 for children and adults in non-MAGI Families and Children's (F&C) and all Medically Needy (MN) covered groups.

For cases processed at Cover Virginia, the individual will be enrolled in the appropriate AC, and the case will be transferred to the local agency for ongoing case maintenance. For CVIU incarcerated individuals refer to Policy M0140.200.3 C.

Once an emergency services alien is found eligible in VaCMS, the enrollment will transfer into the Medicaid enrollment system. Any claims for emergency services will be sent by the provider or treating physician to DMAS for review and reimbursement. Medicaid coverage for emergency services only aliens will be restricted to emergency services (including dialysis).

Appropriate notice must be sent to the applicant of the status of his application and the duration of his eligibility. The notice must specify that their Medicaid coverage is limited to emergency services.



Once an emergency services alien is found eligible in VaCMS, the enrollment will transfer into the Medicaid enrollment system. Any claims for emergency services will be sent by the provider or treating physician to DMAS for review and reimbursement. Medicaid coverage for emergency services only aliens will be restricted to emergency services (including dialysis).

Appropriate notice must be sent to the applicant of the status of his application and the duration of his eligibility. *The notice must specify that their Medicaid coverage is limited to emergency services.*

Once an emergency services alien is enrolled, any requests for coverage of emergency services will not require a new Medicaid application. The individual will be subject to an annual renewal following the policies in subchapter M1520.200. Follow the policies in subchapter M1520.100 for any reported change to the alien's situation.

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

The provider or treating physician will be responsible for submitting all claim request for payment of an emergency service for an approved member, including labor & delivery and dialysis. Refer providers to the Virginia Medicaid Hospital Provider Manual, Chapter VI "Documentation Guidelines."

Providers with questions regarding the submission or payment of claims for emergency services may contact DMAS at:

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

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Virginia Medical Assistance Eligibility	**M02**	**January 2017**
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M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS	**Appendix 1**	**1**

Citizenship & Identity *Procedures*

Workers are to use the following procedures when citizenship and identity verification is required to determine the individual's continued eligibility.

A. Documents Establishing U.S. Citizenship and Identity

1. Documents that Verify Citizenship and Identity

Both U.S. Citizenship and identity are verified by a:

- U.S. Passport,
- Certificate of Naturalization, or
- Certificate of U. S. Citizenship

Documentary evidence issued by a federally recognized Indian tribe which identifies the tribe that issued the document, indentifies the individual by name and confirms membership, enrollment or affiliation with the tribe (tribal enrollment card, certificate of degree of Indian blood, Tribal census. document, documents on Tribal letterhead)If the individual presents one of these documents, he has verified his citizenship and identity. **Photocopies of original documents are acceptable.**

2. Documents that Verify Identity

a. Documents

The agency must accept any of the documents listed below as proof of identity, provided such document has a photograph or other identifying information including, but not limited to, name, age, sex, race, height, weight, eye color or address. **Photocopies of original documents are acceptable.**

- Identity documents listed at 8 CFR 274a.2(b)(1)(v)(B)(l), except a driver's license issued by a Canadian government authority
- Driver's license issued by a State or Territory
- School identification card
- U.S. military card or draft record
- Identification card issued by the Federal, State or local government
- Military dependent's identification card
- U.S. Coast Guard Merchant Mariner's card
- For children under age 19, a clinic, doctor, hospital or school record, including preschool or daycare records

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- *Two documents containing consistent information that corroborates an applicant's identity. Such documents include, but are not limited to, employer identification cards, high school and college diplomas (including high school equivalency diplomas), marriage certificates, divorce decrees and property deeds or titles.*

- *Finding of identity from a Federal or State governmental agency. The agency may accept as proof of identity a finding of identify from a Federal agency or another State agency, including but not limited to a public assistance, law enforcement, internal revenue or tax bureau, or corrections agency, if the agency has verified and certified the identity of the individual*

b. Affidavit

If the applicant does not have any document specified above and identity is not verified, the applicant may submit an affidavit signed, under penalty of perjury, by another person who can reasonably attest to the applicant's identity. Such affidavit must contain the applicant's name and other identifying information. The affidavit does not have to be notarized.

3. Documents that Verify Citizenship

a. Documents

The agency must accept any of the documents listed below as proof of U.S. *Citizenship.* ***Photocopies of original documents are acceptable.***

- *Civil Service employment by the U.S. government prior to 1976*

- *Evidence of compliance with the Child Citizen Act of 2000*

- *Final adoption decree showing U.S. birth, or if adoption is not final, a statement from a State-approved adoption agency that shows the child's name and U.S. place of birth*

- *Homeland Security's Systematic Alien Verification for Entitlements Database (used when individual has become a Naturalized Citizen but information did not show up in SSA database)*

- *Northern Mariana Card for individuals born before 11/4/1986 (I-873)*

- *Office of Vital Records*

- *Official Military Records showing a U.S. birth Report/Certificate of birth abroad of U.S. citizen (dS-1350, FS-240 or FS-545)*

- *U.S. Birth Certificate*

- *U.S. citizen ID card (I-197 or I-179)*

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- *Medical records, including but not limited to, hospital, clinic or doctor records or admission papers from a nursing facility, skilled care facility or other institution that indicate a U.S. place of birth*
- *Life, health or other insurance records that indicate a U.S. place of birth*
- *Official religious record recorded in the U.S. indicating a U.S. birth*
- *School records, including pre-school, Head Start and day care, showing child's name and U.S. place of birth*
- *Federal or state census records showing U.S. citizenship or U.S. place of birth*
- *Certification of U.S. birth*
- *A Certification of Report of Birth, issued to U.S. citizens who were born outside the U.S.*
- *A report of Birth Abroad of a U.S. citizen*

b. ***Affidavit***

If no other documentation exists, the individual may submit an affidavit signed, under penalty of perjury, by another person who can reasonably attest to the applicant's identity. Such affidavit must contact the applicant's name and other identifying information. The affidavit does not have to be notarized.

C. Agency Actions

1. Documentation From Case Record and Individual

Documentation of citizenship and/or identity may be obtained from a number of different sources, *including the sources listed below.* ***Photocopies of original documents are acceptable.***

- Existing LDSS agency records, as long as the documentation conforms to Medicaid policy for citizenship and identity verification in M0220 of the Medicaid Eligibility Manual.
- *A federal agency or another State agency. A verification of citizenship made by a federal or state agency is acceptable, as long as the verification was done on or after July 1, 2006. No further documentation of citizenship* ***or*** *identity is required.*

- Applicants and Recipients. All applicants and recipients, **except** SSI recipients, Medicare beneficiaries, SSDI beneficiaries, individuals born to Medicaid-eligible mothers, all foster care children and IV-E Adoption Assistance children, must provide documents that show proof of United States citizenship and proof of the person's identity if the local DSS is unable to verify citizenship and identity using a data match with the SSA. Contact information for obtaining the various acceptable documents is available on the VDSS local agency intranet and the DSS public website and may be given to individuals to facilitate their obtaining documentation.

- DMAS, for individuals born in Puerto Rico who are unable to provide a birth certificate issued on or after July 1, 2010.

  Puerto Rico invalidated all birth certificates issued prior to July 1, 2010 and reissued the birth certificates. For individuals born in Puerto Rico **who are applying for Medicaid for the first time**, only a birth certificate issued on or after July 1, 2010 may be accepted from the individual. Should an individual born in Puerto Rico be unable to present a birth certificate issued on or after July 1, 2010, contact your Regional Medical Assistance Specialist, who will refer the case to DMAS. DMAS will obtain official birth verification on behalf of the local DSS. If the person is reapplying and the agency has a birth certificate issued prior to July 1, 2010 on record, no additional verification is required.

2. Authorized Representative

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

***3.* Individuals Who No Longer Meet Exception**

When an individual loses the exception status, and his citizenship and identity has not been previously verified, it must be verified for him to remain eligible for Medicaid. If the individual's eligibility in another covered group must be determined (due to the loss of SSI benefits, for example), obtain the documentation of citizenship and identity at the time of the eligibility review. If the verification is not readily available, the individual must be allowed a reasonable opportunity to obtain the documentation. See M0220.100 A 3.

Verify the SSI recipient's or Medicare beneficiary's entitlement to benefits through the Federal Hub or SOLQ-I. A copy of the printout must be placed in the case file.

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

Individuals do not have to submit their citizenship and identity to the agency worker in person. They may mail the original document for the agency to copy and mail back to the individual, **or they may submit a photocopy of the document(s).**

***5.* Special Populations Needing Assistance**

The agency shall assist special populations who need additional assistance, such as the homeless, *intellectually disabled,* or physically incapacitated individual who lacks someone who can act on his behalf, to provide necessary documentation.



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3. **Failure to Provide Requested Verifications**

Failure to provide satisfactory evidence of citizenship and identity, after being provided a reasonable opportunity to present such documentation, *may* result in the termination of MA.

An enrollee who fails to cooperate with the agency in presenting documentary evidence of citizenship may be denied or terminated. Failure to cooperate consists of failure by a recipient or that individual's representative, after being notified, to take a required action within the reasonable opportunity time period. *If the individual provides part of the information or is in the process of getting the information, a new reasonable opportunity period should be provided.*

4. **Notification Requirements**

Prior to the termination of benefits, the enrollee must be sent written notice at least 10 calendar days (plus one day for mailing) prior to the effective date of the closure.

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

5. **Maintain Documents in Case Record**

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

6. **No Reporting Requirements**

There are no monthly reporting requirements. However, the Medical Assistance Program Consultants may conduct reviews of cases where eligibility was denied or terminated because of lack of citizenship and/or identity verification.

7. **Refer Cases of Suspected Fraud to DMAS**

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

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[Used For Adults]

HHS Tracking Number

(Address)

CERTIFICATION LETTER

Dear _____:

This letter confirms that you have been certified by the U.S. Department of Health and Human Services (HHS) pursuant to section 107 (b) of the Trafficking Victims Protection Act of 2000. Your certification date is _____. Certification does not confer immigration status.

With this certification, you are eligible for benefits and services under any Federal or State program or activity funded or administered by any Federal agency to the same extent as an individual who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act, provided you meet other eligibility criteria.

You should present this letter when you apply for benefits or services. Benefit-issuing agencies should call the trafficking verification line at (866) 401-5510 to verify the validity of this document and to inform HHS of the benefits for which you have applied.

Sincerely,

[Signed]
Director/Acting Director
Office of Refugee Resettlement

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[Used For Children Under Age 18 Years]

HHS Tracking Number

(Address)

Dear _____:

This letter confirms that pursuant to section 107 (b) of the Trafficking Victims Protection Act of 2000, you are eligible for benefits and services under any Federal or State program or activity funded or administered by any Federal agency to the same extent as an individual who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act, provided you meet other eligibility criteria.

Your initial eligibility date is _____. This letter does not confer immigration status.

You should present this letter when you apply for benefits or services. Benefit-issuing agencies should call the trafficking verification line at (866) 401-5510 to verify the validity of this document and to inform HHS of the benefits for which you have applied.

Sincerely,

[Signed]
Director/Acting Director
Office of Refugee Resettlement

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Determinations for Months Prior to April 1, 2021

This appendix contains the process for determining the number of qualifying quarters (QQ) with which a lawful permanent resident (LPR) who entered the U.S. on or after 8-22-96 can be credited and is to be used in conjunction with the State Verification Exchange System (SVES) User Guide.

I. Procedures:

A. To determine the number of QQ available to a LPR applicant, ask the applicant the following questions:

1. How many years has the applicant, the applicant's spouse, or the applicant's parents (before the applicant turned 18) lived in this country?

2. How many years has the applicant, the applicant's spouse, or the applicant's parents (before the applicant turned 18) commuted to work in the U.S. from another country before coming to the U.S. to live, or worked abroad for a U.S. company, or worked in self-employment while a legal resident of the U.S.?

   (If the total number of years to both questions is less than 10 years, **STOP** because the applicant cannot meet the 40 QQ requirement.)

3. In how many of the years reported in the answer to question 1 did the applicant, the applicant's spouse, or the applicant's parent earn money through work?

B. To determine whether the applicant's earnings were sufficient to establish "quarters of coverage" in those years, refer to the income chart in section II .

   If the answer to question 3 is 10 years or more, verify from INS documents or other documents the date of entry into the country for the applicant, spouse and/or parent. If the dates are consistent with having 10 or more years of work, initiate a SVES inquiry.

C. Complete or obtain from the applicant a completed "Consent for Release of Information" (see page 4 of this appendix) with the full name, social security number and date of birth of each individual (self, spouse, or parent) whose work history is relevant. In addition, the applicant must provide a form signed by each such individual, except deceased persons, giving SSA permission to release information through SVES on that individual to the agency and/or the applicant. Retain the consent form in the case file to document the individual's consent. A consent form is valid for 12 months from the time of the signature.

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D. Information received through SVES will not report earnings for the current year nor possibly the last year's earnings (i.e. the lag period). The SVES report will also not include employment that is not covered under Social Security (i.e. not requiring payment of FICA/Social Security tax). The applicant must provide verification of earnings through pay stubs, W-2 forms, tax records, employer records, or other documents, if quarters of the lag period or non-covered employment are needed to meet the 40-quarter minimum. Use the information contained in section II to determine QQ for lag periods and non-covered earnings.

If the alien believes the information from SSA is inaccurate or incomplete, beyond the current two-year lag period, advise the applicant to provide the verification to SSA to correct the inaccurate income records.

In evaluating the verification received directly from the applicant or through SVES, **exclude** any quarter, beginning January 1997, in which the person who earned the quarter received benefits from the TANF, SSI, or Medicaid, or SNAP Programs or the food assistance block grant program in Puerto Rico.

E. In situations when consent to release information through SVES cannot be obtained from a parent or spouse, other than death, request information about quarters of coverage directly from the Social Security Administration. Complete or obtain from the applicant a Request for Quarters of Coverage (QC) History Based on Relation form, SSA-513. The form specify the period(s) for which the verification is requested. Submit the completed from to:

Social Security Administration
P.O. Box 33015
Baltimore, Maryland 21290-3015

F. When the SSA is unable to determine if a quarter should be allowed, the SVES inquiry will show "Z" or "#" codes. *The requirement for a 40-quarter work minimum was eliminated effective April 1, 2021*. Use Form SSA-512, "Request to Resolve Questionable Quarters of Coverage (QC)," to resolve quarters before 1978. A copy of the SVES report must accompany the completed form. Submit Form SSA-512 to:

Social Security Administration
Office of Central Records Operations
P.O. Box 33015
Baltimore, Maryland 21290-3015

For questionable quarters for 1978 *thru March 31, 2021,* the applicant must complete Form SSA-7008. "Request for Correction of Earnings." This form is available at local SSA offices. At the top of the form write "Welfare Reform." Submit the form and proof of earnings to:

Social Security Administration
Office of Central Records Operations
P.O. Box 30016
Baltimore, Maryland 21290-3016

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Manual Title	Chapter	Page Revision Date
Virginia Medical Assistance Eligibility	**M02**	**January 2023**
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M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS	**Appendix 3**	**3**

II. Establishing Quarters:

The requirement for a 40-quarter work minimum was eliminated effective April 1, 2021. Use the following information to (1) determine whether the applicant's earnings as reported in section I.A were sufficient to establish quarters of coverage and (2) to determine the number of QQ during lag periods and when the reported employment is not a covered earning for Social Security reporting purposes:

- A quarter is a period of 3 calendar months ending with March 31, June 30, September 30 and December 31 of any year.

- Social Security quarters of coverage are credits earned by working at a job or as a self-employed individual. A maximum of four credits or quarters can be earned each year.

- For 1978 and later, credits are based solely on the total yearly amount of earnings. The number of creditable QQ are obtained by dividing the total earned income by the increment amount for the year. All types of earnings follow this rule. The amount of earnings needed to earn a credit increases and is different for each year. The amount of earnings needed for each credit and the amount needed for a year in order to receive four credits are listed below.

- A current year quarter may be included in the 40-quarter computation. Use the current year amount as the divisor to determine the number of quarters available.

If you need to use quarters before 1978:

- A credit was earned for each calendar quarter in which an individual was paid $50 or more in wages (including agricultural wages for 1951-1955);

- Four credits were earned for each taxable year in which an individual's net earnings from self-employment were $400 or more; and/or

- A credit was earned for each $100 (limited to a total of 4) of agricultural wages paid during the year for years 1955-1977.

Year	Increment Amount	Amount Required for 4 QCs
2013	$1,160	$4,640
2012	$1,130	$4,520
2010 – 2011	$1,120	$4,480
2009	$1,090	$4,360
2008	$1,050	$4,200
2007	$1,000	$4,000
2006	$970	$3880

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Year	*Increment Amount*	*Amount Required for 4 QCs*
2005	*$920*	*$3680*
2004	*$900*	*$3600*
2003	*$890*	*$3560*
2002	*$870*	*$3480*
2001	*$830*	*$3320*
2000	*$780*	*$3120*
1999	*$740*	*$2960*
1998	*$700*	*$2800*
1997	*$670*	*$2680*
1996	*$640*	*$2560*
1995	*$630*	*$2520*
1994	*$620*	*$2480*
1993	*$590*	*$2360*
1992	*$570*	*$2280*
1991	*$540*	*$2160*
1990	*$520*	*$2080*
1989	*$500*	*$2000*
1988	*$470*	*$1880*
1987	*$460*	*$1840*
1986	*$440*	*$1760*
1985	*$410*	*$1640*
1984	*$390*	*$1560*
1983	*$370*	*$1480*
1982	*$340*	*$1360*
1981	*$310*	*$1240*
1980	*$290*	*$1160*
1979	*$260*	*$1040*
1978	*$250*	*$1000*

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Social Security Administration OMB No. 0960-0567

Consent for Release of Information

TO: Social Security Administration

Name	Date of Birth	Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS

I want this information released because:

(There may be a charge for releasing information.)

Please release the following information:

_____ Social Security Number
_____ Identifying information (includes date and place of birth, parents' names)
_____ Monthly Social Security benefit amount
_____ Monthly Supplemental Security Income payment amount
_____ Information about benefits/payments I received from _____ to _____
_____ Information about my Medicare claim/coverage from _____ to _____
(specify) _____
_____ Medical records
_____ Record(s) from my file (specify) _____
_____ Other (specify) _____

I am the individual to whom the information/record applies or that person's parent (if minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature: _____
(Show signatures, names and addresses of two people if signed by mark.)

Date: _____ Relationship: _____

SSA-3288



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OMB NO: 0960-0575

Date of Request_____

REQUEST TO RESOLVE QUESTIONABLE QUARTERS OF COVERAGE (QC)

Complete the information below when the QC array contains either a (#) pound sign or code "Z" prior to 1978. Mail the form and a copy of the system's printout to the Social Security Administration, PO Box 17750, Baltimore, MD. 21235-0001.

Print
Name: _____ _____ _____
Last First MI

SSN_____-_____-_____ Date of Birth----------_____
MM DD YY

Request Years

19_____, 19_____, 19_____, 19_____, 19_____, 19_____,

19_____, 19_____, 19_____, 19_____, 19_____, 19_____,

20_____, 20_____, 20_____.

OR

19_____ thru 19_____, 19_____ thru 19_____, 19_____, thru 19_____,

20_____ thru 20_____.

State's Name & Address _____

_____

_____

Contact Person's Name _____
&
Telephone Number _____

The Paperwork Reduction Act of 1995 requires us to notify that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number.

SSA-512



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Date of Request _____ QMB NO: 0960-0575

REQUEST FOR QUARTERS OF COVERAGE (QC) HISTORY BASED ON RELATIONSHIP

Complete the information below when requesting QC history for spouse(s) or parent (s) of a lawfully admitted non-citizen applicant. Mail the form to the Social Security Administration, PO Box 17750, Baltimore, MD 21235-0001.

Print Name: _____ (Last) _____ (First) _____ (MI)

SSN _____-_____-_____ Date of Birth ---------- _____ (MM DD YY)

Relationship to Applicant _____

NOTE: COMPLETE THE YEAR COLUMN AND CIRCLE THE PERTINENT QUARTER (S) FOR THE YEAR. SSA WILL PROVIDE INFORMATION ONLY FOR YEARS AND QUARTERS YOU INDICATE.

YEAR	QC PATTERN 1ST Q	2nd Q	3RD Q	4TH Q	YEAR	QC PATTERN 1ST Q	2nd Q	3RD Q	4TH Q
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

State's Name & Address _____

_____

_____

Contact Person's Name & Telephone Number _____

_____

FORM SSA-513 (9/97)



Manual Title	Chapter	Page Revision Date	
Virginia Medical Assistance Eligibility	**M02**	**January 2024**	
Subchapter Subject	Page ending with		Page
M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS	**Appendix 4**		**1**

Afghan Special Immigrants

The United States Congress passed the Continuing Resolution on October 1, 2021. Section 2502 of the Continuing Resolution provides that certain Afghan nationals who receive parole between July 31, 2021 and March 31, 2023 "shall be eligible for resettlement assistance, entitlement programs, and other benefits available to refugees" to include Medicaid, until March 1, 2023 (or until their parole expires). *On December 23, 2022 Congress passed the Consolidated Continuing Appropriations Act 2023* which extended the date that parole must have been received by to September 30, 2023 and expanded the *groups of eligible for services.*

Eligibility continues until the parole expires. Afghan parolees who have a pending re-parole application, a pending asylum application, or a pending adjustment of status application with U.S. Citizenship and Immigration Services (USCIS), under the U.S. Department of Homeland Security (DHS) are still eligible for the ***continuation of Medicaid if they were enrolled prior to the expiration of their initial period of*** *parolee.*

Eligible Parolees are:

1. Special Immigrant Parolees (SIP), who are individuals granted Special Immigrant (SI/SQ) Parole (per section 602(B)(1) AAPA/Section 1059(a) NDAA 2006) *who entered the United States between July 1, 2021 and September 30, 2023, including Unaccompanied Afghan Minors,*
2. *Humanitarian* Parolees entering the United States without SI/SQ parole due to the urgent nature of their arrival (Humanitarian status), *who entered the United States between July 1, 2021 and September 30, 2023,*
3. *Afghan SIPs or Humanitarian Parolees who are the spouses or children of eligible Afghan Parolees who entered between July 1, 2021 and September 30, 2023, even if they entered after September 30, 2023, and*
4. *Afghan SIPs or Humanitarian Parolees who are the parents or legal guardians unaccompanied Afghan minors who entered between July 1, 2021 and September 30, 2013, even if they entered after September 30, 2023.*

Afghan nationals who have another Qualifying immigration status, such as refugees, Special Immigrant Visa (SIV) holders, or asylees, are eligible for Medicaid in the standard manner. They are not required to enter within a particular timeframe. Children under 19 years and pregnant women with SIP, or Humanitarian status meet the definition of lawfully residing aliens for Medicaid and FAMIS/FAMIS MOMS coverage.

Afghan Special Immigrant visa holders will have either (1) a passport or I-94 form indicating category SI1, SI2, SI3, SQ1, SQ2, or SQ3 and bearing the Department of Homeland Security stamp or notation or an I-151 ("green card") indicating SI6, SI7, SI8, SQ6, SQ7, or SQ8. Special Immigrant Parolees will have an I-94 form noting SQ or SI Parole (per section 602(B)(1) AAPA/Sec 1059(a) NDAA 2006).

If an individual has attested to eligible immigration status and is found otherwise eligible for Medicaid, but verification of that status cannot be obtained, do not deny or delay coverage. Enroll the individual and provide the 90-day reasonable opportunity period.

Exception: Humanitarian Parolees who arrived **before July 31, 2021**, are eligible only for Medicaid coverage of emergency medical services and Health Insurance Marketplace coverage. Many of these individuals have already been enrolled in subsidized Marketplace coverage or have been granted asylum and are therefore eligible for Medicaid or FAMIS without the 5-year bar.

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Ukraine Humanitarian Parolees

The U.S. Department of Homeland Security (DHS) is providing support and humanitarian relief to Ukrainians who have been displaced by Russia's February 24, 2022 invasion and fled Ukraine. The United States Congress passed the Additional Ukraine Supplemental Appropriations Act (AUSAA) and was signed on May 21, 2022 by President Biden. *It was extended by the Ukraine Security Supplemental Appropriations Act, 2024.* This measure confers eligibility for all Ukrainian Humanitarian Parolees for mainstream federal benefits as well as resettlement services funded by the Office Refugee Resettlement (ORR).

Certain Ukraine nationals entering the U.S. may be eligible for health coverage through Medicaid, the Children's Health Insurance Program (CHIP), the Health Insurance Marketplace, or Refugee Medical Assistance (RMA). These individuals may be granted a range of lawful non-citizen statuses, including parole, temporary protected status (TPS), immigrant and nonimmigrant visas, and refugee or asylees. The primary non-citizen immigrant statuses include:

1. Parolees: Ukrainian nationals who enter the United States as parolees on or **between February 24, 2022 and September 30, *2024*** are eligible for Medicaid or CHIP to the same extent as refugees, without a five-year waiting period, if they meet other eligibility requirements. These Ukrainian parolees are considered "qualified non-citizens" for purposes of Medicaid and CHIP eligibility since they are eligible for the same benefits as refugees.

   Ukrainian nationals who are paroled into the U.S. **after September 30, 2023** and are the spouse or child of a parolee described above, or who is the parent, legal guardian, or primary caregiver of a parolee described above who is determined to be an unaccompanied child will also be eligible for Medicaid and CHIP to the same extent as refugees.

   For eligible Ukrainian parolees who entered the United States with parole between February 24, 2022 – Sept 30, 2023, their date of eligibility is May 21, 2022, or their date of parole, whichever is later.
   For eligible Ukrainian parolees who enter the United States with parole between October 1, 2023 – Sept 30, 2024, their date of eligibility is April 24, 2024, or their date of parole, whichever is later.

2. Temporary Protected Status (TPS): Ukrainian nationals (and individuals having no nationality who last habitually resided in Ukraine) are eligible to apply for TPS. This includes Ukrainians granted TPS or have pending applications for TPS and who have been granted employment authorization. The TPS designation is effective **April 19, 2022 and will remain in effect through October 19, 2023**.

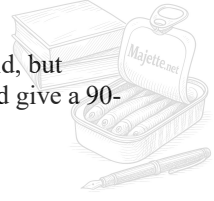
3. Refugees: Some Ukrainian nationals may be granted refugee status and resettled into the U.S. are eligible for full Medicaid or CHIP benefits, without application of the five-year waiting period, if they otherwise meet all other Medicaid eligibility requirements.

4. Lawfully Residing individual: Children under age 19 and pregnant women who are in one of the lawfully residing non-citizen alien groups (see M0220.314) and meet the definition of a lawfully residing alien for Medicaid and FAMIS/FAMIS MOMS coverage may be eligible for assistance.

5. Emergency Services: Ukrainian non-citizens who do not qualify for full Medicaid benefits based on their immigration status may be eligible for "emergency services Medicaid" if they meet all other eligibility requirements. An individual eligible only for emergency Medicaid is permitted to enroll in Marketplace coverage if they meet all Marketplace eligibility requirements.

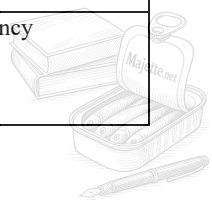
Ukrainian parolees will generally have foreign passports with a DHS stamp admitting them with a PAR, DT, or UHP Class of Admission (COA). DHS will be using the existing COA code DT and PAR for some Ukrainians who were paroled into the U.S. Additional COA code(s) will be programmed into Hub logic in early fall of 2022.

If an individual has attested to eligible immigration status and is found otherwise eligible for Medicaid, but verification of that status cannot be obtained, do not deny or delay coverage. Enroll the individual and give a 90-day reasonable opportunity period.



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Code	MEDICAID ALIEN CODE CHART QUALIFIED ALIEN GROUPS	Arrived Before August 22, 1996	Arrived On or After August 22, 1996	
			1st 5 years	After 5 years
A	Qualified aliens who are Veterans or Active Military (includes spouses/dependent children); certain American Indians [Form DD 214-veteran]	Full Benefit A1	Full Benefit A2	Full Benefit A3
B	Permanent Resident Aliens (Aliens lawfully admitted for permanent residence) who have worked 40 qtrs., except Amerasians [I-151; AR-3a; I-551; I-327; I-688B-274a.12(a)(1)]	Full Benefit B1	Emergency Only B2	Full Benefit ***(40 quarter work requirement ended effective 4-1-21)*** B3
C	Permanent Resident Aliens (Aliens lawfully admitted for permanent residence) who have NOT worked 40 qtrs., except Amerasians and citizens of Micronesia, Marshall Islands, Palau [I-327; I-151; AR-3a; I-551; I688B-274 a.12(a)(1)]	Full Benefit C1	Emergency Only C2	**Full Benefit effective 4-1-21 C1**; Emergency Only for months prior to 4-21 C2
CC	Compact of Free Association (COFA) migrants who are citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau.	Full Benefit CC1	Full Benefits effective 12-27-20. CC1; Emergency Only for months prior to 12-20. CC2	Full Benefit effective 12-27-20. CC1; Emergency Only prior to 12-20. CC2
D	Conditional entrants-aliens admitted pursuant to 8 U.S.C. 1153(a)(7), section 203(a)(7) of the INA [I-94]	Full Benefit D1	Emergency Only D2	Full Benefit D3
E	Aliens, other than Cuban or Haitian Entrants, paroled in the US pursuant to 8 U.S.C. 1182(d)(5) section 212(d)(5) of INA [I-94; I-688B – 274a(12)(c)(11)] Afghan Special Immigrant Parolees paroled into the United States between July 31, 2021, and September 30, 2023 will have an I-94 form noting SQ or SI Parole (per section 602(B)(1) AAPA/Sec 1059(a) NDAA 2006). They are eligible for full coverage without a 5-year waiting period. See Appendix 4. Ukraine Humanitarian Parolees. See Appendix 4.	Full Benefit E1	Emergency Only E2	Full Benefit E3
I	Battered aliens, alien parents of battered children, alien children of battered parents [U.S. Attorney General]	Full Benefit I1	Emergency Only I2	Full Benefit I3
	QUALIFIED ALIEN GROUPS		1st 7 years	After 7 years
F	Aliens granted asylum pursuant to section 208 of the INA [I-94; I-688B – 274a.12(a)(5)]	Full Benefit F1	Full Benefit F2	Emergency Only F3
G	Aliens admitted as refugees pursuant to section 207 of the INA, or as Cuban or Haitian Entrants as defined in section 501(e) of Refugee Education Assistance Act of 1980 {including those under section 212(d)(5)}, or Amerasians [I-551; I-94; I-688B]	Full Benefit G1	Full Benefit G2	Emergency Only G3
H	Aliens whose deportation has been withheld pursuant to Section 243(h) or 241(b)(3) of the INA [I-688B – 274a.12(a)(10); Immigration Judge's Order]	Full Benefit H1	Full Benefit H2	Emergency Only H3



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M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS	**Appendix 5**	**2**

	UNQUALIFIED ALIEN GROUPS	Arrived Before 8-22-96	Arrived On or After 8-22-96	
J	Victims of a Severe Form of Trafficking pursuant to the Trafficking Victims Protection Act of 2000, P.L. 106-386 [ORR Certification/eligibility Letter]	N/A J1	Full Benefit J2	Emergency Only J3
K	Aliens residing in the US pursuant to an indefinite stay of deportation [I-94; Immigration Letter]	Emergency Only K1	Emergency Only K2	Emergency Only K3
L	Aliens residing in the US pursuant to an indefinite voluntary departure [I-94; Immigration Letter]	Emergency Only L1	Emergency Only L2	Emergency Only L3
M	Aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition who are entitled to voluntary departure under 8 CFR 242.5(a)(2)(vi) and whose departure the INS does not contemplate enforcing [I-94; I-210]	Emergency Only M1	Emergency Only M2	Emergency Only M3
N	Aliens who have filed an application for adjustment of status pursuant to §245 INA that the INS has accepted as properly filed and whose departure the INS does not contemplate enforcing [I-181; Endorsed Passport]	Emergency Only N1	Emergency Only N2	Emergency Only N3
O	Aliens granted stay of deportation by court order, statute or regulation, or by individual determination of the INS whose departure the agency does not contemplate enforcing [I-94; Court Order; INS Letter]	Emergency Only O1	Emergency Only O2	Emergency Only O3
P	Aliens granted voluntary departure pursuant to section 242(b) of the INA whose departure the INS does not contemplate enforcing [I-94; I-210; I-688B – 247a.12(a)(11) or (13)]	Emergency Only P1	Emergency Only P2	Emergency Only P3
Q	Aliens granted deferred action status pursuant to INS Operations Instruction 103.1(a)(ii) prior to 6/15/84 or 242.1a22 issued 6/15/84 and later [I-210; INS Letter]	Emergency Only Q1	Emergency Only Q2	Emergency Only Q3
R	Aliens residing in the U.S. under orders of supervision [I-220B]	Emergency Only R1	Emergency Only R2	Emergency Only R3
S	Aliens who entered before January 1972 and have continuously resided in the U.S. since January 1972 [Case Record]	Emergency Only S1	Emergency Only S2	Emergency Only S3

Manual Title	Chapter	Page Revision Date
Virginia Medical Assistance Eligibility	**M02**	**January 2022**
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M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS	**Appendix 5**	**3**

	UNQUALIFIED ALIEN GROUPS **(cont.)**	**Arrived Before 8-22-96**	**Arrived On or After 8-22-96**	
T	Aliens granted suspension of deportation pursuant to Section 244 of the INA and whose deportation the USCIS does not contemplate enforcing [Immigration Judge Court Order]	Emergency Only T1	Emergency Only T2	Emergency Only T3
U	Any other aliens living in the US with the knowledge and permission of the USCIS whose departure the agency does not contemplate enforcing [USCIS Contact]	Emergency Only U1	Emergency Only U2	Emergency Only U3
V	Aliens not lawfully admitted or whose lawful admission status has expired* *For a pregnant woman who is not lawfully residing in the U.S., go to Chapter M23.	Emergency Only V1	Emergency Only V2	Emergency Only V3
W	Visitors (non-immigrants): tourists, diplomas, foreign students, temp. workers, etc. [I-688B – 274a.12(b)(1)-(20); I-94; I-185: I-I186; SW-434; I-95A]	Emergency Only W1	Emergency Only W2	Emergency Only W3

	LAWFULLY RESIDING NON-CITIZENS	**Effective 1/1/10**	**Effective 7/1/12**
Y	Non-citizen (alien) children under the age of 19 and pregnant women lawfully residing in the U.S. who meet the requirements in M0220.314.	Full Benefits for Medicaid children under age 19 (FAMIS Plus)	Full Benefits for Medicaid (FAMIS Plus), Medicaid pregnant women, FAMIS and FAMIS MOMS

	AFGHAN AND IRAQI SPECIAL IMMIGRANTS	**First 7 Years after Entry into U.S.**	**After 7 Years**
Z	Afghan and Iraqi Special Immigrants admitted on a Special Immigrant Visa (SIV), including the spouse and children under age 21 living in the home with the principal visa holder. [I-551 or passport/ I-94 indicating categories SI1, SI2, SI3, SQ1, SQ2, or SQ3 and bearing Department of Homeland Security stamp or notation] *For Afghan special immigrants admitted prior to being granted a Special Immigrant Visa, see M0220, Appendix 4.*	Full Benefits Z1	Emergency Only Z2

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Proof of U.S. Citizenship and Identity for Medicaid

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

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

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

Document	Shows Proof Of	Issued By	Fee	For More Information, Contact
U.S. Passport (unexpired or expired)	Citizenship & Identity (if issued with limitation and expired, only shows proof of identity)	U.S. Department of State	Varies	(202) 647-4000 or www.state.gov
Certificate of Naturalization (N-550 or N-570)	Citizenship & Identity	U.S. Department of Homeland Security, Bureau of Citizenship and Immigration Services	Varies	1-800-375-5283 or www.uscis.gov
Certificate of Citizenship (N5-560 or N-561)—issued when a person was born outside U.S. to U.S. Citizen parent(s)	Citizenship & Identity	U.S. Department of Homeland Security, Bureau of Citizenship and Immigration Services	Varies	1-800-375-5283 or www.uscis.gov

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

Document	Shows Proof Of	Issued By	Fee	For More Information, Contact
U.S. Public Birth Record ("Birth Certificate")—must contain original embossed seal	Citizenship—(Must also provide proof of identity)	The state, commonwealth, territory or local jurisdiction	Va. Birth Cert. $12	For citizens born in Virginia: Department of Health, Division of Vital Records: (804) 662-6200 or www.vdh.virginia.gov (will also assist citizens born outside Virginia with finding contact information for their birth state)

Document	Shows Proof Of	Issued By	Fee	For More Information, Contact
Certification of Report of Birth (FS-240); Consular Report of Birth Abroad of a Citizen of the U.S.A. (FS-545), Certification of Birth Abroad (FS-545	Citizenship (Must also provide proof of identity)	U.S. Department of State	Varies	(202) 647-4000 or www.state.gov
American Indian Card (I-872)	Citizenship (Must also provide proof of identity)	U.S. Department of Homeland Security, Bureau of Citizenship and Immigration Services	Contact agency	1-800-375-5283 or www.uscis.gov
Final adoption decree (or statement from state-approved adoption agency if adoption is not finalized) —must show child's name and U.S. place of birth	Citizenship (Must also provide proof of identity)	The state in which the adoption was finalized	Possible copying fee	The court issuing the decree or the adoption agency that handled the adoption
Evidence of Civil Services Employment by the U.S. Government—must show employment by the U.S. government before June 1, 1976	Citizenship (Must also provide proof of identity)	U.S. Office of Personnel Management	Possible copying fee	1-888-767-6738 or www.opm.gov
Official Military Record of Service—must show a U.S. place of birth (e.g. DD-214)	Citizenship (Must also provide proof of identity)	National Archives Allow 6-8 weeks	None	1-866-272-6272 or www.vetrecs.archives.gov
Extract of hospital record on hospital letterhead (not a "birth certificate" issued by a hospital) — must have been established at the time of birth, created at least 5 years before initial application date for Medicaid, and indicate a U.S. place of birth	Citizenship (Must also provide proof of identity)	Hospital of birth	Possible copying fee	Hospital in which individual was born
Life or health or other Insurance Record—must have been created at least 5 years before the initial application date for Medicaid and show a U.S. place of birth	Citizenship (Must also provide proof of identity)	Insurance Company	Possible copying fee	Insurance company that issued the policy—contact information should be listed on the policy

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Document	Shows Proof Of	Issued By	Fee	For More Information, Contact
A statement signed by the physician or midwife who was in attendance at the time of the birth—must have been created at least 5 years before the date of the initial Medicaid application and show a U.S. place of birth.	Citizenship (Must also provide proof of identity)	Physician or Midwife who delivered the individual	Possible copying fee	Physician or Midwife
Institutional admission papers from a nursing home or other institution or medical records—must have been created at least 5 years before the date of the initial Medicaid application and indicate a U.S. place of birth		Nursing home or other institution in which the individual resides or resided	Possible copying fee	Nursing home or other institution

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

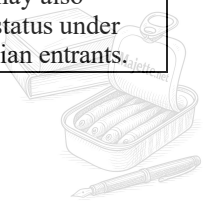
Document	Shows Proof Of	Issued By	Fee	For More Information, Contact
Certificate of Degree of Indian Blood; other U.S. American Indian/Alaska Native or Native American tribal document—must have a photograph of individual or other personal identifying information	Identity	U.S. Department of Interior, Bureau of Indian Affairs	Contact agency	(202) 208-3100 or www.doi.gov
Driver's license issued by a state or territory—must have a photograph of individual or other personal identifying information	Identity	State or Territory	$12 - $28	In Virginia, Division of Motor Vehicles: 1-866-368-5463 or www.dmv.virginia.gov
School identification (ID) card with photograph of individual	Identity	School	Contact agency	School or school district office
U.S. Military card or draft record; military dependent's ID card		Department of Veteran's Affairs	Contact agency	1-800-827-1000 or www.va.gov
Identification card issued by federal, state, or local government with the same information included on driver's licenses	Identity	Va. Division of Motor Vehicles issues non-driver ID cards	Va. ID $10	1-866-368-5463 or www.dmv.virginia.gov

TYPICAL DOCUMENTS USED BY LAWFULLY PRESENT IMMIGRANTS

STATUS	TYPICAL DOCUMENTS
Lawful Permanent Resident (LPR)	• "Green card" (Form I-551) or earlier versions: I-151, AR-2 and AR-3; • Reentry permit (I-327); • Foreign passport stamped to show temporary evidence of LPR or "I-551" status; • Receipt from USCIS (U.S. Citizenship and Immigration Services) indicating that an I-90 application to replace LPR card has been filed; • Memorandum of Creation of Lawful Permanent Residence with approval stamp (I-181); • I-94 or I-94A with stamp indicating admission for lawful permanent residence; • Order issued by the INS/DHS (Immigration and Naturalization Service/Dept. of Homeland Security), an immigration judge, the BIA (Board of Immigration Appeals), or a federal court granting registry, suspension of deportation, cancellation of removal, or adjustment of status; *or* • Any verification from the INS, DHS, or other authoritative document.
Amerasian LPR NOTE: The codes listed here pertain only to the particular Vietnamese Amerasians who qualify for the "Refugee Exemption."	• Any of the LPR documents listed above with one of the following codes: AM-1, AM-2, AM-3, AM-6, AM-7, or AM-8; or • Any verification from the INS, DHS, or other authoritative document
Applicant for Adjustment to LPR Status	• Receipt or notice showing filing or pending status of Form I-485 Application to Register Permanent Residence or Adjust Status; • Form I-797 ASC Appointment Notice with Case Type "I-485 Application to Register Permanent Residence or Adjust Status"; • Form I-688B or I-766 employment authorization document (EAD) coded 274a.12(c)(9) or C9 or C9P; • I-797 receipt for Application for Employment Authorization based on C09; • I-512 authorization for parole, indicating applicant for adjustment of status; or • Any verification from the INS, DHS, or other authoritative document.
Refugee	• Form I-94 or I-94A Arrival/Departure Record or passport stamped "refugee" or "§ 207"; • Form I-688B or I-766 EAD coded 274a.12(a)(3) or A3; or (a)(4) or "A4" (paroled as a refugee); • Refugee travel document (I-571); or • Any verification from the INS, DHS or other authoritative document. • NOTE: If adjusted to LPR status, I-551 may be coded R8-6, RE-6, RE-7, RE-8, or RE-9.
Conditional Entrant	• Form I-94, I-94A, or other document indicating status as "conditional entrant," "Seventh Preference," § 203(a)(7), or P7; or • Any verification from the INS, DHS, or other authoritative document.

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Asylee	• Form I-94, I-94A, or passport stamped "asylee" or "§ 208"; • Order granting asylum issued by the INS, DHS, an immigration judge, the BIA, or a federal court; • Form I-688B or I-766 EAD coded 274a.12(a)(5) or A5; • Refugee travel document (I-571); or • Any verification from the INS, DHS, or other authoritative document. NOTE: If adjusted to LPR status, I-551 may be coded AS-6, AS-7, or AS-8.
Granted Withholding of Deportation or Withholding of Removal	• Order granting withholding of deportation or removal issued by the INS, DHS, an immigration judge, the BIA, or a federal court; • Form I-688B or I-766 EAD coded 274a.12(a)(10) or A10; or • Any verification from the INS, DHS, or other authoritative document.
Granted Withholding of Deportation/Removal under the Convention Against Torture (CAT)	• Order granting withholding of deportation or removal under CAT, issued by an immigration judge, the BIA, or a federal court; • Form I-688B or I-766 EAD coded 274a.12(a)(10) or A10; or • Any verification from the INS, DHS, or other authoritative document
Applicant for Asylum or Withholding of Deportation/Removal, including Applicant for Withholding of Deportation/Removal under CAT, with employment authorization if > 14 years, or application for asylum/withholding pending for 180 days if < 14 years	• Receipt or notice showing filing or pending status of Form I-589 Application for Asylum and Withholding or CAT; • Form I-688B or I-766 EAD coded 274a.12(c)(8) or C8; or • Any verification from the INS, DHS, or other authoritative document.
Cuban or Haitian Entrant	• Form I-94 with a stamp indicating "Cuban/Haitian entrant" (this may be rare, as it has not been used since 1980) or any other notation indicating "parole," any documents indicating pending exclusion or deportation proceedings; • Any documents indicating a pending asylum application, including a receipt from an INS Asylum Office indicating filing of Form I-589 application for asylum; • Form I-688B or I-766 EAD coded 274a.12(c)(8) or C8, or 274a.12(c)(11) or C11; or • Any verification from the INS, DHS, or other authoritative document. NOTE: Individuals who have adjusted to LPR status may have I-551 cards or temporary I-551 stamps in foreign passports coded CAA66, CB1, CB2, CB6, CB7, CH6, CNP, CU6, CU7, CU8, CU9, CUO, CUP, NC6, NC7, NC8, NC9, HA6, HA7, HA8, HA9, HB6, HB7, HB8, HB9, HC6, HC7, HC8, HC9, HD6, HD7, HD8, HD9, HE6, HE7, HE8, HE9. In addition, Cubans or Haitians with the codes LB1, LB2, LB6, or LB7 may also qualify. These codes were used for individuals granted LPR status under any of the 1986 legalization provisions including Cuban/Haitian entrants.



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Paroled into the U.S.	• Form I-94 or I-94A indicating "parole" or "PIP" or "212(d)(5)," or other language indicating parole status; • Form I-688B or I-766 EAD coded 274a.12(a)(4), 274a.12(c)(11), A4, or C11; or • Any verification from the INS, DHS, or other authoritative document. NOTE: If subsequently adjusted to LPR status, may have I-551 card (for Lautenberg parolees, these may be coded LA).
Granted Temporary Protected Status (TPS)	• Form I-688B or I-766 EAD coded 274a.12(a)(12) or A12; • Form I-797 Notice of Action showing grant of TPS status; or • Any verification from the INS, DHS, or other authoritative document.
Applicant for TPS, with employment authorization	• Receipt or notice showing filing or pending status of Form I-821 (Application for Temporary Protected Status); • Form I-688B or I-766 EAD coded 274a.12(c)(19) or C19; or • Any verification from the INS, DHS, or other authoritative document.
Granted Deferred Enforced Departure (DED)	• Form I-688B or I-766 EAD coded 274a.12(a)(11) or A11; or • Any verification from the INS, DHS, or other authoritative document.
Granted Deferred Action Status	• Form I-797 Notice of Action or other form showing approval of deferred action status; • Form I-688B or I-766 EAD coded 274a.12(c)(14) or C14; or • Any verification from the INS, DHS, or other authoritative document.
Applicant for Special Immigrant Juvenile Status	• Form I-797 Notice of Action Special Immigrant Juvenile Approval Notice; • Form I-797 Welcome Notice/Approval of I-485, "Other Basis of Adjustment SL6"; • I-551 coded "SL6"; or • Any verification from the INS, DHS, or other authoritative document.
"Qualified" Domestic Violence Survivor Must have a pending petition for an immigrant visa, either filed by a spouse or a self-petition under the Violence Against Women Act (VAWA), or an application for suspension of deportation or cancellation of removal. The petition or application must either be approved or, if not yet approved, must present a prima facie case.	• Receipt or other proof of filing I-130 (visa petition) under immediate relative (IR) or 2nd family preference (P-2) showing status as a spouse or child; • Form I-360 (application to qualify as abused spouse, child, or parent under the VAWA); • Form I-797 Notice of Action referencing pending I-130 or I-360 or finding establishment of a prima facie case; • Receipt or other proof of filing I-485Application for Adjustment of Status on basis of an immediate relative or family 2nd preference petition or VAWA application; • Any documents indicating a pending suspension of deportation or cancellation of removal case, including a receipt from an immigration court indicating filing of Form EOIR-40 (Application for Suspension of Deportation) or EOIR-42 (Application for Cancellation of Removal); Form I-688B or I-766 EAD coded 274a.12(a)(10) or A10 (applicant for suspension of deportation) or 274a.12(c)(14) or C14 (individual granted deferred action status); or • Any verification from the INS, DHS, or other authoritative document.

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Victim of Trafficking	• Certification from U.S. Dept. of Health and Human Services (HHS) Office of Refugee Resettlement (ORR); • ORR eligibility letter (if under 18); • Certification status verified through HHS Trafficking Verification Line 202-401-5510 or 866-401-5510 ; • I-914 (T status application); • I-766 coded (a)(16); • Form I-797 approval notice for "CP" (continued presence); • Form I-797 indicating approval of T-1 Status; • Bona fide case determination on a T status application; or • Form I-797 "Extension of T or U Nonimmigrant Status"; • I-512 authorization for parole, indicating T-1 status; • I-551 coded ST6; or • Any verification from HHS, INS, DHS, or other authoritative document.
Derivative Beneficiary of Trafficking Survivor	• Proof of approved I-914A petition (derivative T status); • I-94 or passport stamped T-2, T-3, T-4, or T-5; • Form I-797 Notice of Action indicating approval of T-2, T-3, T-4 or T-5 status; • I-766 EAD coded (c)(25); • Form I-797 "Extension of T or U Nonimmigrant Status"; • I-512 authorization for parole, indicating T-2, T-3, T-4 or T-5 status; • I-551 card coded ST7, ST8, ST9, or ST0; or • Any verification from HHS, INS, DHS, or other authoritative document.
Nonimmigrant	• Form I-94 or I-94A Arrival/Departure Record or passport indicating admission to U.S. with nonimmigrant visa; • Receipt for Form I-102 Application for Replacement/Initial Nonimmigrant Arrival-Departure Document; • I-797 approving application to extend/change nonimmigrant status; • I-797 approving application for S, T, U, or V nonimmigrant status; • Form I-688B or I-766 EAD or other INS/DHS document indicating nonimmigrant status; or • Any verification from the INS, DHS, or other authoritative document.
Citizen of Micronesia, the Marshall Islands, and Palau	• Form I-94 or passport noted as "CFA/RMI" or "CFA/FSM" or "CFA/PAL"; • Form I-766 coded (a)(8); or • Any verification from the INS, DHS, or other authoritative document.
Lawful Temporary Resident	• Form I-688 Temporary Resident Card; • Form I-688A EAD; • Form I-688B or I-766 EAD coded 274a.12(a)(2) or A2; or with other evidence indicating eligibility under INA §§210 or 245A ; • Form I-698 Application to Adjust from Temporary to Permanent Residence under INA § 245A; or • Any verification from the INS, DHS, or other authoritative document.

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Applicant for Legalization under IRCA or the LIFE Act, with employment authorization	• Form I-688B or I-766 EAD coded 274a.12(c)(20), (c)(22), or (c)(24); • Form I-687 Application for Temporary Residence under INA § 245A; • Passport, with stamp or writing by INS/DHS officer, indicating pending §245 application; or • Any verification from the INS, DHS, or other authoritative document.
Family Unity	• Form I-797 Notice of Action showing approval of I-817 Application for Family Unity; • Form I-688B or I-766 EAD coded 274a.12(a)(13) or A13; or • Any verification from the INS, DHS, or other authoritative document.
Applicant for Cancellation of Removal or Suspension of Deportation, with employment authorization	• Receipt or notice showing filing Form EOIR-40 (Application for Suspension of Deportation), EOIR-42 (Application for Cancellation of Removal), or I-881 (Application for Suspension of Deportation or Special Rule Cancellation of Removal); • I-256A (former suspension application); • Form I-688B or I-766 EAD coded 274a.12(c)(10) or C10; or • Any verification from the INS, DHS, or other authoritative document.
Order of Supervision, with employment authorization	• Notice or form showing release under order of supervision; • Form I-688B or I-766 EAD coded 274a.12(c)(18) or C18; or • Any verification from the INS, DHS, or other authoritative document.
Registry Applicant, with employment authorization	• Receipt or notice showing filing Form I-485 Application to Register Permanent Resident or Adjust Status; • Form I-688B or I-766 EAD coded 274a.12(c)(16) or C16; or • Any verification from the INS, DHS or other authoritative document.
Abbreviations **BIA -** Board of Immigration Appeals **CAT -** Convention Against Torture **CMS -** Centers for Medicare and Medicaid Services **CP –** continued presence **DHS -** U.S. Dept. of Homeland Security **EAD -** employment authorization document **EOIR -** Executive Office for Immigration Review	 **HHS -** U.S. Dept. of Health and Human Services **INS -** Immigration and Naturalization Service **IR -** immediate relative **LPR -** lawful permanent resident **ORR -** Office of Refugee Resettlement **USCIS -** U.S. Citizenship and Immigration Services **VAWA -** Violence Against Women Act

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Alien Status Reference Guide

		Immigration Status	Eligible for Full Medicaid Benefits?	MMIS Code
Qualified Non-Citizen				
Arrived in U.S. before 8/22/1996	Exempt from 5 year waiting period and no time limit on eligibility	Lawful Permanent Resident	Yes	P
		Refugee under section 207	Yes	R
		Amerasian Immigrant	Yes	P
		Conditional Entrant Under Section 303(a)(7)	Yes	P
		Asylee Under Section 208	Yes	P
		Parolee under section 212(d)(5)	Yes	P
		Deportee whose deportation is withheld under section 243(h) or 241(b)(3)	Yes	P
		Cuban or Haitian Entrant	Yes	P
		Battered alien, alien parent of a battered child, and/or alien child of a battered parent	Yes	P
		Alien who arrived prior to 8/22/96 with unqualified status and who remained physically present in U.S. from date of entry to date of adjustment to a status listed above	Yes	See above
Arrived in U.S. on or after 8/22/1996	Has resided in the U.S. for 7 years or less; exempt from 5 year waiting period	Refugee	Yes	R
		Asylee	Yes	P
		Deportee	Yes	P
		Cuban or Haitian Entrant	Yes	P
		Victim of a severe form of trafficking	Yes	P
		Afghan or Iraqi immigrant admitted on a Special Immigrant Visa	Yes	P
Arrived in U.S. on or after 8/22/1996	Has resided in the U.S. for more than 7 years	Refugee	No—Eligible for Emergency Services Coverage Only	A
		Asylee		A
		Deportee		A
		Cuban or Haitian Entrant		A
		Victim of a severe form of trafficking		A
		Afghan or Iraqi immigrant admitted on a Special Immigrant Visa		A
Arrived in U.S. on or after 8/22/1996	Has resided in the U.S. for at least 5 years	*Effective 4-1-21*, Lawful Permanent Resident	Yes	P
		Conditional Entrants *Parolees, other than Cuban or Haitian Entrants* *Battered aliens, alien parents of battered children, alien children of battered parents*	*Yes*	*P*

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		Immigration Status	Eligible for Full Medicaid Benefits?	MMIS Code
Lawfully Residing Non-Citizen Children Under Age 19 Years and Pregnant Women				
No limitation on date of arrival to the U.S.	No time limitation on eligibility as long as covered group requirements are met	A qualified alien as defined in section 431 of PRWORA (8 U.S.C § 1641) (see M0220.310)	Yes	<19 I Pregnant P
		An alien in a nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission, including individuals with valid visas.	Yes	<19 I Pregnant P
		An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and nationality Act (INA) (8 U.S.C § 1182 (d)(5)) for less than I year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings	Yes	<19 I Pregnant P
		An alien who belongs to one of the following classes:	Yes	<19 I Pregnant P
		• aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C.§§ 1160 or 1255a, respectively)	Yes	<19 I Pregnant P
		• aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. § 1254a), and pending applicants for TPS who have been granted employment authorization	Yes	<19 I Pregnant P
		• aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24)	Yes	<19 I Pregnant P
		• Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended	Yes	<19 I Pregnant P
		• aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President	Yes	<19 I Pregnant P
		• aliens currently in deferred action status, except for individuals receiving deferred status as a result of the Deferred Action for Childhood Arrivals (DACA) process, announced by the U.S. Department of Homeland Security on June 15, 2012	Yes	<19 I Pregnant P
		• aliens whose visa petition has been approved and who have a pending application for adjustment of status	Yes	<19 I Pregnant P
		A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158), or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231), or under the Convention Against Torture who has been granted employment authorization, or such an applicant under the age of 19 who has had an application pending for at least 180 days	Yes	<19 I Pregnant P
		An alien who has been granted withholding of removal under the Convention Against Torture	Yes	<19 I Pregnant P
		A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J)	Yes	<19 I Pregnant P
		An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806 (e)	Yes	<19 I Pregnant P
		An alien who is lawfully present in American Samoa under the immigration laws of American Samoa	Yes	<19 I Pregnant P

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		Immigration Status	Eligible for Full Medicaid Benefits?	MMIS Code
Non-Citizen				
No limitation on date of arrival to the U.S.	No time limitation on eligibility as long as covered group requirements are met	a. A qualified alien and veteran who was discharged honorably not on account of alienage, and who fulfills the minimum active-duty service requirements of section 5303A(d) of title 38, United States Code	Yes	P
		b. A qualified alien on active duty (other than active duty for training) in the Armed Forces of the United States (not in the Armed Forces Reserves)	Yes	R
		The spouse or the unmarried dependent child (see M0220.311 A) of a living (not deceased) qualified alien who meets the conditions in a. or b. above	Yes	P
		The unremarried surviving spouse of an individual described in a. or b. above who is deceased, if the spouse was married to the veteran • before the expiration of fifteen years after the termination of the period of service in which the injury or disease causing the death of the veteran was incurred or aggravated; or • for one year or more; or • for any period of time if a child was born of the marriage or was born to them before the marriage.	Yes	P
		Recipients of Supplemental Security Income (SSI)	Yes	P
		An alien who is • an American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (INA) apply, or • a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)),	Yes	P
		Compact of Free Association (COFA) migrants who are citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau.	Yes Effective 12/27/20	P
Arrived in U.S. on or after 8/22/1996	Regardless of length of residency in U.S.	Individuals other than pregnant women with no immigration documents (undocumented) For a pregnant woman who is not lawfully residing in the U.S., go to Chapter M23.	No—Eligible for Emergency Services Coverage Only	A
		Deferred Action Childhood Arrivals (DACA)	No—Eligible for Emergency Services Coverage Only	A
		Individuals whose immigration status has expired and who do not meet any other immigration status	No—Eligible for Emergency Services Coverage Only	A
		Lawful Permanent Resident who has resided in the U.S. for fewer than 5 years, and/or prior to 4-1-21, without at least 40 qualify quarters of work coverage on record with the Social Security Administration. Effective 4-1-21, there is no longer a work requirement. The 5 year residency requirement remains in effect.	No—Eligible for Emergency Services Coverage Only	A



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M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS	**Appendix 9**	**1**

EMERGENCY SERVICES ALIENS ENTITLEMENT & ENROLLMENT PRIOR TO JULY 1, 2022

A. Policy

Unqualified aliens, and qualified aliens eligible for emergency services only are eligible for Medicaid coverage of emergency medical care only. This care must be provided in a hospital emergency room or as an inpatient in a hospital.

B. Entitlement-Enrollment Period

If the applicant is found eligible and is certified for emergency services, eligibility exists only for the period of coverage certified by the eligibility worker or DMAS staff on the Emergency Medical Certification form *#DMAS Form 2019NR.*

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

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

DMAS will certify dialysis patients for up to a one year period of services without the need for a new Medicaid application. However, due to edits in MMIS, only one six-month certification period at a time can be entered. The worker must manually enter the second certification period of up to six months (as certified by DMAS) after the first period expires.

The dialysis patient must reapply for Medicaid after his full certification period expires.

C. Enrollment Procedures

Once an emergency services alien is found eligible for coverage of emergency services, enroll the individual in the eligibility and enrollment system using the following data:

In this field, Country of Origin, enter the code of the client's country of origin.

2. Citizenship Status

In this field, Citizenship Status code, enter :

A = Emergency services alien (Alien Chart codes B2, C2, C3, CC2, D2, E2, F3, G3, H3, I2, codes J3 through V3, Z2) other than dialysis patient.

D = Emergency services alien who receives dialysis.

V = Visitor, non-immigrant alien (Alien Chart codes W1, W2, W3).

The Alien Codes Chart is found in Appendix 5 to this subchapter.

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NOTE: Foreign visitors are not usually eligible for Medicaid because usually they do not meet the Virginia state residency requirement.

3. Entry date **THIS FIELD MUST BE ENTERED.** Enter the date on which the alien entered the U.S., except for asylees and deportees. For asylees, enter the date asylum was granted. For deportees, enter the date deportation withholding was granted.

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

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

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

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

D. Notices

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

The USCIS requires that all benefit applicants who are denied benefits based **solely or in part** on the SAVE response be provided with adequate written notice of the denial as well as the information necessary to contact USCIS, so that the individual may correct his records in a timely manner, if necessary. The fact sheet, "Information for Applicants: Verification of Immigration Status and How to Correct Your Record with USCIS" (Form # 032-03-0427-00) must be included with the Notice of Action when benefits are denied, **including the approval of emergency-services-only Medicaid coverage**, and with the Advance Notice of Proposed Action when benefits are subsequently cancelled based on the results of a SAVE inquiry. The fact sheet is available at https://fusion.dss.virginia.gov/Portals/[bp]/Files/SAVE/Inform%20for%20Applicants%20Verification%20of%20Immigration%20Status.pdf?ver=2019-05-29-135745-363.

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

The agency must contact the provider(s) and supply the eligibility dates and Medicaid number for billing purposes by sending a copy of the completed Emergency Medical Certification *#DMAS Form 2019NR*, to the provider(s).

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CHAPTER M02
NONFINANCIAL ELIGIBILITY REQUIREMENTS
SUBCHAPTER 30

VIRGINIA RESIDENCY REQUIREMENTS

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M0230 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Page 3
TN #DMAS-2	10/1/16	Pages 1, 6
TN #100	5/1/15	Pages 3, 4
TN #98	10/1/13	Table of Contents pages 3-6 Page 7 was deleted.
TN #97	9/1/12	Page 4
TN #95	3/3/11	Pages 1, 2
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M0230.000 VIRGINIA RESIDENCY REQUIREMENTS

M0230.001 POLICY PRINCIPLES

A. Policy

An individual must be a Virginia resident in order to be eligible for Medicaid, but is not required to have a fixed address. This subchapter, M0230, explains in detail how to determine if an individual is a Virginia resident.

An individual placed by a Virginia government agency in an institution is considered a Virginia resident for Medicaid purposes even when the institution is in another state (section M0230.203 below).

For all other individuals, Virginia residency is dependent on whether the individual is under age 21 years or is age 21 or older (sections M0230.201 and 202 below).

B. Retention of Residency

Residence is retained until abandoned. Temporary absence from Virginia with subsequent return to the state, or intent to return when the purposes of the absence have been accomplished, does not interrupt continuity of Virginia residence.

C. Non-immigrant Aliens

*Regardless of an individual's immigration status, accept declaration of Virginia residency on the application as verification of residency. Do **NOT** require individuals who have been admitted into the U.S. on non-immigrant visas and other non-immigrants to sign a statement of intended residency.*

D. Cross-Reference to Intra-State Transfer

Procedures for handling cases where individuals who are Virginia residents move from one Virginia locality to another are described in subchapter M1520.

E. No Fixed Address

The agency cannot deny Medicaid to an eligible Virginia resident just because the resident has no fixed address. A Virginia resident is not required to have a fixed address in order to receive Medicaid.

For an eligible Virginia resident who does not have a fixed address, use the local social services department's address for the Medicaid card and inform the resident that he must come to the social services department to receive his card until he obtains a fixed address.

F. Length of Residency

The agency may not deny Medicaid eligibility because an individual has not resided in Virginia for a specified period of time.

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G. Residency in Virginia Prior to Admission to Institution

The agency may not deny Medicaid eligibility to an individual in an institution who meets the Virginia residency requirements previously identified in this subchapter, because the individual did not establish residence in Virginia before entering the institution.

H. Temporary Absence

The agency may not deny or terminate Medicaid eligibility because of that individual's temporary absence from Virginia if the individual intends to return to Virginia when the purpose of the absence has been accomplished, UNLESS another state has determined that the individual is a resident there for Medicaid purposes.

I. Disputed or Unclear Residency

If state residency is unclear or is in dispute, contact the regional specialist for help in resolution. When two or more states cannot resolve the residency, the state where the individual is physically located becomes the state of residence.

M0230.100 DEFINITION OF TERMS

A. Introduction

For purposes of this subchapter only, the terms in this section have the following meanings:

B. Institution

An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor is an **institution**.

For purposes of state placement of an individual, the term "institution" also includes foster care homes approved by the state and providing food, shelter and supportive services to one or more persons unrelated to the proprietor.

C. In An Institution

"In an institution" refers to an individual who is admitted to live in an institution and receives treatment or services provided there that are appropriate to his requirements.

D. Incapable of Indicating Intent

An individual is incapable of declaring his intent to reside in Virginia or any state if the individual:

- has an I.Q. of 49 or less or has a mental age of 7 or less, based on tests acceptable to the Virginia Department of Behavioral Health and Developmental Services (DBHDS);
- is judged legally incompetent; or
- is found incapable of declaring intent to reside in a specific state based on medical documentation obtained from a physician, psychologist, or other professional licensed by the State in the field of mental retardation.

E. Virginia Government Agency

A Virginia government agency is any state or local government agency, and any entity recognized by State law as being under contract with a Virginia state or local government agency.



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M0230.200 RESIDENCY REQUIREMENTS

M0230.201 INDIVIDUALS UNDER AGE 21

A. Under Age 21 NOT In An Institution

An individual under age 21 is considered a resident of Virginia if he:

a. is married or emancipated from his parents, is capable of indicating intent and is residing in Virginia with the intent to reside Virginia.

b. is not emancipated but is not living with a parent or caretaker and is presently residing in Virginia with the intent to reside in Virginia;

c. lives with a parent or caretaker who is presently residing in Virginia with the intent to reside in Virginia;

d. is a non-IV-E (state/local) foster care child whose custody is held by Virginia (see M230.204 C. and D.);

e. is a non-IV-E foster care child whose custody is held by another state but who has been placed with and is residing in Virginia with a parent or caretaker relative;

f. is a non-IV-E child adopted under an adoption assistance agreement with Virginia (see M230.204 C. and D.);

g. is a non-IV-E foster care child whose custody is held by a licensed, private foster care agency in Virginia, regardless of the state in which the child physically resides;

h. is under age 21 and is residing in another state for temporary period (for reasons such as medical care, education or training, vacation, (or visit) but is still in the custody of his/her parent(s) who reside in Virginia.

i. is living with a parent(s) who is a non-immigrant alien (admitted to the U.S. for a temporary or limited time) when the parent has declared his intent to reside in Virginia permanently or for an indefinite period of time, and no other information is contrary to the stated intent.

j. Is placed out of state for a trial home visit with parents (while custody is retained by Virginia).

B. Under Age 21 In An Institution

If the individual was placed in the institution by a state government agent, go to section M0230.203 below.

An institutionalized individual (who was not placed in the institution by a state government) who is under age 21 and is not married or emancipated, is a resident of Virginia if:

1. the individual's parent or legal guardian was a Virginia resident at the time of the individual's institutional placement;

2. the individual's parent or legal guardian who applies for Medicaid is a Virginia resident and the individual is institutionalized in Virginia; or

3. the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, and the individual is institutionalized in Virginia.



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C. Under Age 21, Custody or Adoption Agreement with Another State

When another state's child-placing agency has custody of a child who lives in Virginia with a foster family, the child is NOT a Virginia resident unless the child is eligible as a IV-E Foster Care child and receives a IV-E Foster Care maintenance payment.

1. IV-E Eligible Children

A Title IV-E Foster Care child who lives in Virginia and who receives a Title IV-E maintenance payment from another state meets the Virginia residency requirements for Medicaid.

A Title IV-E Adoption Assistance child who lives in Virginia and has a Title IV-E Adoption Assistance agreement in effect with another state's child-placing agency meets the Virginia residency requirements for Medicaid.

***2.* Non-IV-E Foster Care Children**

A non-IV-E Foster Care child placed in Virginia from another state does NOT meet the Virginia residency requirements for Medicaid *unless placed with and residing in Virginia with a parent or caretaker-relative.*

3. Foster Care Children with SSI

A foster care child who receives Supplemental Security Income (SSI) benefits meets the Virginia residency requirement regardless of which state's child-placing agency maintains custody.

***4.* Non-IV-E Adoption Assistance and Adoptive Placement Children**

A child who lives in Virginia with an adoptive family is considered to be living with a parent, regardless of whether a final order of adoption has been entered in court. When his adoptive parent is a Virginia resident, the child is a Virginia resident for Medicaid eligibility purposes. A Non-IV-E Adoption Assistance child whose adoption assistance agreement is signed by another state's child-placing agency is a Virginia resident when the child lives in Virginia with the adoptive parent(s).

M0230.202 INDIVIDUALS AGE 21 OR OLDER

A. Introduction

For an individual age 21 or older, the determination of state residency depends on

- whether or not the individual is in an institution, and
- whether or not the individual is capable of indicating his or her intent to reside in the state.

B. Age 21 Or Older NOT In An Institution

For any individual age 21 or older NOT residing in an institution, the state of residence is Virginia when:

- the individual is living in Virginia with or without a fixed address with the intention to reside in Virginia;
- the individual is living in Virginia and entered the state with a job commitment or seeking employment (whether or not currently employed).
- the individual is incapable of indicating intent and the individual is living in Virginia.

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C. Age 21 Or Older In An Institution — **If the individual was placed in the institution by a state government agent, go to section M0230.203 below.**

1. Capable of Stating Intent — An individual in an institution who is age 21 or over and who is capable of declaring his intent to reside in Virginia, is a resident of Virginia if the individual is in an institution in Virginia with the intent to remain permanently or for an indefinite period.

2.* Incapable *of Stating Intent — An individual in an institution who is age 21 or over and who became incapable of stating intent at or after age 21 is a Virginia resident if he or she is residing in Virginia.

M0230.203 STATE PLACEMENT IN INSTITUTION

A. Policy — Any agency of the state, including an entity recognized under state law as being under contract with the state for such purposes, that arranges for an individual to be placed in an institution located in another state, is recognized as acting on behalf of the state in making the placement. The state arranging or actually making the placement is considered the individual's state of residence. When an individual is placed by state or local government in an institution in another state, the individual remains the responsibility of the placing state unless the state or local government agency in the other state assumes responsibility for the individual's care or Medicaid eligibility.

When an individual is placed by a Virginia government agency in an institution in another state, the individual remains the responsibility of Virginia unless

- a state or local government agency in the other state assumes responsibility for the individual's care or Medicaid eligibility,
- the individual is a child who receives a IV-E foster care or adoption assistance payment, or
- the individual is a child who receives **non-IV-E adoption assistance** and the state in which he is placed is a reciprocal state under the interstate compact, verified by the central office Deputy Compact Administrator, Adoption Unit, Division of Family Services, Virginia Department of Social Services (DSS).

B. State Placement — Placement by a state government agency is any action taken by the agency, beyond providing general information to the individual and his family, to arrange admission to an institution for the individual. The following actions do not constitute state placement:

- providing basic information to individuals about other states' Medicaid programs or about the availability of health care services and facilities in other states;
- assisting an individual, who is capable of declaring intent and who independently decides to move out-of-state, in locating an institution in another state.



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1. Lack Of Facilities

When a placement is initiated by a state because the state lacks a sufficient number of appropriate facilities to provide services to its residents, the state making the placement is the individual's state of residence for Medicaid purposes.

2. Individual Leaves Facility

When a competent individual leaves the facility in which he was placed by a state, that individual's state of residence for Medicaid purposes is the state where the individual is physically located.

C. Individual Placed Out-of-State by Virginia Government

An individual can leave Virginia and retain Virginia residency if he is placed in an institution outside Virginia by a Virginia government agency. Out-of-state placement into a long-term care facility must be preauthorized by the Director of the Virginia Department of Medical Assistance Services for Virginia Medicaid to pay for the institutional care.

When a competent individual voluntarily leaves the facility in which Virginia placed him, he becomes a resident of the state where he is physically located.

M0230.204 CASH ASSISTANCE PROGRAM RECIPIENTS

A. Introduction

Certain individuals are considered residents of Virginia for Medicaid purposes if they live in Virginia and receive a cash assistance payment specified below in this section. Some recipients of cash assistance from a Virginia social services agency who do NOT reside in Virginia are considered residents of Virginia for Medicaid purposes, as specified below.

B. Auxiliary Grants Recipients

An individual receiving an Auxiliary Grants (AG) payment from a locality in Virginia is considered a Virginia resident.

An individual who receives a State Supplement of SSI payment from another state is considered a resident of the state making the State Supplement payment.

C. IV-E Payment Recipients

For an individual of any age who receives federal foster care or adoption assistance payments under Title IV-E of the Social Security Act, the state of residence for Medicaid eligibility is the state where the child lives.

D. Non-IV-E Foster Care Payment Recipients

A child in foster care receiving a non-IV-E (state and local) payment whose custody is held by another state but who has been placed with and is residing in Virginia with a parent or care-taker relative is considered a resident of Virginia. If the child is not living with a parent or care-taker relative, the child is a resident of the state that is making the non IV-E payment.

E. Non-IV-E Adoption Assistance Payment Recipients

The non IV-E (state/local) Adoption Assistance recipient is a resident of the state in which the child's adoptive parent(s) resides, regardless of whether a final order of adoption has been entered in court.

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SOCIAL SECURITY NUMBER REQUIREMENTS

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TN #DMAS-32	7/1/24	Pages 3 and 5
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TN #DMAS-21	10/1/21	Pages 1, 3, 5
TN #DMAS-20	7/1/21	Table of Contents Pages 1, 3, 5 Page 6a was renumbered to Page 7. Pages 2, 4, 6 and 7 are runover pages.
TN #DMAS-13	7/1/19	Page 1 Pages 2 and 3 are runover pages.
TN #DMAS-10	10/1/18	Pages 3, 4
TN #DMAS-9	7/1/18	Table of Contents Page 6 Page 6a is a runover page
TN #DMAS-2	10/1/16	Pages 1, 4 Page 2 is a runover page.
TN #100	5/1/15	Page 2
TN #98	10/1/13	Table of Contents Pages 1-5 Page 6 was deleted.
TN #96	10/1/11	Pages 2-4
TN #94	9/1/10	Pages 1-6
TN #93	1/1/10	Pages 1-4
Update (UP) #1	7/1/09	Pages 1, 2
TN #91	5/15/09	Pages 1, 2

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M0240.000 SOCIAL SECURITY NUMBER REQUIREMENTS

M0240.001 GENERAL PRINCIPLES

A. Policy

To be eligible for medical assistance (MA), an individual must provide his Social Security number (SSN) as well as the SSN of any person for whom MA is requested, or must provide proof of application for an SSN. This requirement applies to both the Medicaid and FAMIS Programs.

Exceptions – the SSN requirement does not apply to:

- an alien who is eligible only for Medicaid payment of emergency services, as defined in subchapter M0220,
- a non-citizen who is only eligible to receive an SSN for a valid non-work reason,
- a child under age one born to a Medicaid-eligible or FAMIS- covered mother (see M0330.301 B. 2 and M2220.100.), or
- an individual who refuses to obtain an SSN because of well-established religious objections.

An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

B. Failure to Meet SSN Requirement

Any individual for whom an application for an SSN has not been filed or for whom the SSN is not furnished **is not eligible** for MA EXCEPT for the following individuals.

1. Child Under Age 1

A child under age one born to a Medicaid-eligible or to a FAMIS-covered mother is deemed to have applied and been found eligible for MA, whether or not the eligibility requirements, including SSN, have actually been met. This includes an infant born to a mother in FAMIS Prenatal Coverage who is *assigned to* Aid Category 110 AND who is NOT in managed care.

An infant born to a mother in FAMIS Prenatal Coverage who *is assigned to* AC 110 and who IS in managed care OR who *is assigned to* in AC 111 is not a deemed newborn; however, the infant is not required to provide an SSN or proof of application for an SSN in order to be enrolled. See M0240.200 C.

2. Individual With Religious Objections

An individual who refuses to obtain an SSN due to well-established religious objections must provide documentation of (1) membership of a recognized religious sect of division of the sect and (2) adherence to the tenets or teachings of the sect or division of the sect and for that reason being conscientiously opposed to applying for or using a national identification number.

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3. Emergency-Services Aliens and other Non-Citizens

An alien eligible for Medicaid payment of emergency services only, as defined in M0220.410 and M0220.41, is not required to provide or apply for an SSN.

Any non-citizen who is only eligible to receive an SSN for a valid non-work reason is not required to provide or apply for an SSN. These individuals include, but are not limited to, undocumented aliens, non-citizens admitted to the U.S. on non-immigrant visas and individuals who do not intend to work in the U.S. and would only have needed an SSN for the purposes of receiving public assistance.

C. Relationship to Other Medicaid Requirements

An applicant who cannot provide documentation that he is a citizen or legally present at the time of application must sign an affidavit under oath attesting that he is a U.S. citizen or legally present in the U.S. in order to temporarily meet the requirement for proof of legal presence (see M0210.150). **Submission of the affidavit without proof of application for an SSN does NOT meet the SSN requirement.**

D. Verification

1. Name

The name entered in the official case record and computer enrollment systems for an applicant must match the applicant's name on his Social Security card or Social Security Administration (SSA) records verification. It is important to spell the name correctly so that when the Medicaid Management Information System (MMIS) sends the enrollee information to SSA for the Medicare Buy-in or the citizenship and identity match, the enrollee can be matched to SSA records.

The Federally managed Data Services Hub verifies the individual's name and SSN with the SSA for cases processed in the Virginia Case Management System (VaCMS). For an individual whose name and SSN cannot be verified in VaCMS and for all individuals whose cases are not processed in VaCMS, either the State Verification Exchange System (SVES) or the State Online Query-Internet system (SOLQ-I) SSA Title II and Title XVI results may be used.

2. SSN

The individual's SSN must be verified. The worker may use the SOLQ-I or SVES to verify an individual's SSN.

3. Verification Systems - SVES & SOLQ-I

SVES verifies the individual's SSN, name spelling, entitlement to SSA benefits and the amount of the benefit, entitlement to SSI and the amount, and entitlement to Medicare & the Medicare premium amounts. SVES tells the worker what is wrong with the name, if the name is incorrectly spelled.

The SOLQ-I verifies the individual's SSN, entitlement to SSA benefits and the amount of the benefit, entitlement to SSI and the amount, and entitlement to Medicare & the Medicare premium amounts. SOLQ-I does not verify the individual's name according to the SSA records.

E. Procedure

Section M0240.100 below explains in detail how to determine if an individual meets the SSN requirements when the individual or child does not have an SSN.



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M0240.100 APPLICATION FOR SSN

A. Policy

If an SSN has not been issued for the individual or the individual's child(ren), the applicant must cooperate in applying for a number with the local Social Security Administration Office (SSA). Instruct the applicant to submit form SS-5, the Application for Social Security Number, to the SSA and to obtain a receipt from SSA verifying that the application was submitted. The SS-5 is available online at: http://www.socialsecurity.gov/ssnumber/ss5.htm.

The agency must provide *at least one* 90-calendar-day reasonable opportunity period for the individual to obtain and provide an SSN and may not delay, deny, reduce or terminate benefits for an individual whom the agency determines to be otherwise eligible for Medicaid during such reasonable the opportunity period. If the application for an SSN was made through hospital enumeration, the agency must allow 120 calendar days for the SSN to be obtained and provided.

The applicant must provide the SSN to the local social services department as soon as it is received and the number must be verified and entered in the eligibility/enrollment system.

1. Newborns

In the case of a newborn child, the applicant/recipient may satisfy this requirement by requesting that an SSN be applied for by hospital staff in conjunction with the filing of the birth record at the time of the child's birth. Form SSA-2853 will be given to the mother by hospital staff as verification of application for the child's SSN.

For an infant born to a mother in FAMIS Prenatal Coverage who is assigned to AC 110 and who is in managed care OR who is enrolled in AC 111, see M0240.200 C.

2. Failure to Apply for SSN

Applicants who refuse to furnish an SSN or to show proof of application for a number are ineligible for Medicaid.

3. Retroactive Eligibility

An individual who provides proof of application for an SSN after he applies for medical assistance, meets the application for SSN requirement in the three months retroactive to his medical assistance application.

M0240.200 FOLLOW-UP REQUIREMENTS FOR SSN APPLICATION

A. Applicant Applied for SSN

When an applicant who has applied for an SSN is determined eligible for medical assistance, he is enrolled with a pseudo-SSN. The worker must obtain the enrollee's SSN when it is assigned and enter it into the enrollee's records.

For an infant born to a mother in FAMIS Prenatal Coverage who is assigned to AC 110 and who is in managed care OR who is assigned to AC 111, see M0240.200 C.

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B. Follow-Up Procedures for Individuals Who Are Not Infants Born to Women Enrolled in FAMIS Prenatal Coverage

The follow-up procedures below do not apply to individuals listed in M0240.100 B.

1. Documentation

If the applicant does not have an SSN, the agency must document in the record the date he applied for an SSN.

2. Entering Computer Systems

*If a date is necessary w*hen entering the individual the eligibility/enrollment system, use the date the individual applied for an SSN, or the individual's date of birth, preceded by "000" as the individual's SSN.

For example, an individual applied for an SSN on October 13, 2006. Enter "000101306" as the individual's SSN in the eligibility/enrollment system.

3. Follow-up

a. Follow-up in 90 *Calendar* Days

After enrollment of the eligible individual, the agency must follow-up within 90 *calendar* days of the Social Security number application date or 120 *calendar* days if application was made through hospital enumeration.

b. Check for Receipt of SSN

Check the system records for the enrollee's SSN. If the SSN still has "000" the first 3 digits, contact the enrollee to obtain the enrollee's SSN verbally or by mail. *If the individual has not applied for an SSN, send advance notice that the individual is no longer eligible for coverage and cancel coverage.*

c. Verify SSN by a computer system inquiry of the SSA records.

d. Enter Verified SSN in the eligibility/enrollment system.

4. Renewal Action

If the enrollee's SSN has not been assigned by the 90-day follow-up, the worker must follow-up no later than the enrollee's annual renewal, by checking the systems for the enrollee's SSN and by contacting the enrollee if necessary.

a. Check for Receipt of SSN

Before or at renewal, the SSN must be entered into the eligibility/enrollment system. Check the system records for the enrollee's SSN. If the SSN has "000"as the first 3 digits, contact the enrollee to obtain the enrollee's SSN verbally or by mail, or on the renewal form if a renewal form is required.

b. Verify SSN by a computer system inquiry of the SSA records.

c. Enter Verified SSN in the eligibility/enrollment system.

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d. SSN Not Provided by Renewal Deadline

The worker must assist the enrollee in obtaining the applied-for SSN. The worker will ask the enrollee for the assigned SSN at the first renewal, and give a deadline date for the enrollee to provide the SSN.

If the enrollee does not provide the SSN by the deadline, the worker will ask the enrollee why it was not provided to the worker:

- Did the enrollee ever receive the SSN from SSA?
- If not, why not?

If the problem is **not** an SSA administrative problem, the worker must cancel MA coverage for the enrollee whose SSN is not provided.

C. Follow-Up Procedures For an Infant Born to a Woman Enrolled in FAMIS Prenatal Coverage

An infants born to a mother enrolled in FAMIS Prenatal Coverage assigned to Aid Category (AC) 110 and who is NOT in managed care is a deemed newborn. Follow up on the SSN is not required until the time of the newborn's first renewal *during the month or after turning one.*

An infant born to a mother in FAMIS Prenatal Coverage who is assigned to AC 110 and who IS in managed care OR who is assigned to AC 111 is not a deemed newborn; however, the infant is not required to provide an SSN or proof of application for an SSN in order to be enrolled. Follow the procedures in M0240.200 B.3 above 90 days following the infant's enrollment to determine if an SSN has been assigned. If the SSN number has not yet been issued at 90 days, obtain the SSN or proof of application for an SSN at the first renewal of the infant's coverage *during the month or after turning one.*

M0240.300 SSN Verification Requirements

A. SSN Provided By Individual

The individual's SSN must be verified. When the individual provides his SSN, the worker may use the SOLQ-I or SVES to verify the individual's SSN. The individual is not eligible for MA and cannot be enrolled in the eligibility/enrollment system if his SSN is not verified.

B. Procedures

1. Enter Verified SSN in Systems

Enter the eligible enrollee's verified SSN in the eligibility/enrollment system.

2. Resolving Unverified SSN Discrepancies

a. Data Entry Error Caused Discrepancy

If it is determined that the discrepancy was the result of an error made while entering the SSN in the system, steps must be taken to correct the information in the eligibility/enrollment system so that a new data match with SSA can occur in the next month.

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b. Discrepancy Not Caused by Data Entry Error

If the discrepancy is not the result of a typographical or other data entry error, the individual must be given a period of 10 *calendar* days to resolve the issue or provide written verification from SSA of the individual's correct SSN. The eligibility worker must send a written notification to the enrollee that informs the enrollee of the SSN discrepancy and gives him 10 *calendar* days from the date of the notice to either resolve the discrepancy with the SSN or to provide written verification of his correct SSN to the worker. The notice must inform the individual that if he does not verify his SSN by the deadline, his Medicaid coverage will be canceled.

c. Individual Provides SSN Verification

If verification of the SSN is received within the 10 *calendar days*, update the eligibility/enrollment system accordingly so that the enrollee's information will be included in a future data match.

d. SSN Verification Not Provided

If verification of the SSN is NOT received within the 10 *calendar* days, send the individual an advanced notice of proposed cancellation and cancel the individual's coverage in the eligibility/enrollment system.

M0240.400 SOCIAL SECURITY NUMBER DISCREPANCIES

A. Policy

To be eligible for medical assistance (MA), an individual must provide his Social Security number (SSN) as well as the SSN of any person for whom MA is requested, or must provide proof of application for an SSN.

As required by 42 CFR 435.910(g), "the agency must verify each SSN of each applicant and recipient with the SSA [Social Security Administration], as prescribed by the Commissioner, to insure that each SSN was furnished to that individual, and to determine whether any others were issued."

In addition, 42 CFR 435.920 states, "In redetermining eligibility, the agency must review case records to determine whether they contain the recipient's SSN or, in the case of families, each family member's SSN."

The Medical Assistance enrollment system generates a Social Security number and citizenship report (RS-O-485-A) and makes the report available to the local departments of social services (LDSS) on a monthly basis. LDSS agencies are responsible for reviewing the monthly report and correcting any discrepancies. If the agency is not able to resolve SSN discrepancies in a timely manner, an ineligible individual should not receive Medicaid services. Refer to Medicaid Policy M0240.300 regarding SSN Verification Requirements.

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Staff at the Department of Medical Assistance Services will oversee and monitor the process of SSN resolution on a monthly basis to ensure that action has been taken to correct Social Security Numbers in the system.

B. Process

1. **Generation of the RS-O-485-A Report**

The RS-O-485-A Report is produced monthly and posted for LDSS review.

2. **VDSS Requirements**

It is the responsibility of the LDSS to review the report and research each entry to resolve any discrepancies concerning an individual's social security number. An ineligible individual should not receive Medicaid services.

VDSS is responsible for implementing the necessary procedures to ensure that all corrections or changes will be made within a 30-day period and updated in the MMIS system accordingly. Policy guidelines are located in the Medicaid Policy Manual. See Policy M0240.300

3. DMAS Review

DMAS staff will concurrently review an internal report showing how long each individual discrepancy continues to appear. The number of new (first time) and repeat (not first time on report) occurrences will be noted. Repeat occurrences will be further broken down by those that have appeared from prior month, in the prior two months, in the prior three months, and the total that have been on the report for four or more months.

4. Forward List to VDSS

DMAS will provide a monthly outcome report of the number of discrepancies reported and the individuals with discrepancies that remain on the report after 90 days.

This report will be forwarded to the VDSS Medical Assistance Programs Manager and to the VDSS Regional Medicaid consultants for review. VDSS will review the report and provide to DMAS a corrective action plan for resolving the discrepancies. All discrepancies must be resolved within 30 days of receiving the report from DMAS.

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CHAPTER M02
NONFINANCIAL ELIGIBILITY REQUIREMENTS
SUBCHAPTER 50

ASSIGNMENT OF RIGHTS *AND PURSUIT OF SUPPORT FROM THE ABSENT PARENT REQUIREMENTS*

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M0250 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-18	1/1/21	Page 4
TN #98	10/1/13	Pages 1-4 Page 5 was deleted.
TN #97	9/1/12	Page 5
TN #96	10/1/11	Page 3
TN #94	9/1/10	Pages 3-5

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M0250 ASSIGNMENT OF RIGHTS AND PURSUIT OF SUPPORT	**TOC**	**i**

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

M0250.001 GENERAL PRINCIPLES

A. Introduction

The assignment of rights to medical support and the pursuit of support from absent parent(s) are Medicaid nonfinancial requirements that must be met as a condition of Medicaid eligibility. *The assignment of rights to medical support requirement also applies to children eligible for the Family Access to Medical Insurance Security Plan (FAMIS).*

B. Policy and Procedures

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

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

M0250.100 ASSIGNMENT OF RIGHTS

A. Assignment of Rights Policy

To be eligible for Medicaid, a Medicaid applicant or recipient must:

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

B. Individual Unable To Assign Rights

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

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



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M0250.200 PROCEDURES FOR ASSIGNMENT OF RIGHTS

A. Forms

The assignment of rights information is *incorporated into the online and paper applications for medical assistance (MA).*

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

B. Refusal To Assign Rights Or Cooperate

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

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

C. Cooperation – Assignment of Rights

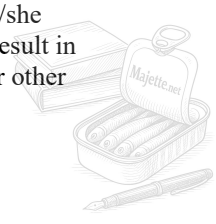
Cooperation in assisting the agency in securing medical support and payments includes requiring the individual to:

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

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

1. Waiver of Cooperation

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



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

M0250.300 PURSUIT OF MEDICAL SUPPORT FROM THE ABSENT PARENT

A. Policy

To be eligible for Medicaid, an individual applicant or recipient must cooperate with the agency in obtaining medical support and payments from, or derived from, the absent parent(s) of a child for whom the individual is applying, unless the individual establishes good cause for not cooperating. The individual's non-cooperation does NOT affect the individual's Plan First eligibility, nor the individual's child(ren)'s Medicaid eligibility.

A pregnant woman is not required to cooperate with DCSE when requesting assistance for herself and her child(ren) born out of wedlock. If she is or was married, she is required to cooperate in pursuing medical support for her legitimate child(ren) from the legitimate child(ren)'s absent father.

A married pregnant woman who meets the medical assistance support requirement **cannot be denied** medical assistance for failure to cooperate in pursuing support even when ineligible for another program because of failure to cooperate with pursuit of support.

B. Definition of Cooperation

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

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

2. Ongoing After the individual's application has been approved, if DCSE, DMAS or the local agency requests information from the individual about the absent parent, or otherwise requires the individual's cooperation with the pursuit of medical support from the absent parent, the individual must cooperate in order for the individual's eligibility to continue.

Medicaid enrollees who were approved for Medicaid before January 1, 2007, and who were referred to DCSE, must continue to cooperate with DCSE in the pursuit of medical support from the absent parent to remain eligible for Medicaid.

C. Local DSS Agency Responsibility

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1. **Applicants**

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

Give the applicant the DCSE Fact Sheet available on the intranet at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/References*.

2. **Enrollees**

If the local agency or DMAS requires from the enrollee information related to medical support from the absent parent, such as the policy number of the health insurance policy the absent parent has that covers the child, and the enrollee refuses to give it to the requesting agency but does not have good cause for refusing, the enrollee is no longer eligible for Medicaid because of failure to cooperate in pursuing medical support and third party liability. The child(ren) remain eligible for Medicaid.

a. Enrollees who were approved before January 1, 2007

For a Medicaid enrollee who was approved for Medicaid before January 1, 2007, and was referred to DCSE, the local agency must take action when notified by DCSE that the enrollee is not cooperating in the pursuit of medical support from the absent parent. The child(ren)'s eligibility for Medicaid is NOT affected.

b. Enrollees who applied on or after January 1, 2007

If the enrollee who applied for Medicaid on/after January 1, 2007, chooses to apply for DCSE services and DCSE opens a case for the applicant, the enrollee must cooperate with DCSE in the pursuit of medical support from the absent parent, unless there is good cause for not cooperating. If the agency is notified by DCSE that the enrollee is not cooperating, the agency worker must take appropriate action on the enrollee's Medicaid coverage; the child(ren)'s eligibility for Medicaid is NOT affected.

If the recipient wants to claim good cause for not cooperating, contact a Medical Assistance Program Consultant for instructions.

3. TANF Recipients

If an applicant for or recipient of Temporary Assistance for Needy Families (TANF) fails to cooperate with DCSE, the individual's eligibility for Medicaid is not impacted unless the individual previously requested assistance from DSCE for Medicaid purposes per M0250.300 C.2.b above.

D. DCSE

DCSE District Offices have the responsibility of pursuing support from absent legally responsible parent(s), establishing paternity when the alleged father is absent from the home, and notifying the local DSS when the enrollee does not cooperate. This responsibility entails locating the parent(s), determining ability to support, collecting support from legally responsible parent(s), establishing medical support and/or health insurance covering the applicant child(ren), and court action to secure support from the absent legally responsible parent.

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



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CHAPTER M02
NONFINANCIAL ELIGIBILITY REQUIREMENTS
SUBCHAPTER 60

RESERVED

NOTE: Policy references to M0260 that are still in effect have been moved to subchapter M0250.

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CHAPTER M02
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APPLICATION FOR OTHER BENEFITS

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M0270 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Subchapter removed
TN #DMAS-20	7/1/21	Page 2
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CHAPTER M02
NONFINANCIAL ELIGIBILITY REQUIREMENTS
SUBCHAPTER 80

INSTITUTIONAL STATUS REQUIREMENTS

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M0280 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-36	10/1/25	Pages 6,7 and 10
TN #DMAS-32	7/1/24	Page 7
TN #DMAS-20	7/1/21	Table of Contents Page 1 Appendix 2 was added.
TN #DMAS-19	4/1/21	Pages 3, 4 Appendix 1 Page 4a was added.
TN #DMAS-17	7/1/20	Pages 7, 9, 10 Page 11 was deleted.
TN #DMAS-15	1/1/20	Page 9 Appendix 1
TN #DMAS-14	10/1/19	Pages 6, 7, 9, 11
TN #DMAS-2	10/1/16	Pages 7, 9
TN #100	5/1/15	Table of Contents Pages 1-11 Appendix 1 was added Pages 12 and 13 were deleted.
UP #9	4/1/13	Page 5
Update (UP) #7	7/1/12	Table of Contents Page 8 Appendix 1 was deleted.
TN #94	9/1/10	Page 1
TN #93	1/1/10	Page 13

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Appendix

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M0280.000 INSTITUTIONAL STATUS REQUIREMENTS

M0280.001 GENERAL PRINCIPLES

A. Introduction

To be eligible for Medicaid, an institutionalized individual must meet the institutional status requirement. An individual does not necessarily have to live in an institution (facility) to be considered an "inmate of a public institution." While inmates of public institutions are generally NOT eligible for Medicaid, incarcerated individuals may be eligible for Medicaid payment limited to inpatient hospitalization, provided they meet all other eligibility requirements.

B. Procedure

This subchapter, M0280, contains the Medicaid institutional status policy, inmate of a public institution policy and procedures for determining whether an individual meets the Medicaid institutional status eligibility requirement.

M0280.100 DEFINITION OF TERMS

A. Child Care Institution

A child care institution is a

- non-profit private child-care institution, or
- a public child care institution that accommodates no more than 25 children which has been licensed by the state in which it is located or has been approved by the agency of the state responsible for licensing or approval of institutions of this type, as meeting the standards established for licensing.

The term "child care institution" does NOT include detention facilities, forestry camps, training schools or any other facility operated primarily for the detention of children who are determined to be delinquent.

B. Inpatient

Inpatient means a patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist and who is admitted and receives room, board and professional services in the institution for a 24 hour period or longer, or is expected by the institution to receive room, board and professional services in the institution for a 24 hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another medical facility and does not actually stay in the institution for 24 hours.

C. Institution

An institution is an establishment that furnishes (in single or multiple facilities) food, shelter and some treatment or services to four or more persons unrelated to the proprietor.

D. Institution for the Treatment of Mental Diseases (IMD)

An IMD is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, to persons with mental diseases. A psychiatric residential treatment facility for children and adolescents is an IMD. An institution for individuals with intellectual disabilities is NOT an IMD. *A list of IMDs in Virginia is contained in M0280, Appendix 2*

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E. ***Institution for Individuals with Intellectual Disabilities***

An "institution for individuals with intellectual disabilities" means an institution that is primarily for the diagnosis, treatment, or rehabilitation of individuals with Intellectual Disabilities or persons with related conditions that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination , and integration of health or rehabilitative services to help each individual function at his greatest ability. An intermediate care facility for individuals with intellectual disabilities (ICF-ID) is not an IMD. Therefore, an individual under age 65 who is in an ICF-ID meets the institutional status eligibility requirement.

F. **Medical Facility**

A medical facility is an institution that:

- is organized to provide medical care, including nursing and convalescent care,
- has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,
- is authorized under state law to provide medical care, and
- is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

G. **Public Institution (Facility)**

A public institution is an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control, and which is NOT a medical facility.

The following are NOT public facilities for this section's purposes:

- a medical facility, including a nursing facility;
- a publicly operated community residence (serves no more than 16 residents);
- a child care institution, for children who receive foster care payments under Title IV-E, that accommodates no more than 25 children;
- an institution certified as an ICF-*ID* for individuals with mental retardation or related conditions.

H. **Publicly Operated Community Residence**

A publicly operated community residence is a public residential facility (institution) with 16 beds or less, that provides some services beyond food and shelter such as social services, help with personal living activities or training in socialization and life skills. Occasional medical or remedial care may also be provided.

Publicly operated community residences do NOT include the following facilities even though these facilities have 16 or *fewer* beds:

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- residential facilities located on the grounds of, or adjacent to, any large (more than 16 beds) institution;
- correctional or holding facilities for individuals who are prisoners, who have been arrested or detained pending disposition of charges, or who are held under court order as material witnesses or juveniles
- educational or vocational training institutions that primarily provide an approved, accredited or recognized program to individuals residing there
- hospitals, nursing facilities, and intermediate care facilities for individuals with intellectual disabilities.

NOTE: An individual residing in a public educational or vocational training institution for purposes of securing education or vocational training is NOT an inmate of a public institution, and therefore may be eligible for Medicaid, even though the educational or training facility is not a publicly operated community residence.

I. Residential Institution

An institution that does not meet the definition of a "medical facility."

M0280.200 INSTITUTIONAL STATUS RULE

A. Introduction

Federal regulations in 42 CFR 435.1008 prohibit federal financial participation (FFP) for individuals who are inmates of a public institution, *with certain exceptions for patients in an IMD.*

Federal regulations limit FFP for individuals who are age 22 years or over but under age 65 years and who are patients in an institution for the treatment of mental diseases (IMD). An individual who is age 22 or over, but under age 65 and who is enrolled in Medicaid at the time of admission to an IMD may remain enrolled in Medicaid. The Department of Medical Assistance Services (DMAS) will coordinate with the Centers for Medicare and Medicaid Services (CMS) to ensure that no unauthorized FFP occurs.

There is no prohibition on FFP for individuals under age 22 years if they are receiving inpatient psychiatric services.

NOTE: an ICF-*ID* is not an IMD.

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B. Procedures

The policy and procedures for determining whether an individual is in an IMD are contained in subchapter M1430.

The policy and procedures for determining whether an individual is an inmate of a public institution are contained in the following sections:

- M0280.201 Individuals in Medical Facilities
- M0280.202 Individuals in Residential Facilities
- M0280.300 Inmate of A Public Institution
- M0280.301 Who Is NOT An Inmate of A Public Institution
- M0280.400 Procedures For Determining Institutional Status
- M0280.500 Individuals Moving To or From Public Institutions
- M0280.600 Departmental Responsibility.

See Appendix 1 to this subchapter for an Institutional Status Quick Reference Guide.

M0280.201 INDIVIDUALS IN MEDICAL FACILITIES

A. Public or Private

The public or private ownership or administration of a **medical** facility is irrelevant because a medical facility is not a public institution as defined in this subchapter.

B. Individuals in IMD*s*

The following individuals in public or private IMDs are NOT eligible for *enrollment into* Medicaid because they do not meet the institutional status requirement:

- an individual who is age 22 or over, but under age 65;
- an individual who is under age 22 who is NOT receiving inpatient psychiatric services in the IMD.

An individual who is age 22 or over, but under age 65 and who is enrolled in Medicaid at the time of admission to an IMD may remain enrolled in Medicaid. The Department of Medical Assistance Services (DMAS) will coordinate with the Centers for Medicare and Medicaid Services (CMS) to ensure that no unauthorized FFP occurs.

1. Patient *Under Age 22 or 65 Years and Older* in an IMD

An individual is in an IMD when he/she is admitted to live there and receive treatment or services provided there that are appropriate to his/her requirements. A patient in an IMD is an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or lessening of illness, disability, or pain. An individual is *considered to be* in an IMD from the date of admission to the IMD until discharge from the IMD.

An individual who is age 65 or older and who is a patient in a public or private IMD meets the institutional status requirement for Medicaid. An individual who is under age 22, who is a patient in a public or private IMD and who is receiving inpatient psychiatric services in the IMD meets the institutional status requirement for Medicaid.

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2. ***Patient Age 22-65 Years***

An individual who is age 22 or over, but under age 65 and who is enrolled in a Medicaid at the time of admission to an IMD may remain enrolled in Medicaid. ***Do not cancel coverage****. The Department of Medical Assistance Services (DMAS) will coordinate with the Centers for Medicare and Medicaid Services (CMS) to ensure that no unauthorized FFP occurs.*

For an individual age 22 or over, but under age 65 and who is a patient residing in an IMD at the time of application, follow the policy and procedures in M1510.102 A.5.

3. **Conditional Release From IMD**

A patient in an IMD who is transferred or discharged to a medical facility that is not an IMD, including a patient under conditional release or convalescent leave from the IMD, meets the institutional status requirement and may be eligible for Medicaid.

C. **ICF-ID**

An ICF-ID is not an IMD. Therefore, an individual under age 65 who is in an ICF-ID meets the institutional status eligibility requirement.

D. **Residential Facilities With Certified Medical Beds**

Some institutions have both medical and residential sections. Individuals in the residential section (or beds) are residents of a residential facility. If the resident receives Medicaid Community-based Care (CBC) waiver services, use chapter M14 to determine the individual's eligibility. If the resident does not receive Medicaid CBC, he is not in long-term care; use the Medicaid eligibility requirements for non institutionalized individuals.

Individuals in the medical certified portion (or beds) of an institution are patients in a medical facility. Use chapter M14 in determining their Medicaid eligibility.

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E. **Cross Reference** — If the individual has been, or is expected to be, in the medical facility or medical section of the facility for 30 or more consecutive days, the individual is receiving long-term care. Chapter 14 contains additional eligibility policy for individual in long term care.

M0280.202 INDIVIDUALS IN RESIDENTIAL FACILITIES

A. Institutions With Medical and Residential Sections

Some institutions have both medical and residential sections. An individual in the medical certified section (or beds) of the institution is a patient in a medical facility. If the individual has been, or is expected to be, in the medical facility for 30 or more consecutive days, the individual is receiving long-term care. Go to chapter M14 to determine the individual's eligibility.

An individual in the residential portion (or beds) of the institution is a resident of a residential facility. Use this subchapter to determine the resident's institutional status.

B. Private Residence or Group Home

An individual who lives in a private residence in the community that is not an institution (it is an establishment that provides food, shelter and some services to three or less persons unrelated to the proprietor) is not living in an institution. **A group home that has a capacity of no more than three residents is not an institution.**

C. Private Residential Facility

A resident of any age in a private residential facility meets the institutional status requirement for Medicaid UNLESS the individual is incarcerated, as defined below.

D. Public Residential Facility

A resident of any age in a PUBLIC residential facility meets the institutional status requirement for Medicaid UNLESS:

- the public residential facility has more than 16 beds, or
- the individual is an inmate - an incarcerated adult or a juvenile in detention - as described in section M0280.300 below, and is not an individual listed in M0280.301 below.

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M0280.300 INMATE OF A PUBLIC INSTITUTION

A. Policy

Inmates of public institutions fall into three groups:

- individuals living in ineligible public institutions;
- incarcerated adults; and
- juveniles in detention.

An individual is an inmate of a public institution from the date of admission to the public institution until discharge, or from the date of actual incarceration in a prison, county or city jail or juvenile detention facility and considered incarcerated until permanent release, bail, probation or parole. An offender sentenced to the Community Corrections Alternative Program (CCAP) *is* confined in a DOC facility *is* not considered released, and *is* not a parolee or probationer.

Incarcerated individuals (adults and juveniles) who are hospitalized can be eligible for Medicaid payment limited to services received during an inpatient hospitalization, provided they meet all other Medicaid eligibility requirements.

An individual released from jail under a court probation order due to a medical emergency is NOT an inmate of a public institution because he is no longer incarcerated.

B. Public Residential Facility Residents

An individual who lives in a public residential facility that serves more than 16 residents is NOT eligible for Medicaid.

A public residential facility that does not meet the definition of a "publicly operated community residence" in section M0280.100 above, is an "ineligible public institution."

The following are ineligible public institutions:

- public residential institutions with more than 16 beds
- residential facilities located on the grounds of, or adjacent to, a public institution with more than 16 beds:

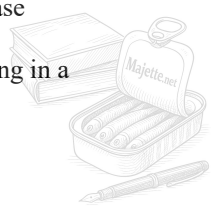
C. Incarcerated Adults

Offenders can be eligible for Medicaid payment limited to services received during an inpatient hospitalization of 24 hours or longer.

Offenders include:

- individuals under the authority of the Department of Corrections (DOC)
- individuals held in regional and local jails, including those on work release

Individuals are not eligible for full benefit Medicaid coverage while they are living in a correctional facility, regional or local jail. For a juvenile in a facility, refer to M0280.300.D below and Appendix 1.



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An offender who transfers temporarily to a halfway house, residential re-entry center (RRC), or residential treatment facility prior to a formal probation release order is still an inmate of a public institution and can only be eligible for Medicaid payment limited to services received during an inpatient hospitalization. Note: some drug or alcohol rehabilitation centers may be referred to as a "halfway house"; the eligibility worker should confirm the individual is not an inmate or incarcerated.

Once an incarcerated individual who is enrolled in Medicaid is released from the correctional facility, he may be eligible for all benefits available under the Medicaid covered group he meets.

D. Juveniles in Detention

In determining whether a juvenile (individual under age 21 years) is incarcerated, the federal Medicaid regulations distinguish between the nature of the detention, pre- and post- disposition situations, and types of facilities.

1. Held for Care, Protection or Best Interest

A juvenile who is in a detention center due to care, protection or in the best interest of the child can be eligible for full benefit Medicaid or Family Access to Medical Insurance Security (FAMIS) coverage. *A child who is incarcerated in a Department of Juvenile Justice Facility is considered to be temporarily absent from home.*

2. Held for Criminal Activity

a. Prior to Court Disposition

The following juveniles can be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

- juvenile who is in a detention center due to criminal activity
- juvenile who has criminal charges pending (no court disposition has been made) who is ordered by the judge to go to a treatment facility, then come back to court for disposition when the treatment is completed

b. After Court Disposition

Juveniles who are on probation with a plan of release which includes residence in a detention center are inmates of a public institution. If they go to any of the secure juvenile correctional facilities, they are inmates of a public institution and can only be eligible for Medicaid payment limited to inpatient hospitalization. A list of secure detention facilities in Virginia is available on the Department of Juvenile Justice's web site at Juvenile-Detention-Centers-and-Homes-Contacts.pdf (virginia.gov). Because this list is subject to change, consult the list whenever eligibility must be evaluated for a juvenile who is reportedly in a detention center.

If the juvenile goes to a non-secure group home, he can be eligible for Medicaid or FAMIS because a non-secure group home is not a detention center.

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3. Type of Facility

The type of facility, whether it is residential or medical and whether it is public or private must be determined. A juvenile is not eligible *for full-benefit Medicaid* if he/she is a resident of an ineligible public residential facility. *He can be eligible for Medicaid coverage limited to inpatient hospitalization if he is admitted to a medical facility for inpatient services.*

EXAMPLE #1: A juvenile is detained for criminal activity. He is placed on probation with specific conditions of release, including a stay of 30 days or longer at a detention facility. The facility is identified as a juvenile detention center, not a treatment center. Upon release from the detention center, he will be placed on probation and will live with his mother. Because of the nature of his custody (criminal activity) and the nature of the facility (a detention center is a public institution) he is not eligible for *full-benefit* Medicaid/*FAMIS* during the period of incarceration, *but can be eligible for Medicaid coverage for inpatient hospitalization*. After he is released from the detention center and while he is on probation, he is NOT an inmate of a public institution and may be eligible for *full benefit* Medicaid/*FAMIS*.

M0280.301 WHO IS NOT AN INMATE OF A PUBLIC INSTITUTION

A. Who Is NOT An Inmate of a Public Institution

An individual is NOT an inmate of a public institution if:

- he is in a public educational or vocational training institution for purposes of securing education or vocational training OR
- he is in a public institution for a temporary period pending other arrangements appropriate to his needs.

B. Educational or Vocational Institution

An individual residing in a public educational or vocational training institution for purposes of securing education or vocational training is NOT an inmate of a public institution, and therefore may be eligible for Medicaid.

C. Temporary Stay

An individual residing in a public institution for a temporary period pending other arrangements appropriate to his needs is NOT an inmate of a public institution, and therefore may be eligible for Medicaid.

D. Admitted Under TDO

An individual over age 18 who was arrested or detained, but did not reside overnight in a prison or jail before being admitted to a public institution under a temporary detention order (TDO) is NOT an inmate of a public institution because he did not reside in the jail or prison immediately before admission to the treatment facility.

E. Arrested Then Admitted to Medical Facility

An individual who, after arrest but before booking, is escorted by police to a hospital for medical treatment and held under guard is NOT an inmate of a public institution and may be eligible for Medicaid. He is not an inmate of a public institution because he did not reside in a jail, prison or secure detention facility immediately prior to admission to the medical facility.

F. Inmate Out On Bail

An inmate in a prison or jail prior to arraignment, conviction, or sentencing is not eligible for Medicaid unless he/she is out on bail or released on his/her own recognizance.



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G. Probation, Parole, Conditional Release, *Furlough*

An individual released from prison or jail on probation, parole, or release order, with a condition of:

- home arrest
- community services
- outpatient treatment
- inpatient treatment (not inpatient hospitalization)

is not an inmate of a public institution and may be eligible for Medicaid.

An individual released from prison or jail under a court order due to a medical emergency, medical treatment, or pregnancy is NOT an inmate of a public institution and may be eligible for Medicaid.

An individual released from a correctional facility on furlough, for example during a pregnancy, is not an inmate of a public institution while furloughed and may be eligible for Medicaid.

For an offender sentenced to the DOC Community Corrections Alternative Program (CCAP) refer to M0280.140.A

H. Juvenile in Detention Center Due to Care, Protection, Best Interest

A minor in a juvenile detention center prior to disposition (judgment) due to care, protection or the best interest of the child (e.g., Child Protective Services [CPS]), if there is a specific plan for that child that makes the detention center stay temporary, is NOT an inmate of a public institution and may be eligible for Medicaid.

This could include a juvenile awaiting placement but who is still physically present in the juvenile detention center.

I. Juvenile on Probation in Secure Treatment Center

A minor placed on probation by a juvenile court and placed in a secure treatment facility is NOT an inmate of a public institution and may be eligible for Medicaid.

J. Juvenile On Conditional Probation

A minor placed on probation by a juvenile court with, as a condition of probation, treatment in a psychiatric hospital or a residential treatment center, or treatment as an outpatient may be eligible for Medicaid.

However, if the minor is NOT on probation but is ordered to the treatment facility, he remains an inmate of a public institution and not eligible for full benefit Medicaid. He may be eligible for Medicaid coverage limited to inpatient hospitalization.

K. Juvenile On Probation in Secure Treatment Center

A minor placed on probation by a juvenile court and placed in a secure treatment facility may be eligible for Medicaid.

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M0280.500 INDIVIDUALS MOVING TO OR FROM PUBLIC INSTITUTIONS

A. Moves To Public Institution

If a currently eligible individual enters a public institution, a partial review must be completed to determine if he continues to meet institutional status requirements for continued coverage, as well as all other Medicaid eligibility requirements.

Outstanding bills for covered medical services incurred prior to his admission and during his Medicaid coverage period will be paid.

B. Moving From Public Institution

Although a person may not be eligible for Medicaid while living in a specified public institution or part thereof, he may apply for such assistance as a part of prerelease planning. If he is found eligible (except for institutional status), do not enroll until he leaves the institution to live elsewhere.

C. Resident Admitted to Medical Facility

A resident of an ineligible public institution may be eligible for Medicaid coverage limited to inpatient hospitalization when admitted to a medical institution (general hospital) for inpatient care.

M0280.600 DEPARTMENTAL RESPONSIBILITY

A. Incarcerated Individuals

The Cover Virginia Incarcerated Unit (CVIU) is responsible for case management of incarcerated individuals with active Medicaid coverage enrolled in aid categories 108 and 109, regardless of the facility where the offender resides. See M0140 for additional information.

B. All Other Institutions

Local social services departments are responsible for the Medicaid eligibility determination and enrollment of individuals in institutions **EXCEPT** for incarcerated individuals in aid category 108 or 109. The local DSS agency in the Virginia locality where the individual last resided outside of an institution is the responsible DSS agency. If the individual resided outside of Virginia immediately before admission to the institution, the responsible local DSS is the DSS agency serving the locality where the institution is located.

When a local department carries responsibility for eligibility determination and enrollment of an individual living in an institution, the department is also responsible for:

- advising the institution of the individual's eligibility for Medicaid and enrollment in the program;
- submitting a DMAS-225 form to the institution to indicate the patient's eligibility and availability of current patient pay information in the Medicaid Management Information System (MMIS), if applicable; and
- seeing that the Medicaid card is forwarded to the institution for the enrollee's use.

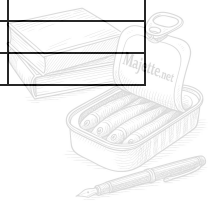


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Institutional Status Quick Reference Guide

Placement or living arrangement	Full Benefit	Inpatient Only	Ineligible
IMDs			
age 22-65, *Medicaid open at time of admission*	***Medicaid Remains Open***		
age 22-65, *Medicaid not open at time of admission*			**X**
under age 22 and receiving inpatient psychiatric treatment	**X**		
age 65 and older	**X**		
conditional release	**X**		
ICF-ID – all ages	**X**		
Residential			
medical section	**X**		
private group home with no more than 3 beds	**X**		
private residential	**X**		
public residential			
less than 16 beds	**X**		
16 or more beds			**X**
educational or vocational Institution	**X**		
Correctional Facilities			
adults			
DOC		**X**	
regional jails		**X**	
local jails		**X**	
juveniles (DJJ) in secure facilities			
held for care, protection, best, interest	**X**		
on probation	**X**		
held for criminal activity		**X**	
juvenile on probation placed in psychiatric hospital or residential treatment center	**X**		
juvenile not on probation ordered to treatment in a psychiatric hospital/residential treatment facility		**X**	
Adult arrested, but not held in corrections			
in medical facility prior to correctional facility placement	**X**		
in regional or local jail prior to medical facility		**X**	
TDO			
not in jail prior to hospitalization	**X**		
in jail prior to hospitalization		**X**	
Individual out on bail/released on own recognizance	**X**		
Adult on probation, parole, conditional release, *or furlough*	**X**		



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Institutions for the Treatment of Mental Diseases in Virginia

Facility	Location
State Facilities	
Catawba Hospital*	
Central State Hospital	Petersburg
Commonwealth Center (for children and adolescents)	Staunton
Eastern State Hospital*	Williamsburg
Northern Virginia State Mental Health Hospital	Falls Church
Piedmont Geriatric Hospital*	
Southern Virginia Mental Health Institute	Danville
Southwestern Virginia Mental Health Institute	Marion
Western State Hospital	Staunton
*Not covered by Medicaid	
Private Freestanding Psychiatric Hospitals	
Dominion Hospital	Falls Church
Kempsville Center for Behavioral Health	Norfolk
Keystone Newport News LLC	Newport News
North Spring Behavioral Health Inc.	Leesburg
Poplar Springs Hospital	Petersburg
Virginia Beach Psychiatric Center	Virginia Beach

Contact VaMedicaidQuestions@dmas.virginia.gov for guidance regarding other types of facilities, such as crisis stabilization units, psychiatric residential facilities, or Addiction and Recovery Treatment Services (ARTS) facilities.

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CHAPTER M03

COVERED GROUPS REQUIREMENTS

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TN #DMAS-33	10/1/24	Page 28
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TN #DMAS-24	7/1/22	Page 36 Page 37 is a runover page.
TN #DMAS-23	4/1/22	Pages 2, 5, 6, 6a
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TN #DMAS-20	7/1/21	Page 6 Pages 5 and 5a are runover pages.
TN #DMAS-18	1/1/21	Table of Contents, page ii Pages 26, 27 Appendix 1 was removed. Appendix 2 was renumbered to Appendix 1.
TN #DMAS-17	7/1/20	Page 7 Pages 8 and 9 are runover pages.
TN #DMAS-15	1/1/20	Pages 29, 30
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TN #DMAS-12	4/1/19	Pages 8, 9, 13
TN #DMAS-10	10/1/18	Table of Contents, page ii Pages 1-4 Page 40 was added.
TN #DMAS-9	7/1/18	Page 35 Appendix 2, Page 1
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TN #DMAS-1	6/1/16	Table of Contents, page ii Pages 13, 26, 28 Appendix 2, page 1
TN #100	5/1/15	Table of Contents, pages i, ii Pages 11, 23, 28b, Pages 27a-27c were renumbered to 28-28a for clarity. Page 10 is a runover page. Appendix 2
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M0310.000 GENERAL RULES & PROCEDURES

M0310.001 GENERAL PRINCIPLES OF MEDICAID COVERED GROUPS

A. Introduction

An individual who meets all the non-financial eligibility requirements in Chapter M02 and who is not an ineligible person listed in M0210.100, must meet a Medicaid covered group in order to be eligible for Medicaid. Chapter M03 explains in detail each of the Medicaid covered groups and how to determine if an individual meets the covered group requirements.

The Medicaid covered groups are divided into two classifications: the categorically needy (CN) and the medically needy (MN). CN individuals meet all Medicaid non-financial requirements (see M02) and the definition for a covered group. MN individuals meet all Medicaid non-financial requirements and resource requirements, but have income in excess of the Medicaid limits. MN individuals may be placed on a spenddown (SD). The covered groups are also divided into Aged, Blind and Disabled (ABD) and Families & Children (F&C) covered groups. Within some covered groups are several definitions of eligible individuals. Some individuals may meet the requirements of more than one group. The agency must verify the individual meets a definition for a covered group and the group's financial requirements.

B. Refugees

If the Medicaid applicant is a refugee, first determine if the refugee meets the requirements in a Medicaid covered group using the policy and procedures in this chapter. If the refugee does not meet the requirements of a Medicaid covered group, the refugee is not eligible for Medicaid under a Medicaid covered group. Go to the Refugee Resettlement Program Manual Volume XVIII to determine the refugee's eligibility for assistance under the Refugee Resettlement Program.

The requirements for the Refugee Other (Cash Assistance) and Refugee Medicaid Other and Refugee Medicaid Unaccompanied Minors programs are found in another manual: the Refugee Resettlement Program Manual Volume XVIII.

C. Covered Group Information

This subchapter contains the general principles for determining if the individual meets a definition and covered group(s).

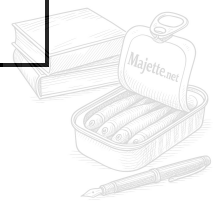
- M0310.002 contains the list of Covered Groups;
- M0310.100 - M0310.134 contains the Definitions;
- M0320 contains the detailed policy and covered group requirements for the Aged, Blind and Disabled Groups;
- M0330 contains the detailed policy and covered group requirements for the Families & Children Groups, *and includes the Modified Adjusted Gross Income (MAGI) Adults covered group, effective January 1, 2019.*

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M0310.002 LIST OF MEDICAID COVERED GROUPS

Group and Description Mandatory = required under federal regulations Optional = State Plan Option		**Categorically Needy (CN)**	**Medically Needy(MN)**
Aged, Blind, or Disabled (ABD)	SSI – mandatory	**X**	
	AG – mandatory	**X**	
	Protected – mandatory	**X**	
	≤ 80% FPL – optional	**X**	
	≤ 300% of SSI – optional (institutionalized only)	**X**	
	Medicaid Works – optional	**X**	
	Medicare Savings Programs (QMB, SLMB, QI, QDWI) --all mandatory	**X**	
	Aged Blind Disabled --all optional		**X**
Families & Children (F&C) `	IV-E Foster Care or Adoption Assistance - mandatory	**X**	
	LIFC Parent/Caretaker Relatives - mandatory	**X**	
	Pregnant woman/newborn child – mandatory	**X** mandatory	**X** optional
	Child under age 19 – mandatory	**X**	
	BCCPTA – optional	**X**	
	Plan First – optional	**X**	
	Child under 18 – optional		**X**
	Individuals under age 21, Adoption Assistance Children with Special Needs for Medical or Rehabilitative Care Adoption Assistance	**X** optional	**X** optional
	Former Foster Care Children under age 26 – mandatory (effective January 1, 2014)	**X**	
	MAGI Adults – optional (effective January 1, 2019)	**X**	



A. Categorically Needy (CN)

The ABD, and F&C (including the *MAGI Adults)* covered groups in the CN classification are listed below.

1. ABD Groups

a. SSI cash assistance recipients who meet more restrictive Medicaid resource eligibility requirements.

b. Auxiliary Grants (AG) cash assistance recipients.

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

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

e. ABD individuals who have a "protected" status:

1) individuals who received OAA, AB, APTD, or ADC as of August 1972, and meet specified requirements.

2) individuals who are former SSI/AG recipients and meet specified requirements.

3) individuals who are widows(ers) and meet specified requirements.

4) individuals who are classified as 1619(b) by Social Security and meet specified requirements.

5)individuals who are adult disabled children and meet specified requirements

f. Hospice--a hospice patient is a person who is terminally ill and has elected to receive hospice care; if the individual is not aged, presume that the individual is disabled.

g. Qualified Medicare Beneficiaries (QMBs).

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

i. Qualified Disabled and Working Individuals (QDWIs).

j. Qualified Individuals (QIs).

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

l. MEDICAID WORKS.

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2. F&C Groups, *Including the MAGI Adult Group*

a. foster care children receiving IV-E and adoption assistance children receiving IV-E.

b. Low income families with children (LIFC) eligible children, parents, non-parent caretaker-relatives, and EWBs (*essential to the well-being* applications submitted prior to October 1, 2013).

c. Children under age 1 born to mothers who were eligible for and receiving MA at the time of the child's birth.

d. Individuals under age 21
   1. Title IV-E Eligible Foster Care children who do not receive a Title IV-E maintenance payment
   2. Non-IV-E Foster Care
   3. Juvenile Justice Department children
   4. Non-IV-E Adoption Assistance children
   4. Individuals in an ICF or ICF-MR

e. Former foster care children under age 26 years (Effective January 1, 2014)

f. Pregnant women

g. Plan First; Family Planning Services

h. Children under age 19 years

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

j. *MAGI Adults, 19 – 64 years of age (Effective January 1, 2019)*

B. Medically Needy (MN)

The ABD and the F&C covered groups in the MN classification are listed below.

1. ABD Groups

a. Aged - age 65 years or older.

b. Blind - meets the blind definition

c. Disabled - meets the disability definition.

d. Individuals who received Medicaid in December 1973 as AB/APTD-related MN and who continue to meet the December 1973 eligibility requirements.

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2. F&C Groups

a. Children under age 18

b. Children under age 1

c. Pregnant Women

d. Children with Special Needs for Medical or Rehabilitative Care

e. Individuals under age 21

E. Refugees

"Refugees" are a special group of individuals who have an alien status of "refugee" and are eligible for Medicaid under a different federal funding source. Virginia receives full federal funding with no state matching funds for the medical assistance provided to these individuals during the first *4* months they are in the U.S who entered as of 10/1/2021.

There are two aid categories (ACs) for this group. AC 078 is used for Refugee Other and Refugee Medicaid Other and AC 079 is used for Refugee Medicaid Unaccompanied Minors. The policy and procedures used to determine whether an individual is eligible in this group are found in the Refugee Resettlement Program Manual, Volume XVIII.

M0310.100 DEFINITION OF TERMS

A. Introduction

The terms used in the covered groups policy and procedures and the procedures for determining if an individual meets a definition are stated in sections M0310.101 through 131 below.

M0310.101 ABD

A. ABD Definition

"ABD" is the short name used to refer to aged, blind or disabled individuals.

B. Procedures

See the following sections for the procedures to use to determine if an individual meets an ABD definition:

- M0310.105 Age and Aged
- M0310.106 Blind
- M0310.112 Disabled

M0310.102 ADOPTION ASSISTANCE

A. Definition

Adoption Assistance is a Title XX of the Social Security Act social services program that provides cash assistance and/or social services to adoptive parents who adopt "hard to place" foster care children who were in the custody of a local department of social services or a child placing agency licensed by the state of Virginia.

***1.* Residing in Virginia**

Adoption assistance children are children who reside in Virginia who are adopted under a Title IV-E or Non-IV-E (state-local) adoption assistance agreement with a department of social services or in conjunction with a child-placing agency.



2. Special Medical Needs

Children with special needs for medical or rehabilitative care adopted under a Non IV-E Adoption Assistance agreement with a Virginia local department of social services or a Virginia private, non-profit child placement agency in conjunction with a local department of social services, in accordance with policies established by the State Board of Social Services *are considered to be residing in Virginia*.

a. Documentation must indicate that the child has special needs for medical or rehabilitative care

One of the following documents must indicate the child's special needs for medical or rehabilitative care:

- an adoption assistance agreement specifying that the child has a special need for medical or rehabilitative care; the agreement does NOT need to specify a particular diagnosis or condition.

- an amendment to the adoption assistance agreement specifying that the child has a special need for medical or rehabilitative care.

- a signed letter on official letterhead from the state that facilitated the adoption assistance agreement confirming that the child has a special need for medical or rehabilitative care.

b. Virginia Medicaid coverage for children with special needs for medical or rehabilitative care

Medicaid coverage is to be provided to any child who has been determined to be a Non-IV-E Adoption Assistance Child with special needs for medical or rehabilitative care for whom there is in effect an adoption assistance agreement between a local Virginia department of social services (LDSS) or a Virginia child-placing agency and an adoptive parent(s).

Virginia Medicaid coverage MAY be provided to a child with special needs for medical or rehabilitative care for whom there is in effect an adoption assistance agreement between another state's child-placing agency and an adoptive parent(s) IF the other state reciprocates with Virginia per the Interstate Compact on Adoption and Medical Assistance (ICAMA).

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3. **Verification**

a. **Adoption assistance agreement with Virginia agency**

A child's status as an adoption assistance child is verified by the LDSS agency foster care/adoption assistance worker. Documentation of the child's IV-E or Non-IV-E adoption assistance eligibility must be part of the Medicaid case record.

Verification of a child's status as a Virginia IV-E, Non-IV-E, or adoption assistance child with special needs *for medical or rehabilitative care* is obtained through the local agency's Service Programs Division.

b. **IV-E adoption assistance agreement with another state**

When the IV-E adoption assistance agreement is with another state and the IV-E child resides in Virginia, verification of the child's status as a Title IV-E adoption assistance recipient is verified through the Deputy Compact Administrator, Adoption Unit, Division of Family Services, Virginia Department of Social Services.

c. **Non-IV-E adoption assistance agreement with another state**

Verification of the child's Non-IV-E adoption assistance status with another state, and the state's reciprocal agreement under the Interstate Compact on Adoption and Medical Assistance (ICAMA), is obtained through the Deputy Compact Administrator, Adoption Unit, Division of Family Services, Virginia Department of Social Services.

If the state that signed the non-IV-E adoption assistance agreement does NOT reciprocate Non-IV-E adoption assistance eligibility with Virginia, then the Non-IV-E Adoption Assistance child is not eligible for Virginia Medicaid in the Adoption Assistance classification of the "Individuals Under Age 21" covered group.

M0310.103 AFDC

A. Aid To Families With Dependent Children (AFDC)

AFDC is the short name of the Aid to Families With Dependent Children cash assistance program that was operated in Virginia prior to the February 1, 1997, implementation of TANF (Temporary Assistance to Needy Families). It was a federally funded assistance program under Title IV-A of the Social Security Act. In Virginia, AFDC was replaced by TANF on February 1, 1997.

B. Procedure

AFDC is defined here because of the occasional references in Medicaid policy to the AFDC program that was in effect on July 16, 1996. There are no current recipients of AFDC because the AFDC program no longer exists.

M0310.104 AG

A. Auxiliary Grants (AG)

"AG" is the short name for the Auxiliary Grants Program. AG is Virginia's assistance program that supplements the federal Supplemental Security Income (SSI) assistance program. AG is Virginia's "State Supplementation of SSI." AG is available only to ABD financially eligible individuals who reside in licensed Adult Care Residences (ACRs).

B. Procedure

Check the local agency records of AG recipients. If the individual is eligible for and receiving an AG payment, he is an AG recipient for Medicaid purposes.



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M0310.105 AGE and AGED

A. Age

"Age" is the individual's age reached on the anniversary of birth. If the year but not the month and day of the individual's birth is known, July 1 is assigned for both eligibility determination and enrollment.

For covered groups with a maximum age requirement, an individual meets the age requirement for the month of his birthday unless his birthday falls on the first day of the month.

Examples:

Gracie has been enrolled in the Child Under 19 covered group. She turns 19 on August 15. She continues to be eligible in the Child Under 19 covered group through the month of August.

Oliver has been enrolled in the MAGI Adults covered group. He turns 65 on July 1. Therefore, he is no longer eligible for the MAGI Adults covered group for the month of July.

B. Aged

"Aged," means age 65 years or older.

C. Procedures

For individuals under age 21, accept the date of birth provided on the application/redetermination form. No verification is required.

For aged individuals, verify the individual's age by Social Security records or documents in the individual's possession. Acceptable documents include:

- birth certificate or notification of birth;
- hospital or physician's record;
- court record of adoption;
- baptismal record;
- midwife's record of birth;
- form VS95 from state Bureau of Vital Statistics; or
- marriage records.

M0310.106 BLIND

A. Definition

The Medicaid blindness definition is the same as that of the Supplemental Security Income (SSI) blindness definition.

Blindness is defined by using one of two criteria. The first criteria indicates that blindness is defined as having best corrected central visual acuity of 20/200 or less in the better eye. The second criteria indicates that blindness is defined as the contraction of the visual field in the better eye with the widest diameter subtending an angle around the point of fixation no greater than 20 degrees.

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B. Procedures

An SSI recipient who receives SSI as blind meets the blindness definition for Medicaid. Verify the SSI recipient's SSI eligibility via SVES (State Verification Exchange System).

Virginia no longer maintains a central registry of individuals who have been certified as blind or visually impaired. For an individual who alleges blindness or a visual impairment but does not receive SSI or Social Security Disability Income benefits, refer to section M0310.112 B to establish whether or not the individual requires a referral to the Disability Determination Services (DDS). If the individual requires a determination of blindness, refer the individual to the DDS using the procedure in M0310.112 E. 1.

M0310.107 CARETAKER-RELATIVE

A. Definitions

1. Caretaker-relative

A "caretaker-relative" is an individual who is not a parent, but who

- is a relative, of a specified degree, of a dependent child (as defined in M0310.111) and
- is living with and assuming continuous responsibility for day to day care of the dependent child (as defined in M0310.111) in a place of residence maintained as his or their own home.

A caretaker-relative is also referred to as a "non-parent caretaker" to distinguish the caretaker-relative from the parent.

2. Specified Degree

A relative of specified degree of the dependent child is

- any blood relative, including those of half-blood and including first cousins, nephews or nieces and persons of preceding generations as denoted by prefixes of grand, great, or great-great;
- a stepfather, stepmother, stepbrother, and stepsister;
- a relative by adoption following entry of the interlocutory or final order, whichever is first; the same relatives by adoption as listed above: including first cousins, nephews or nieces and persons of preceding generations as denoted by prefixes of grand, great, or great-great, and stepfather, stepmother, stepbrother, and stepsister.
- spouses of any persons named in the above groups even after the marriage is terminated by death or divorce.

Neither severance of parental rights nor adoption terminates the relationship to biological relatives.

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B. Procedures

1. Relationship The relationship as declared on the application/redetermination form is used to determine the caretaker-relative's relationship to the child. No verification is required.

2. *Child* Living in the Home A child's presence in the home as declared on the application/ redetermination form is used to determine if the child is living in the home with a parent or a caretaker-relative. No verification is required.

3. Parent and Stepparent in Home The presence of a parent in the home does not impact a stepparent's eligibility in the Low Income Families with Children (LIFC) covered group. Both the parent and stepparent may be eligible in the LIFC covered group. See M0330.300.

4. Parent and Other Relative in Home When a parent is in the home, no relative other than a stepparent can be eligible for Medicaid in the LIFC covered group. See M0330.300.

***2.* Caretaker-Relative Living in the Home** A caretaker-relative who is absent from the home is considered living with a child in the household if the absence is temporary and the caretaker-relative intends to return home when the purpose of the absence (such as military service, vacation, education, medical care or rehabilitation) is complete.

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M0310.108 CATEGORICALLY NEEDY (CN)

A. CN Definition

"CN" is the short name for "categorically needy." CN is a federal classification of a Medicaid covered group. The CN covered groups include both the mandatory categorically needy groups listed in the federal Medicaid regulations as well as the optional groups Virginia has chosen to cover in the Medicaid State Plan.

B. Procedures

See subchapter M0320 for the policy and procedures to use to determine if an individual meets an ABD CN covered group.

See subchapter M0330 for the policy and procedures to use to determine if an individual meets a F&C CN covered group.

M0310.109 COVERED GROUP

A. Definition

The federal Medicaid law and the State Plan for Medicaid describe the groups of individuals who may be eligible for Medicaid benefits. These groups of individuals are the Medicaid covered groups. The individuals in the covered groups must meet specified definitions, such as age or disability, and other specified requirements such as living in a medical facility.

The covered groups are classified in Virginia as CN and MN. The covered groups are divided into the ABD and F&C covered groups for financial eligibility purposes.

B. Procedure

The covered groups are listed in section M0310.002.

The detailed requirements of the covered groups are in subchapters M0320 and M0330.

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M0310.110 CHILD

A. Definition

The definition of "child" that is applicable depends on the individual's covered group.

1. Covered Groups to Which Modified Adjusted Gross Income (MAGI) Is Applicable

a. Tax-filer Household

A child is an individual of any age who is claimed as a tax dependent by a biological or adopted parent or step-parent.

b. Non-filer Household

A child is an individual under age 19.

2. F&C Non-MAGI, ABD and MN covered groups

A child is an individual under age 21 years who has not been legally emancipated from his/her parent(s).

A married individual under age 21 is a child unless he/she has been legally emancipated from his/her parents by a court. Marriage of a child does not emancipate a child from his/her parents and does not relieve the parents of their legal responsibility to support the child.

M0310.111 DEPENDENT CHILD

A. Definition

The definition of "dependent child" is the definition in section 406(a) of the Social Security Act: the term "dependent child" means a child who is:

- under the **age of 18**, OR
- under the **age of 19** and is a **full-time student** in a secondary school or in the equivalent level of vocational or technical training, or in a General Educational Development (GED) program IF he may be reasonably expected to complete the secondary school, training or program before *or in the month* he attains age 19; **AND**

  NOTE: The above definition of a full-time student does NOT apply when determining student status for the student earned income exclusion. See sections M0720.500 B.2 and M0720.510 for the student income exclusion requirements.

- **living in the home of a parent or a caretaker-relative** of the first, second, third, fourth or fifth degree of relationship in a place of residence maintained by one or more of such relatives as his or their own home. See section M0310.107 for the definition of a caretaker-relative.

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B. Age & School Enrollment

1. Age

The child's date of birth declared on the application/redetermination form is used to determine if the child meets the age requirement. No verification is required.

A child who becomes 18 after the first day of his birth month meets the age requirement in the month of his 18th birthday; he is still considered under age 18 during his birth month. If he becomes age 18 on the first day of his birth month, he is age 18 for the whole birth month.

An 18 year old child does **not** meet the age requirement in the month following the month in which his 18th birthday occurs unless the child is enrolled full-time in a secondary school or vocational/technical school of secondary equivalency, AND the child is reasonably expected to complete the program of secondary school or vocational/technical training before or in the month he attains age 19.

2. School Enrollment

Accept the declaration of school enrollment.

C. Living With a Parent or Caretaker-Relative

1. Relationship

The child's relationship to the parent or caretaker-relative with whom he lives as declared on the application or redetermination document is used to determine if the child is living with a relative. No verification is required.

For the purpose of determining a relationship, neither death, divorce, *nor* adoption terminates relationship to the biological relatives.

***3.* Child's Father**

Virginia law considers a man who is legally married to the mother of a child on the date of the child's birth to be the legal father of the child **UNLESS** DCSE or a court has determined that another man is the child's father. NOTE: The mother's marriage at the time of the child's birth does not require verification; the mother's declaration is sufficient.

The man listed on the application form as the child's father is considered the father when:

- the mother was not married to another man on the child's birth date, or
- the mother was married to another man on the child's birth date but DCSE or a court determined that the man listed on the application is the child's father

unless documentation, such as the child's birth certificate, shows that another man is the child's father.

See M0310.123 for the definition of a parent.

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4. ***Child* Living in the Home**

A child's presence in the home as declared on the application/ redetermination is used to determine if the child is living in the home with a parent or caretaker-relative. No verification is required unless the information contained in the application does not clearly establish whether or not the child is living with the parent or care-taker relative.

A dependent child is considered living with only one parent for Medicaid eligibility purposes When separated/divorced parents who claim to have equal physical custody of the child both apply for Medicaid and neither spouse has other children under age 18 in the home, obtain a copy of the custody agreement and verify the custody arrangements. If the custody is divided exactly equally between both parents, the parents must decide which parent the dependent child lives with for Medicaid purposes.

A child who is living away from the home is considered living with his parents in the household if:

- the child is not emancipated, and
- the absence is temporary and the child intends to return to the parent's home when the purpose of the absence (such as vacation, visit, education, rehabilitation, placement in a facility for less than 30 days) is complete.

  NOTE: If the stay in the medical facility has been or is expected to be 30 days or more, go to M1410.010 to determine if the child is institutionalized in long-term care.

Children living in foster homes or medical institutions are NOT temporarily absent from the home. They are indefinitely absent from home and are NOT living with their parents or siblings for Medicaid purpose.

Children placed in Level C psychiatric residential treatment facilities (PRTF) are considered absent from their home if their stay in the facility has been 30 days or more. A child who is placed in a Level C PRTF is considered NOT living with his parents for Medicaid eligibility purposes as of the first day of the month in which the 30th day of residential placement occurs. Modified Adjusted Gross Income (MAGI) methodology contained in Chapter M04 is applicable to children in PRTFs; long-term care rules do not apply to these children.

5. ***Parent Living in the Home***

A parent who is absent from the home is considered living with his child in the household if the absence is temporary and the parent intends to return home when the purpose of the absence (such as military service, vacation, education, medical care or rehabilitation) is complete.

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M0310.112 DISABLED

A. Introduction

For individuals who meet no other full-benefit covered group and claim to have a disabling condition, Medicaid eligibility uses the same definition of "being disabled" that the Social Security Administration (SSA) uses.

1. Definition of a Disabled Individual

For an individual 18 or older, the SSA defines "being disabled" as an individual's inability to do any substantial gainful activity (SGA) or work because of a severe, medically determinable physical or mental impairment or combination of impairments. This impairment(s) has lasted or is expected to last for a continuous period of not less than 12 months, or the impairment is expected to result in death.

For a child under 18, the SSA defines "being disabled" as having a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations. These limitations must have lasted or be expected to last for a period of not less than 12 continuous months, or the impairment is expected to result in death. However, a child cannot be found disabled if, at application, the child is performing SGA and is not currently entitled to Supplemental Security Income (SSI) benefits.

2. Disability Determination Services

Disability Determination Services (DDS) is a division of the Virginia Department *for Aging and* Rehabilitative Services *(DARS)* DDS is charged with making disability determinations for individuals who allege they are disabled for the purpose of qualifying for Social Security Disability Insurance (SSDI) and/or Supplemental Security Income (SSI) disability or blindness benefits, and/or Medicaid. An individual must file separate applications for SSDI/SSI benefits with SSA and for Medicaid with LDSS.

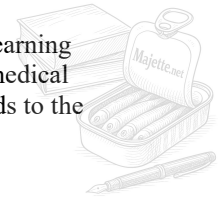
The Department of Medical Assistance Services (DMAS) contracts with *DARS* to have DDS process disability and blindness claims and make determinations of "disabled" or "not disabled" based upon federal regulations. DDS uses the same definitions of disability and blindness and the same evaluation criteria for all three programs. See M0310.106 for the definition of blindness.

3. Factors Involved in a Disability Decision

The LDSS does not determine whether or not an individual meets the disability requirements. DDS determines whether or not an individual is disabled as defined by the SSA by evaluating a series of factors in sequential order. The following information is intended to provide a general overview for the LDSS worker of this sequential process and does not provide a complete explanation of the disability determination process:

a. Engaged in Substantial Gainful Activity (SGA)?

Is the individual currently engaged in substantial gainful activity (SGA)? SGA means work that: (1) involves doing significant and productive physical or mental duties and (2) is done (or intended) for pay or profit and (3) earnings are above a certain amount. If an individual is working and earning SGA, a finding must be made that the person is not disabled, and no medical evaluation is done. If the individual is not earning SGA, DDS proceeds to the next step.



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b. ***Severe Impairment?***

Does the individual have a severe impairment, as defined by SSA, that meets the durational requirement (i.e. has lasted or is expected to last for a continuous period of not less than 12 months, or which is expected to result in death)? If no, the person is not disabled. If yes, DDS will proceed to the next step.

c. ***Impairment Equals Severity Requirements?***

Does the individual have an impairment that meets or equals the severity requirements of a medical condition contained in the Social Security Listing of Impairments? If yes, a finding of disability is made. If no, DDS will proceed to the next step.

d. ***Prevents Performing Past Relevant Work?***

Does the individual have an impairment that prevents him from performing past relevant work? If the individual can perform past relevant work, the person will be found not disabled. If the individual cannot perform past relevant work, DDS will proceed to the next step.

e. ***Prevents Performing Any Work?***

Does the individual have an impairment that prevents him from performing any substantial gainful employment? If the individual cannot perform any work, the person will be found disabled. If the person has the capacity to adjust to other types of work, the person will be found not disabled. Age, education, training and skills acquired in past work are considered in making this determination.

4. Other Benefits Related to Disability

a. Benefits Administered by the SSA

The SSA uses the SSA disability definition in the determination of eligibility for SDDI and SSI benefits.

b. Benefits Administered by the Railroad Retirement Board (RRB)

The RRB makes disability determinations for railroad employees who have applied for the Railroad Retirement (RR) disability benefits. A determination of "total" disability means the individual is disabled for all regular work. "Occupational" disability means the individual is disabled for regular railroad occupation, but is not "totally" disabled. Individuals who receive a ***"total"*** *disability determination are disabled using the SSA criteria.*

B. Policy

The following individuals meet the definition of being disabled for the purposes of meeting a Medicaid covered group and are ***not to*** *be referred to DDS:*

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- individuals who received SSDI or SSI disability benefits or RR total disability benefits in one or more of the 12 months preceding the Medicaid application and whose benefits were terminated for a reason **other than no longer meeting the disability or blindness requirements**.
- individuals who have been determined disabled or blind by DDS for Medicaid or for SSA, without a subsequent decision by SSA reversing the disability determination, and
- individuals who have been determined "totally" disabled by the RRB.

C. Procedures for Verifying Disability Status

1. Receives SSDI/SSI Disability Benefits

Verify SSDI/SSI disability status through a SVES (State Verification Exchange System) or SOLQ (State Online Verification Query) request or through documentation provided to the applicant by the SSA.

2. Receives RRB Disability Benefits

Verify RRB disability by contacting the RRB National Telephone Service at 1-877-772-5772 or through documentation provided to the applicant by the RRB.

3. Determined Disabled by DDS

If disability status cannot be ascertained **after** reviewing SVES or SOLQ, contact your regional DDS office to verify disability status. Contact information for the regional DDS offices is contained in Appendix 2 of this subchapter.

4. Incarcerated Disabled Individual

Although benefits administered by the Social Security Administration are suspended while an individual is incarcerated, a disabled individual continues to meet the definition of a disabled individual while incarcerated.

D. When a DDS Disability Determination is Required

- The DDS makes a disability determination for Medicaid when the individual alleges a disabling condition and has never applied for disability benefits from SSA or has not been denied disability within the past 12 months; **or**
- the individual alleges a disabling condition and SSA has not yet made a determination on a pending SSDI/SSI claim; **or**
- the individual alleges a disabling condition which is different from that considered by SSA or is in addition to that considered by SSA.

An individual must have his disability determined by DDS if he:

- is claiming to have a disabling condition but does not receive SS/SSI disability benefits or RR total disability benefits, **and**
- has not been denied SSDI or SSI disability benefits in the past 12 months.

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1. Individual Under Age 19 and Not Receiving Long-term Care

A child under age 19 who is not receiving LTC services and who is claiming to have a disabling condition must have his disability determined by DDS if:

- he is not eligible for FAMIS Plus or FAMIS, or
- it is 90 calendar days prior to his 19th birthday.

Do **NOT** refer a disabled child under age 19 to DDS for the sole purpose of participation in the Health Insurance Premium Payment (HIPP) program

2. Individual Under 21 in LTC

a. Facility-based Care

An individual under age 21 in a nursing facility or intermediate care facility for the intellectually disabled (ICF-ID) must have his disability determined if

- he is not eligible in the Individuals Under 21 covered group, or
- it is 90 calendar days prior to his **21st** birthday.

b. **Home and Community-based Services (HCBS)**

A child who is receiving HCBS waiver services and has not previously had a disability determination must have his disability determined prior to his **18th** birthday because he will no longer be eligible in the F&C 300% SSI covered group (*under which parental income is not counted)*, once he turns 18. The child must be evaluated for coverage as a blind or disabled individual using the income and resource rules applicable to blind/disabled institutionalized individuals. For a child under 19 who is not disabled, MAGI income counting rules require that parental income be included in the eligibility determination.

Ninety days (90) prior to the child turning age 18, the eligibility worker must contact the parent or responsible party and send a verification checklist to request the required documents to start the DDS referral process. Follow the procedure in M0310.112 G below to make a referral to DDS.

Note: *The local DSS is not responsible for initiating a DDS referral for a child turning 18 who receives SSI. The child will have a review of continuing disability and SSI eligibility completed by the SSA.* The child remains disabled for Medicaid purposes unless and until his disability status is discontinued by SSA.

E. When an LDSS Referral to DDS is Required

1. Disability Determination Has Not Been Made

The DDS must make a determination of disability when the applicant alleges a disability and a disability determination has not been made by SSA or the RRB. The DDS must make a disability determination within a time frame that will allow the LDSS to process the application within 90 days, provided all medical information has been submitted.



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2. SSA Denied Disability Within the Past 12 Months

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

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

OR

b) The applicant alleges his condition has **changed** or **deteriorated** causing a new period of disability **AND** he requested SSA reopen or reconsider his claim **AND** SSA has refused to do so or denied it for non-medical reasons. Proof of the decision made by SSA is required.

If the applicant indicates that one of the above exceptions applies, the Medicaid referral should be documented appropriately and sent to the DDS. After reviewing the Medicaid referral and Social Security decision, the DDS may determine that the SSA decision addressed all the conditions reported to Medicaid. In this situation, the DDS will determine that no exception applies and that the SSA decision is still binding. In this situation, the DDS will not make an independent disability determination for Medicaid. Instead, the DDS will document that an exception does not apply and that the SSA determination is still binding until the end of the 12-month period.

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

3. SSA Denied Disability More Than 12 Months Ago

If the applicant alleges a disability and SSA denied the disability more than 12 months ago, follow the procedure in M0310.112 G below to make a referral to DDS. DDS will accept and fully develop the Medicaid referral if more than 12 months have passed since the most recent SSA medical determination, regardless of appeal status with SSA, and for any reason.

F. Decision Pathway for DDS Referrals

When determining whether or not a referral to DDS is required, the worker should ask the following questions:

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Has the individual applied for SSDI or SSI?

If no, refer to DDS.

If yes and a decision **has not** been made, refer to DDS.

If yes and a decision **has** been made, was the disability allowed or denied?

If allowed, refer to M0310.112 B, because another determination of disability may not be necessary.

If denied, look at the date of the last determination.

If the last SSA denial determination was made more than 12 months in the past, refer to DDS *regardless of whether or not the decision is in an appeal with SSA.*

If the last SSA denial determination was made less than 12 months in the past, and there is a new condition that has not been evaluated by SSA, refer to DDS.

If the last SSA denial determination was made less than 12 months in the past, and there has not been a worsening of a condition already evaluated by SSA, do not refer to DDS.

If the last SSA denial determination was made less than 12 months in the past, but there is a worsening of a condition already evaluated by SSA, ask if the individual has filed for a reconsideration or reopening of his case with SSA.

If yes and the case is currently under reconsideration, do not refer to DDS. The SSA decision remains binding unless SSA reverses the decision.

If yes and the SSA refused to reconsider his case <u>because he does not meet the SSI eligibility requirements,</u> refer to DDS.

If no, do **NOT** refer to DDS. The individual must initiate an appeal of his denial with SSA. Unless SSA refuses the appeal request or turns it down for non-disability related reasons, the disability determination remains binding for 12 months.

G. LDSS Procedures When a Disability Determination is Required

There are two types of DDS referrals for the purposes of Medicaid eligibility: non-expedited and expedited. Most referrals are non-expedited. Expedited referrals are limited to individuals who are hospitalized and require a Medicaid disability determination so they can be transitioned directly from the hospital to a rehabilitation facility

For both types of referrals, the eligibility worker must request the necessary verifications needed to determine eligibility so that the application can be processed when the disability determination is received.



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1. LDSS Referrals to DDS for Non-expedited Cases

a. Send the following forms to the applicant for completion immediately, giving the applicant 10 calendar days to return the completed forms:

- a copy of the Frequently Asked Questions—Disability Determinations for Medicaid (form #032-03-0426), available on SPARK at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/References*, explaining the disability determination process and the individual's obligations;
- the Disability Report Adult (SSA-3368-BK), available at http://www.socialsecurity.gov/online/ssa-3368.pdf, or the Disability Report Child (SSA-3820-BK), available at http://www.socialsecurity.gov/online/ssa-3820.pdf,
- an Authorization to Disclose Information to the Social Security Administration form (SSA-827), available at http://www.socialsecurity.gov/online/ssa-827.pdf.

b. In most cases, the DDS referral is transmitted electronically to DDS through VaCMS. Form 3368-BK or 3830-BK and SSA-827 are uploaded to VaCMS for submission to DDS. No DDS Referral Form is used for electronic submissions. Follow the instructions in the Quick Reference Guide "Sending a DDS Referral in the VaCMS," available in VaCMS.

c. If the DDS referral cannot be completed in VaCMS, manually submit the referral. Complete the DDS Referral Form, available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms. Use the DDS Referral Form that corresponds with the DDS Regional Office to which the LDSS has been assigned (#032-03-0095, #032-03-0096, #032-03-0097, or #032-03-0098). To the form, attach the following:

- the completed Disability Report
- the signed Authorization to Disclose Information
- copies of paystubs, if the applicant is currently working.

If the individual's application was filed with the assistance of a hospital-based eligibility assistance organization, a copy of the consent to release information to the organization must be included with the referral so DDS staff can communicate with them, if necessary.

Mail the DDS Referral form and attachments to the *DDS Central Regional (Richmond)* Office. See *Appendix 1* to this subchapter for the *contact information*. **Do not send referrals to DDS via the courier.**

2. Expedited Referrals for Hospitalized Individuals Awaiting Transfer to a Rehabilitation Facility

The 2004 Budget Bill mandated that DDS make a disability determination within seven (7) working days of the receipt of a referral from the LDSS when the Medicaid applicant is hospitalized, needs to be transferred directly to a rehabilitation facility AND the individual does not already have a disability application pending with DDS. To ensure that the DDS is able to make the disability determination within the mandated timeframe, the procedures below shall be followed:

a. Hospital staff shall simultaneously send:

- the Medicaid application and a cover sheet, available on Fusion at to the LDSS or the hospital outstationed eligibility worker
- the medical documentation (disability report, authorizations to release information and medical records) and cover sheet to the DDS.

b. LDSS shall **immediately** upon receipt of the Medicaid application:

- fax a completed DDS Referral Form (#032-03-0095, #032-03-0096, #032-03-0097, or #032-03-0098) *available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, to the DDS Central Regional Office at 804- 527-4518* to verify receipt of the Medicaid application unless it is known to the agency that the individual already has a pending disability claim with DDS. If the individual already has a pending disability claim with DDS, the claim cannot be treated as an expedited referral.
- give priority to processing the applications and immediately request any verifications needed; and
- process the application as soon as the DDS disability determination and all necessary verifications are received; and
- notify the hospital contact identified on the cover sheet of the action on the application and provide the Medicaid enrollee number, if eligible.

c. DDS shall make a disability determination within seven (7) working days and fax the result of the disability decision to the LDSS. DDS is not responsible for notifying either the applicant or the hospital of the outcome of the disability determination.

If DDS is unable to render a decision within 7 working days, DDS will send a communication to the LDSS advising that the disability determination has been delayed.

3. Application Processing When DDS Referral is Pending

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

Individuals who require a disability determination must meet all non-financial requirements other than covered group, within 45 calendar days or the application must be denied. If these requirements are met, the application timeframe may be extended to 90 days while DDS is making the disability determination. If any non-financial requirement other than covered group is not met by the 45th calendar day, his application must be denied and DDS must be notified of the denial.

DDS does NOT stop the disability determination process when the individual meets all non-financial requirements, but has excess resources (see M0130.100 B.4) because he might reduce his resources while the

application is pending for the disability determination. DDS does NOT stop the disability determination when the individual has excess income because of possible spenddown eligibility

4. LDSS Responsibilities for Communication with DDS

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

5. Evaluation for Plan First and Referral to Health Insurance Marketplace

While an individual's application is pending during the non-expedited disability determination process, evaluate his eligibility in non-ABD covered groups (e.g. MAGI Adults, and Plan First if requested). If the individual is not eligible for full Medicaid coverage, refer the individual to the Virginia Health Insurance Marketplace (VIM) for evaluation for the Advance Premium Tax Credit (APTC).

H. Notification of DDS Decision to LDSS

1. Hospitalized Individuals

The DDS will advise the agency of the applicant's disability status as soon as it is determined by either SSA or the DDS. For hospitalized individuals who meet the requirements for an expedited disability determination, DDS will fax the outcome of the disability determination directly to the LDSS responsible for processing the application and enrolling the eligible individual.

2. Individuals Not Hospitalized

For all other disability determinations, DDS will notify the LDSS responsible for processing the application and enrolling the eligible individual *will fax the outcome of the disability determination directly to the LDSS responsible for processing the application and enrolling the eligible individual.* If the claim is denied, DDS will also include a personalized denial notice to be sent to the applicant explaining the outcome of his disability determination.

3. Disability Cannot Be Determined Timely

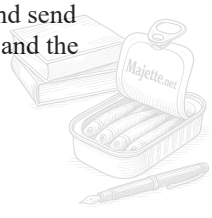
A disability determination cannot be completed within the allotted time when there is missing or incomplete medical information. DDS will notify the applicant about 75 days from the application date of the delay. DDS will notify the LDSS *with a delay letter to the worker and the client. Upon receipt of the delay letter* the LDSS must send the applicant a Notice of Action to extend the pending application.

4. DDS Rescinds Disability Denial

DDS will notify the agency if it rescinds its denial of an applicant's disability to continue an evaluation of the individual's medical evidence. If the Medicaid application has been denied, the agency must reopen the application and notify the applicant of the action. The application continues to pend until notification is received from DDS of the disability determination. If an appeal has been filed with DMAS, the agency must notify the DMAS Appeals Division so that the appeal may be closed (see M1650.100).

I. LDSS Action & Notice to the Applicant

The eligibility worker must complete the Medicaid eligibility determination immediately after receiving notice of the applicant's disability status and send the applicant a Notice of Action regarding the disability determination and the agency's decision on the Medicaid application.



J. Applicant is Deceased

When a Medicaid applicant who has been referred to DDS dies or when the applicant is deceased at the time of the Medicaid application, DDS will determine if the disability requirement for Medicaid eligibility was met. The LDSS must immediately notify DDS of the individual's death and make every effort to provide a copy of the death certificate.

K. Subsequent SSA or RRB Disability Decisions

When SSA or the RRB make a disability decision subsequent to the *DDS* (Medicaid) decision which differs from the *DDS* decision, the SSA or RRB decision must be followed in determining Medicaid eligibility unless one of the conditions in M0310.112 E.2 above applies.

1. SSA/RRB Approval

If SSA approves disability or the RRB approves total disability, the disability definition is met. If DDS initially denied disability and the decision is reversed, re-evaluate the denied Medicaid application. The individual's Medicaid entitlement is based on the Medicaid application date, including the retroactive period, if all eligibility requirements were met during the retroactive period. However, eligibility as a disabled individual cannot begin prior to the disability onset date (month) established by SSA. Do not send the claim back to DDS for an earlier onset date.

Disability Approved More Than 12 Months Past

If, based upon the re-evaluation, the individual is determined to be eligible and more than 12 months have passed since the application was filed, complete an eligibility renewal to determine whether or not the individual remains eligible.

Spenddown

If, based upon the re-evaluation, the individual is determined not eligible for Medicaid but met the requirements in Chapter M13 for placement on a spenddown, a first prospective and additional 6 month spenddown budget periods may be established to cover the period of time between the date of application and the date action is taken on his case. A new application is not required for each 6 month spenddown budget period leading up to the date of processing, however, verification of all income and resources for those time periods must be obtained.

2. SSA Denial or Termination And Appeal

If SSA denies disability, the disability definition is not met. If the individual has been enrolled in Medicaid as disabled and is not eligible in another covered group, send an advance notice to the enrollee to cancel Medicaid.

If the individual appeals the SSA's disability decision timely (within 60 calendar days from the SSA notification or with good cause for exceeding 60 days) and SSA agrees to reconsider the decision, the Medicaid coverage must be reinstated until the final decision on the SSA appeal is made. **The individual must provide verification that he filed the appeal and SSA agreed to reconsider the case**. The individual must also provide verification of the decisions made at all levels of appeal in order for Medicaid to continue during the process. The Medicaid coverage will continue until a final decision is made and the individual has no right to further SSA appeals.



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The levels of administrative review are in the following order:

a. reconsideration,
b. the hearing before an administrative law judge (ALJ), and
c. the Appeals Council

For example: An individual is enrolled in Medicaid as disabled. However, his SSA claim is denied at the ALJ hearing level. If the individual fails to appeal the ALJ decision to the Appeals Council and the Appeals Council does not decide on its own to review the case, the ALJ decision becomes the final decision once the 60-day deadline for requesting further review has passed. Because the individual no longer meets the disabled definition for another covered group, his Medicaid coverage must be canceled.

6. **RRB Denial, Termination and RRB Appeal**

If RRB denies disability, the disability definition is not met. If the individual has been enrolled in Medicaid as disabled and is not eligible in another covered group, send an advance notice to the recipient to cancel Medicaid.

Persons who believe that their claims have not been adjudicated correctly may ask for reconsideration by the Board's Office of Programs. If not satisfied with that review, the applicant may appeal to the Board's Bureau of Hearings and Appeals. Further, if the individual timely appeals the RRB disability decision, Medicaid coverage must be reinstated until the final decision on the RRB appeal is made. The individual must provide verification that he filed a timely appeal with RRB and must provide verification of the decisions made at all levels of appeal in order for Medicaid to continue during the process.

7. **Subsequent SSA/SSI Disability Decisions**

If the individual appeals a disability denial and the decision is subsequently reversed, reopen and re-evaluate the denied Medicaid application as long as the disability onset month is prior to the month of application or is no later than 90 days after the month of application. If the individual has moved to another locality in Virginia, it is the responsibility of the agency that processed the application to reopen the application and determine eligibility prior to transferring the case. See M1510.104.

M0310.113 RESERVED

M0310.114 FAMILIES & CHILDREN (F&C)

"Families & Children (F&C)" is the group of individuals that consists of

- children under 19,
- pregnant women,
- specified subgroups of children under age 21,
- *Former Foster Care Children* under age 26 (effective January 1, 2014), and
- parent/caretakers of dependent children under age 18.

Also included in the F&C groups are individuals eligible only for family planning services (Plan First) and participants in BCCPTA.



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M0310.115 FOSTER CARE

A. Definition

Foster Care provides maintenance and care for children whose custody is held by:

- a local board of social services;
- a licensed private, non-profit child placement agency;
- the Department of Juvenile Justice; or
- the child's parent(s), under a non-custodial agreement.

Federal regulations define "foster care" as "24-hour substitute care for children placed away from their parents or guardians and for whom the State agency has placement and care responsibility" (45 C.F.R. §1355.20). Transfer of the legal custody of the child is not a component when determining if a child is considered to be in foster care. The federal definition is based upon the child being placed outside of the home and who has placement and care responsibility for the child. If a child is placed outside of the home and LDSS is the case manager with placement and care responsibility, then the federal government considers the child to be in foster care. For the federal government, the term "placement and care" means that LDSS is legally accountable for the day-to-day care and protection of the child through either a court order or a voluntary placement agreement.

1. Custody

Custody may be given to an agency by the court or may be retained by the parent(s) or guardian when a non-custodial agreement is involved. If custody is retained by the parent under a parental agreement with the Community Policy and Management Team (CPMT), the child is NOT in foster care.

2. Child Placing Agency

A child placing agency is an agency that is licensed by the State Department of Social Services for child placing services. Not all child placing agencies provide adoption services; some may provide foster home placement. The services offered must be identified in the description given for the license. The foster care service unit of the local department of social services should be familiar with the function of the child placing agency, and whether or not it is licensed.

***3.* Independent Living and Fostering Futures**

A foster care child who is under age 18 who is in an Independent Living arrangement and receives full or partial support from a local social services agency, continues to meet the foster care definition and may be eligible in the covered group of Individuals Under Age 21. A child age 18 and over who is in an Independent Living arrangement with a local department of social services or in the Fostering Futures Program is considered a former foster care child and may be eligible in the Former Foster Care Child Under Age 26 covered group.

4. Kinship Guardianship Payments

Kinship Guardianship Payments are not income. These payments are a stipend paid to a relative caregiver who has assumed custody of a child as an alternative to that child remaining in foster care.

Children who are eligible for Title IV-E KinGAP (federal funds) Payments are categorically eligible for Medicaid.



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5. **Independent Living**

A foster care child who is under age 21, who is in an Independent Living arrangement and receives full or partial support from a local social services agency, continues to meet the foster care definition and may be eligible in the covered group of Individuals Under Age 21.

6. **Non-custodial and Parental Agreements**

a. **Non-custodial Agreement**

A non-custodial agreement is an agreement between the child's parent or guardian and the local Board of Social Services. The parent(s) or guardian retains legal custody of the child. The social services agency agrees to provide financial assistance and/or services to the child, such as placement in and payment for residential facility services.

Non-custodial agreements are used when LDSS serves as the case manager and has placement and care responsibilities to place a child outside of his home for treatment.

Children with non-custodial agreements are considered to be in foster care for Medicaid eligibility purposes.

b. **Parental Agreement**

A parental agreement is an agreement between the child's parent or guardian and an agency **other than DSS** which is designated by the CPMT. The other agency designated by the CPMT has placement and care responsibility for the child and agrees to provide financial assistance and/or services to the child, such as placement in and payment for residential facility services.

Parental agreements are used when an agency other than LDSS is designated by the CPMT as case manager and the child is placed outside of the home for treatment.

Children with parental agreements ARE NOT considered to be in foster care for Medicaid eligibility purposes.

c. **Placement**

Federal Title IV-E funds can only be claimed if LDSS has placement and care responsibility for the child **and** the child is placed by LDSS outside the child's home. If the LDSS has placement and care responsibility for the child and the child is placed in the child's home, the child is not eligible for Title IV-E funds and is a Non-IV-E foster child for Medicaid eligibility purposes.

7. **Department of Juvenile Justice**

A child in the custody of the Virginia Department of Juvenile Justice or who is the responsibility of a court is a "Department of Juvenile Justice (DJJ) child."

B. Procedures

1. IV-E Foster Care

Children who are eligible for and receive Title IV-E (AFDC-FC) foster care maintenance payments *or Title IV-E KinGAP payments* are IV-E Foster Care for Medicaid eligibility purposes. A child of a IV-E foster care child is also considered to be a IV-E foster care child when the mother's IV-E payment includes an allocation for her child.



A child who is eligible for IV-E Foster Care but who does not receive a IV-E Foster Care maintenance payment is considered a "Non-IV-E Foster Care" child for Medicaid eligibility purposes.

Children in the custody of another state's social services agency, who are eligible for and receive Title IV-E Foster Care maintenance payments and who now reside in Virginia, are IV-E Foster Care for Medicaid eligibility purposes. Verify the child's IV-E eligibility from the other state's department of social services which makes the IV-E payment.

2. Non IV-E Foster Care

Children who are eligible for but do not receive IV-E maintenance payments or who are eligible for Non-IV-E (state/local) Foster Care (whether or not they receive a Non-IV-E payment), and who reside in Virginia are Non-IV-E Foster Care for Medicaid eligibility purposes.

3. Non-IV-E Children in Another State's Custody

A child in the custody of another state's social services agency who *is* not receiving IV-E foster care maintenance or SSI payments, does NOT meet the Virginia residency requirement for Medicaid (M0230) and *is* not eligible for Virginia Medicaid UNLESS the child has been placed with and is residing in Virginia with a parent or care-taker relative.

4. Trial Home Visits

A foster care or DJJ child continues to meet the foster care definition (either IV-E or non-IV-E) when placed by the agency in the child's own home for a trial period, if the child continues to be in the agency's custody or remains the financial responsibility of DJJ or the court. *If a* Medicaid *renewal is due* during the trial home visit, *continue to treat the child as a foster care or DJJ child.*

M0310.116 HOSPICE

A. Definition

"Hospice" is a covered group of terminally ill individuals whose life expectancy is 6 months or less and who have voluntarily elected to receive hospice care. The term "hospice" is also used to refer to the covered service for a terminally ill Medicaid recipient, regardless of his covered group. Hospice services can be provided in the individual's home or in a medical facility, including a nursing facility.

1. Hospice Care

"Hospice care" means items and services are provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan of care for the individual that is established and periodically reviewed by the individual's attending physician and the hospice program's medical director:

2. Hospice Program

A "hospice program" is a public agency or private organization which

- is primarily engaged in providing hospice care, makes hospice care services available as needed on a 24-hour basis, and provides bereavement counseling for the terminally ill individual's immediate family;
- provides hospice care in individuals' homes or in medical facilities on a short-term inpatient basis;
- meets federal and state staffing, record-keeping and licensing requirements.

B. Procedure The individual must elect hospice care in a non-institutional setting. Election of hospice care is verified either verbally or in writing from the hospice care provider. If verification is verbal, document the case record.

M0310.117 INSTITUTION

A. Definition An **institution** is an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

B. Medical Institution (Facility) A **medical institution** is an institution that:

- is organized to provide medical care, including nursing and convalescent care,
- has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,
- is authorized under state law to provide medical care, and
- is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

C. Procedures The procedures used to determine if an individual meets a covered group of individuals in institutions are contained in subchapters M0320 and M0330.

M0310.118 LIFC

A. Low Income Families with Children (LIFC) Low Income Families with Children (LIFC) is a covered group of individuals in families who have a dependent child(ren) living in the home, and whose income is within the Medicaid F&C income limits.

B. Procedure Section *M0330.200* contains the detailed requirements for the LIFC covered group.

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M0310.120 MEDICALLY NEEDY (MN)

A. Definition

"MN" is the short name for "medically needy." MN is one of the two federal classifications of Medicaid covered groups. All MN covered groups are optional; the state can choose whether or not to cover MN individuals in its State Plan. However, if the state chooses to cover MN individuals, it must at least cover children under age 18, pregnant women and the protected group of individuals who were eligible as MN blind or disabled in December 1973 and continue to meet the December 1973 eligibility criteria. The state may choose to cover additional groups of individuals as MN.

The MN individual is one who has income and resources enough to meet his maintenance needs, but not enough to meet his medical needs. MN individuals whose income exceeds the MN income limit *may be placed on a spenddown (SD) and establish eligibility when incurred medical and/or remedial expenses equal or exceed the SD amount.*

B. Procedure

The procedures used to determine if an individual meets a MN covered group are in subchapter M0320 *for ABD and M0330 for F&C.*

M0310.121 MEDICARE BENEFICIARY

A. Definition

A Medicare beneficiary is an individual who is entitled to Medicare (Title XVIII of the Social Security Act). Medicare is a federally funded and administered health insurance program and consists of hospital insurance (Part A), medical insurance (Part B) and, beginning January 1, 2006, prescription drug coverage (Part D).

1. Part A

A person is entitled to Medicare Part A if he

a. is age 65 or older and:

- eligible for monthly Social Security benefits on the basis of covered work under the Social Security Act,
- a qualified Railroad Retirement beneficiary,
- not eligible for *S*ocial *S*ecurity or Railroad Retirement benefits but meets the requirements of a special transitional provision,
- not eligible for Social Security or Railroad Retirement benefits but voluntarily enrolls and pays a monthly premium, or

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- would be eligible for Social Security benefits if his governmental employment were covered work under the Social Security Act; OR

b. is under age 65, disabled and

- entitled to or deemed entitled to Social Security disability benefits for more than 24 months,
- would be entitled to Social Security disability benefits for more than 24 months if his governmental employment were covered work under the Social Security Act,
- under specified circumstances, entitled to Railroad Retirement benefits because of disability,
- loses his entitlement to disability benefits and Medicare Part A solely because he is engaging in substantial gainful employment but voluntarily elects to enroll and pay a monthly premium; OR

c. is any age and has end-stage renal disease treated by a kidney transplant or a regular course of kidney dialysis and meets the special insured status requirements.

2. Part B

A person is eligible to enroll in Medicare Part B if he

a. is entitled to premium-free Medicare Part A or pays a premium for Medicare Part A, OR

b. is age 65 or older, a resident of the U.S., and either

- a citizen of the U.S., or
- an alien lawfully admitted for permanent residence who has resided in the U.S. continuously during the 5 years immediately prior to the month in which he or she applies for enrollment.

3. Part D

A person is eligible to enroll in Medicare Part D if he:

a. is entitled to Medicare Part A and/or enrolled in Medicare Part B; and

b. is a resident of the United States.

B. Procedures

A Medicare beneficiary may be eligible for Medicaid if he meets all of the Medicaid eligibility requirements including any one or more of the covered groups. Four of the Medicaid covered groups are specifically for Medicare beneficiaries and *provide a limited benefit package that pays costs related to Medicare, such as premiums, copays, and deductibles. These groups include Qualified Medicare Beneficiaries (QMBs), Special Low- income Medicare Beneficiaries (SLMBs), Qualified Disabled and Working Individuals (QDWIs) and Qualified Individuals (QI). QMBs, SLMBs, and QIs are also referred to as Medicare Savings Programs (MSP).*



See sections *M0320.601 (QMB), M0320.602 (SLMB), and M0320.603 (QI)* for the procedures to use to determine if an individual meets an MSP covered group. See section *M0320.604* for the procedures to use to determine if an individual meets the QDWI covered group.

M0310.122 OASDI

A. Old Age, Survivors & Disability Insurance (OASDI)

Old Age, Survivors & Disability Insurance (OASDI) is the federal insurance benefit program under Title II of the Social Security Act that provides cash benefits to workers and their families when the workers retire, become disabled or die.

OASDI is sometimes called RSDI - Retirement, Survivors & Disability Insurance. Because Title II of the Social Security Act is still officially called "Old Age, Survivors & Disability Insurance", the Medicaid manual uses the abbreviation "OASDI" interchangeably with "Title II" to refer to Title II Social Security benefits.

B. Entitlement

An individual is fully insured if he has at least 1 credit for each calendar year after 1950, or if later, after the year in which he attained age 21, and prior to the year in which he or she attains age 62 or dies or becomes disabled, whichever occurs earlier.

A worker is entitled to retirement insurance benefits if he is at least age 62, is fully insured and files an application for retirement insurance benefits.

A claimant who is the worker's spouse is entitled to spouse's benefits on the worker's record if the claimant is age 62 or over, has in care a child under age 16 or disabled who is entitled to benefits on the worker's record, and the claimant has been married to the worker for at least 1 year before filing the claim or the claimant is the natural mother or father of the worker's biological child.

A child is entitled to child's insurance benefits on a parent's work record if an application for child's benefits is filed, the child is or was dependent on the parent, the child is unmarried, the child is under age 18 or is age 18-19 and a full-time elementary or secondary school student or age 18 or over and under a disability which began before the child attained age 22; and the parent is entitled to retirement or disability insurance benefits, or died and was either fully or currently insured at the time of death.

When an insured worker dies, monthly cash benefits may be paid to eligible survivors as follows: widow(er)'s benefits, surviving child's benefits, mother's or father's benefits, and parent's benefits.

C. Procedures

Verify an individual's entitlement to OASDI by inquiring the MMIS computer system or entering the required data into the State Verification Exchange System (SVES). The individual's award letter from SSA is acceptable verification of OASDI entitlement.

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M0310.123 PARENT

A. Definition

Under federal regulations, a parent means either the mother or the father, married or unmarried, natural or adoptive following entry of the interlocutory or final adoption order, whichever comes first.

***1.* Mother Married on Child's Birth Date**

A mother who was married at the time of her child's birth may name on the application someone other than her husband as the child's father. The man to whom she was married at the time of the child's birth, however, is considered the child's father unless DCSE or a court determines otherwise. DCSE or the court must exclude the mother's husband, considered the legal father, as the child's father before the paternity status of the man named on the application is determined.

***2.* Mother NOT Married on Child's Birth Date**

If the mother was NOT married when the child was born, the man who is living in the home and who is listed on the application as the child's father is the child's acknowledged father, unless the agency receives evidence that contradicts the application, such as the child's birth certificate that has another man named as the child's father.

***3.* Paternity Evidence**

If evidence of paternity is required to establish eligibility or ineligibility, such evidence must be entered in the eligibility case record.

B. Procedures

NOTE: The mother's marital status at the time of the child's birth does not require verification; her declaration of her marital status is sufficient.

Section M0330.200 contains the detailed requirements for the LIFC covered group in which a parent of a dependent child can be eligible for Medicaid.

M0310.124 PREGNANT WOMAN

A. Definition

A woman of any age who attests that she is pregnant meets the definition of a pregnant woman.

At the time of application, applicants are asked if they are pregnant and if so, how many babies are expected. The pregnant woman definition is met the first day of the month *in which* the woman attests she is pregnant. She meets the definition of a pregnant woman for the retroactive period if she was pregnant during the retroactive months.

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The definition of "pregnant woman" *for the purposes of the eligibility determination and covered group designation* is met for *12 months* following the last day the woman was pregnant regardless of the reason the pregnancy ended, and continues to be met until the last day of the month in which the *12th month* occurs.

After a woman's eligibility as a pregnant woman is established for Medicaid or FAMIS MOMS, her entitlement continues for 12 months following the end of the month in which her pregnancy ends, regardless of income changes. Medicaid and FAMIS MOMS coverage ends the last day of the 12th month.

B. Procedures

1. No Further Verification of Pregnancy Required

If the woman has indicated on the application that she is pregnant or subsequently reports a pregnancy, no further information regarding her pregnancy is to be requested nor verification is to be required unless the agency has reason to question the applicant's statement that she is pregnant.

If a woman is applying after the end of a pregnancy, her report of the birth or pregnancy end date is sufficient to establish (1) for purposes of retroactive coverage, her pregnancy in the three months prior to the child's birth month or pregnancy end date, or (2) for purposes of new, prospective coverage through the end of the 12-month postpartum period, her pregnancy in the twelve months prior.

2. Covered Groups Eligibility

A pregnant woman may be eligible for Medicaid if she meets all of the Medicaid eligibility requirements including any one or more of the covered groups. Once eligibility is established in any covered group, changes in income do not affect her eligibility as long as she continues to meet the definition of a pregnant woman and all non-financial eligibility requirements.

See section M0330.400 for the pregnant woman covered group requirements and M0330.801 for the MN Pregnant Woman requirements.

M0310.125 QDWI

A. Qualified Disabled & Working Individuals (QDWI)

QDWI is the short name used to designate the Medicaid covered group of Medicare beneficiaries who are "Qualified Disabled and Working Individuals." A qualified disabled and working individual means an individual

- who is entitled to enroll for Medicare Part A,
- whose resources do not exceed twice the maximum amount of resources that an individual or couple may have and be eligible for SSI,
    - whose income does not exceed 200% of the federal poverty limit,
- who is NOT otherwise eligible for Medicaid.

B. Procedure

QDWI is a mandatory covered group that the state plan must cover for the purpose of paying the beneficiary's Medicare Part A premium. See section M0320.604 for the procedures to use to determine if an individual meets the QDWI covered group.

M0310.126 Qualified Individuals

A. Qualified Individuals (QI)

QI is the short name used to designate the Medicaid covered group of "Qualified Individuals." A qualified individual means a Medicare beneficiary

- who is entitled to Medicare Part A,
- who has resources that are within the resource limits for the Medicare Savings Programs (MSPs). See chapter section M1110.003 for the current resource limits; and
- whose income is equal to or more than 120% of the federal poverty level (FPL) and is less than 135% FPL.

B. Procedure

QI is a mandatory covered group that the State Plan must cover for the purpose of paying the Medicare Part B premium for the QI. See section M0320.603 for the procedures used to determine if an individual meets the QI covered group.

M0310.127 QMB

A. Qualified Medicare Beneficiary (QMB)

QMB is the short name used to designate the Medicaid covered group of "Qualified Medicare Beneficiary." A qualified Medicare beneficiary means an individual

- who is entitled to enroll for Medicare Part A,
- who has resources that are within the resource limits for the Medicare Savings Programs (MSPs). See chapter section M1110.003 for the current resource limits; and
- whose income does not exceed 100% of the FPL.

B. Procedure

QMB is a mandatory covered group that the state plan must cover for the purpose of paying the beneficiary's Medicare premiums and cost sharing expenses. See section M0320.601 for the procedures to use to determine if an individual meets the QMB covered group.

M0310.128 RSDI

A. Retirement, Survivors & Disability Insurance (RSDI)

Retirement, Survivors & Disability Insurance (RSDI) is another name for Old Age, Survivors & Disability Insurance (OASDI) - the federal insurance benefit program under Title II of the Social Security Act that provides cash benefits to workers and their families when the workers retire, become disabled or die.

B. Procedure

RSDI Is not used in the Medicaid manual. Because Title II of the Social Security Act is still officially called "Old Age, Survivors & Disability Insurance", the Medicaid manual uses the abbreviation "OASDI" interchangeably with "Title II" to refer to Title II Social Security benefits.

M0310.129 SLMB

A. Special Low-income Medicare Beneficiary (SLMB)

SLMB is the short name used to designate the Medicaid covered group of "Special Low-income Medicare Beneficiary". A special low-income Medicare beneficiary means an individual

- who is entitled to enroll for Medicare Part A,
- *who has resources that are within the resource limits for the Medicare Savings Programs (MSPs). See chapter section M1110.003 for the current resource limits; and*
- whose income exceeds the QMB income limit (100% of the FPL) but does NOT exceed the higher SLMB income limit, which is 120% of the FPL.

B. Procedure

SLMB is a mandatory covered group that the state plan must cover for the purpose of paying the beneficiary's Medicare Part B premium. See section M0320.602 for the procedures to use to determine if an individual meets the SLMB covered group.

M0310.130 SSI

A. Supplemental Security Income (SSI)

Supplemental Security Income (SSI) is the federal cash assistance benefit program under Title XVI of the Social Security Act that provides cash assistance to eligible aged, blind or disabled individuals to meet their shelter, food and clothing needs.

B. Procedures

Individuals who receive SSI (SSI recipients) are not "automatically" eligible for Medicaid in Virginia. SSI recipients must meet all of the Medicaid nonfinancial eligibility requirements and must meet the Medicaid resource eligibility requirements that are more restrictive than SSI's resource requirements. See section M0320.101 for the procedures to use to determine if an SSI recipient meets a covered group.

M0310.131 STATE PLAN

A. Definition

The State Plan for Medical Assistance is a comprehensive written statement submitted by the Department of Medical Assistance Services (DMAS) describing the nature and scope of Virginia's Medicaid program. It contains all the information necessary for the federal Centers for Medicare and Medicaid Services (CMS) to determine whether the state plan can be approved for federal financial participation (FFP) in the state's Medicaid program expenses.



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B. State Plan Governs Medicaid Eligibility Rules

The State Plan consists of preprinted material that covers the basic Medicaid requirements and individualized material written by DMAS that reflects the particular requirements and choices made by Virginia for its Medicaid program. The State Plan is included in DMAS' state regulations promulgated according to the Virginia Administrative Process Act (APA). The State Plan is kept and updated by DMAS.

The State Plan shows the eligibility requirements for Virginia Medicaid, including the mandatory and optional groups of individuals covered by Virginia Medicaid and the medical services covered by Medicaid for those groups. The covered groups eligibility requirements in this chapter are based on the State Plan.

M0310.132 TANF

A. Temporary Assistance for Needy Families (TANF)

TANF is the federally-funded (with matching funds from the states) block grant program in Title IV Part A of the Social Security Act that provides temporary cash assistance to needy families. In Virginia, TANF replaced the previous Title IV-A program called Aid to Families With Dependent Children (AFDC) on February 1, 1997.

M0310.133 BCCPTA

A. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)

The BCCPTA created a Medicaid covered group for women and men age 18 through 64 who have been identified by the Centers for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program (BCCEDP) as being in need of treatment for breast or cervical cancer.

B. Procedures

Section M0330.700 contains the detailed requirements for the BCCPTA covered group.

M0310.134 VIEW PARTICIPANT

A. Virginia Initiative for Employment not Welfare (VIEW) Participants

A VIEW participant is an individual who has signed the TANF Agreement of Personal Responsibility. *For renewals completed and changes reported prior to April 1, 2014,* VIEW participants have a higher earned income limit than non-VIEW participants. An individual under a TANF VIEW sanction is a VIEW participant for Medicaid purposes. An individual only receiving TANF transitional support services is not a VIEW participant for Medicaid purposes.

Modified Adjusted Gross Income (MAGI) methodology does not differ between VIEW participants and other individuals.

M0310.135 HIPP PROGRAM

A. Health Insurance Premium Payment (HIPP) Program

HIPP is a cost savings program administered by the DMAS for Medicaid enrollees which reimburses some or all of the employee portion of group health insurance premiums. HIPP is available to Medicaid enrollees when a family member is employed at least 30 hours per week and is enrolled in an employer's group health plan. Eligibility for HIPP is determined by the HIPP Unit at DMAS. Participation in HIPP is voluntary.

B. Procedures

M0130.200 G contains additional information about HIPP.

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M0310.136 MAGI ADULT

A. Definition

A MAGI Adult is a person who is not defined as a "child" (see M0310.110).

The 2018 Appropriations Act mandated that Medicaid in Virginia be expanded effective January 1, 2019. This new expanded coverage group is called MAGI Adults and covers individuals ages 19-64 who are not eligible for or enrolled in Medicare and who have income at or below 138% of FPL. Several new aid categories have been added for the MAGI Adults covered group.

- Childless adults, income less than 100% FPL;
- Childless adults, income less than 138% FPL (133% + 5% income disregard);
- Parent/Caretaker adult relatives, above current LIFC income limit and at or below 100% FPL;
- Parent/Caretaker adult relatives, above 100% FPL and at or below 138% FPL (133% + 5% income disregard);
- Presumptive eligible adult, income at or below 138% FPL (133% + 5% income disregard);
- Incarcerated adult who otherwise meet a Medicaid MAGI Adult aid category but not enrolled due to incarceration.

B. Procedure

The procedures used to determine if an individual meets the MAGI Adults covered group are contained in subchapters M0320 and M0330.

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Disability Determination Services (DDS) Contact Information

Send ALL expedited and non-expedited disability referrals to the DDS Central *District* Office.

DDS *District* Office	**Hearing Contacts**
Central *District* Office Disability Determination Services 9960 Mayland Drive. Suite 200 *Henrico*, Virginia 23233 Phone: *855-445-3938* FAX: 804-*527*-4523 Operations Manager: Talya Brown Professional Relations Officer: Bonita Jones District Director: Elliot Duncan	Primary Contact for Scheduling a hearing: Bonita Jones (804) 367-4707 Backup: Shawnelle Martin 804-367-*3292*

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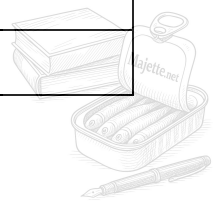
CHAPTER M03
MEDICAID COVERED GROUPS
SUBCHAPTER 20

AGED, BLIND & DISABLED GROUPS

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M0320 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Page 11
TN #DMAS-35	7/1/25	Sections .400 and .500
TN #DMAS-34	1/1/25	Pages 11, 27, 32, 34 Pages 32a and 34a are added
TN #DMAS-33	10/1/24	Pages 1, 5, 27, 37
TN #DMAS-32	7/1/24	Pages 24-26a, 29
TN #DMAS-29	10/1/23	Pages 1, 25, 26, 26a, 27, 28
TN #DMAS-27	4/1/23	Pages 11, 24, 25, 27
TN #DMAS-26	1/1/23	Page 11
TN #DMAS-24	7/1/22	Pages 2, 30, 31, 33
TN #DMAS-23	4/1/22	Page 27
TN #DMAS-22	1/1/22	Pages 11, 26a, 27
TN #DMAS-20	7/1/21	Pages 24, 26-29
TN #DMAS-19	4/1/21	Pages 26a, 29
TN #DMAS-18	1/1/21	Pages 11, 22, 26, 27
TN #DMAS-17	7/1/20	Pages 24. 25. 26, 27 Page 26a was added as a runover page.
TN #DMAS-15	1/1/20	Pages 11, 26, 27, 29
TN #DMAS-14	10/1/19	Page 40
TN #DMAS-13	7/1/19	Pages 1, 24-27
TN #DMAS-11	1/1/19	Pages 2a, 11, 35, 37
TN #DMAS-10	10/1/18	Page 1; 1a added as a runover page
TN #DMAS-9	7/1/18	Page 2, 17
TN #DMAS-7	1/1/18	Page 2, 3, 4, 11, 26-27.
TN #DMAS-4	4/1/17	Page 26
TN #DMAS-3	1/1/17	Pages 11, 27, 29, 40, 41, 44, 45, 52
TN #DMAS-2	10/1/16	Pages 4, 15, 16, 18, 20, 22, 30, 33, Pages 39- 41, 43-45, 48, 51, 52, 55
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 1, 11, 25-27, 46-49;Page 50 is a runover page.
TN #100	5/1/15	Pages 6, 11, 24, 25-27, 29-30
TN #99	1/1/14	Page 11
TN #98	10/1/13	Pages 1, 54, 55.
UP #9	4/1/12	Pages 11, 26, 32, 34-37, 45, 46, 55
TN #97	9/1/12	Table of Contents; Pages 1-56 (all pages)
UP #6	4/1/12	Pages 11, 12, 46a
TN #96	10/1/11	Table of Contents; Pages 46f-50b; Page 50c deleted
TN #95	3/1/10	Pages 11, 12, 42c, 42d, 50, 53, 69 Pages 70, 71; Page 72 added.
TN #94	9/1/10	Pages 49-50b
UP #3	3/1/10	Pages 34, 35, 38, 40, 42a, Pages 42b, 42f
TN #93	1/1/10	Pages 11-12, 18, 34-35, 38 Pages 40, 42a-42d, 42f-44, 49 Pages 50c, 69-71
UP #2	8/24/09	Pages 26, 28, 32, 61, 63, 66
Update (UP) #1	7/1/09	Pages 46f-48
TN #91	5/15/09	Pages 31-34 Pages 65-68



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M0320.000 AGED, BLIND & DISABLED (ABD) GENERAL POLICY PRINCIPLES

A. Overview

A State Plan for Medicaid must include the mandatory federal categorically needy (CN) groups of individuals as well as the optional groups a state has elected to cover.

This subchapter divides the ABD covered groups into categorically needy and medically needy (MN) groups.

B. Procedure

Determine an individual's eligibility first in a CN covered group. This includes eligibility in the Modified Adjusted Gross Income (MAGI) Adults covered group (see M0330.250). If the individual is not eligible in a full-benefit CN covered group, determine the individual's eligibility as MN (on a spenddown).

An evaluation of eligibility for an aged, blind or disabled individual should follow this hierarchy:

1. If the individual is a current SSI/AG recipient, evaluate in this covered group. Exception-- if the individual requests MEDICAID WORKS, go to *5* below.

2. If the individual is a former SSI or AG recipient, evaluate first in the protected covered groups. Exception-- if the individual requests MEDICAID WORKS, go to *5* below.

3. If the individual does not meet the criteria for SSI/AG or protected, is between ages 19 and 64, and is not eligible for or enrolled in Medicare, evaluate next in the MAGI Adults covered group.

4. If the individual is aged and/or is eligible for or has Medicare, evaluate next in the ABD with income $\leq$ 80% FPL covered group.

5. If a disabled individual has income at or below *138%* FPL (including SSI recipients and 1619(b) individuals) and is going back to work, evaluate the individual in the MEDICAID WORKS covered group.

6. If the individual does not meet the requirements for MAGI Adults, 80% FPL group or MEDICAID WORKS, but meets the definition of an institutionalized individual, evaluate in the 300% of SSI covered groups.

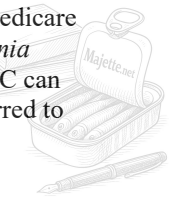
7. If the individual is a Medicare beneficiary with income or resources in excess of the full-benefit Medicaid covered groups, evaluate in the Medicare Savings Programs (MSP) groups (QMB, SLMB, QI, QDWI).

8. If the individual is not eligible for Medicaid coverage in an MSP group *AND* a Plan First evaluation *is requested*, evaluate in the Plan First covered group.

9. If the individual meets all the requirements, other than income, for coverage in a full benefit Medicaid group, evaluate as MN.

C. Referral to Health Insurance Marketplace

Unless an individual is incarcerated, an ABD individual who does not have Medicare and is not for eligible for full Medicaid coverage must be referred to the *Virginia* Health Insurance Marketplace (*V*IM) so the applicant's eligibility for the APTC can be determined. Incarcerated individuals and those with Medicare are not referred to the *V*IM.



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D. Aid Categories *Aid Categories (ACs) are used in the eligibility and enrollment systems to denote covered group. Some covered groups have multiple ACs for designating disability status, age, income, and other demographic information. These ACs may be used for reporting and funding purposes. The policy sections for each ABD covered group in this subchapter contain the assigned ACs*

Exception–ABD individuals of any age who have been determined to be eligible for Medicaid coverage of emergency services based on the alien status requirement policies in subchapter M0220 will be assigned to AC 113 regardless of their covered group.

M0320.001 ABD CATEGORICALLY NEEDY

A. Introduction To be eligible in an ABD covered group, the individual must meet all Medicaid non-financial requirements in chapter M02 and an "Aged," "Blind" or "Disabled" definition in subchapter M0310. If he does not, then go to the Families & Children covered groups in subchapter M0330.

B. Procedures The policy and procedures for determining whether an individual meets an ABD CN covered group are contained in the following sections:

- M0320.202 Conversion Cases
- M0320.203 Former SSI/AG Recipients
- M0320.206 Protected Adult Disabled Children
- M0320.207 Protected SSI Disabled Children
- M0320.300 ABD with Income ≤ 80% FPL
- M0320.400 MEDICAID WORKS
- M0320.501 ABD In Medical Institution, Income ≤ 300% SSI
- M0320.502 ABD Receiving CBC Services
- M0320.503 ABD Hospice
- M0320.601 Qualified Medicare Beneficiary (QMB)
- M0320.602 Special Low-income Medicare Beneficiary (SLMB)
- M0320.603 Qualified Individuals (QI)
- M0320.604 Qualified Disabled & Working Individual (QDWI))

M0320.100 ABD CASH ASSISTANCE COVERED GROUPS

A. Legal base Medicaid eligibility for certain individuals is based on their receipt of cash assistance from another benefit program that has a cash assistance component.

B. Procedure The policy and procedures for cash assistance recipients are found in the following sections:

- M0320.101 SSI Recipients
- M0320.102 AG Recipients

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M0320.101 SSI RECIPIENTS

A. Introduction

42 CFR 435.121 - SSI recipients are a mandatory CN Medicaid covered group. Many states automatically *enroll an individual in* Medicaid when the individual is approved for SSI. However, in Virginia, not all SSI recipients are eligible for Medicaid. Virginia has chosen to impose real property eligibility requirements that are more restrictive than the federal SSI real property eligibility requirements. SSI recipients living in Virginia must apply separately for Medicaid because they are subject to a resource evaluation.

The Social Security Administration may approve an SSI applicant as conditionally or presumptively eligible for SSI. Conditionally-eligible SSI recipients are being allowed time to dispose of excess resources. Presumptively blind or disabled SSI recipients are presumed to be blind or disabled; no final blindness or disability determination has been made. An individual who has been conditionally or presumptively approved for SSI is NOT eligible for Medicaid in the SSI Recipients covered group. Evaluate the individual's eligibility in the MAGI Adults covered group.

SSI payments for eligible individuals are effective the first day of the month following the month in which the SSI application was filed. When the Medicaid application is filed in the same month as the SSI application, the applicant is not eligible for Medicaid as an SSI recipient until the month for which he receives his first SSI payment. See policy M0320.101.C. When the SSA record indicates a payment code(s) of "C01" and no payment amount is shown, the individual is considered to be a SSI recipient for Medicaid purposes. If the SSA record indicates a code of EO1 or E02 and no SSI payment has been received in more than twelve months, the individual's SSI status must be confirmed.

Eligibility for months prior to SSI entitlement must be evaluated *in the MAGI Adults* covered group.

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***B*. Financial Eligibility**

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

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

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

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

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

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

When an SSI recipient has any of the real property listed in 1) through 5) above, ALL of the recipient's resources must be verified, evaluated, and counted together to determine if the SSI recipient meets the Medicaid resource requirements. Calculate resources according to the assistance unit policy in chapter M05. If current resources are within the limit, go on to determine income eligibility. If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he may be eligible as MSP (which has more liberal resource methods and standards).

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When an SSI recipient has no real property resource listed in 1) through 5) above, do NOT determine the SSI recipient's resources. The SSI recipient meets the Medicaid resource requirements because he receives SSI and does not have a real property resource listed above.

2. Income

Verify the SSI recipient's eligibility for SSI payments by an SSI awards notice and inquiring the State On-line Query-Internet (SOLQ-I) system, SDX (State Data Exchange) or SVES (State Verification Exchange System). If the recipient is eligible for SSI, he meets the Medicaid income eligibility requirement.

C. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month, including the receipt of, or entitlement to, an SSI payment in that month. *When the SSA record indicates a payment code(s) of "C01" and no payment amount is shown, the individual is considered to be an SSI recipient for Medicaid purposes. If the SSA record indicates a code of EO1 or E02 and no SSI payment has been received in more than twelve months, the individual's SSI status must be confirmed.*

Retroactive coverage is applicable to this covered group. However, if the individual did not receive, or was not entitled to, an SSI payment in the retroactiv period, the individual is not eligible for retroactive Medicaid in the SSI recipients covered group. His retroactive eligibility must be evaluated in another Medicaid covered group.

The ACs are:

- 011 for an aged SSI recipient;
- 031 for a blind SSI recipient;
- 051 for a disabled SSI recipient.

D. Ineligible as SSI Recipient

If a non-institutionalized SSI recipient is ineligible for Medicaid because of resources, evaluate the individual's eligibility in all other Medicaid covered groups including, but not limited to, the ABD with Income ≤ 80% FPL and the MSP covered groups.

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M0320.102 AG RECIPIENTS

A. Policy

42 CFR 435.234 - An Auxiliary Grants (AG) recipient is eligible for Medicaid if he meets the assignment of rights to medical support and third party payments requirements (see M0250). AG eligibility is determined using the AG eligibility policy in the Auxiliary Grant Eligibility Manual.

B. Financial Eligibility

Verify the AG recipient's eligibility for AG by agency records. Individuals who receive AG as "**Conditional"** SSI recipients do **not** meet the requirements for this covered group.

C. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group. *If the person is already eligible for Medicaid as a LTSS recipient, they are eligible as an AG recipient the first day they reside in the Adult Home. The AC should be changed as of that date. If they leave the AH to receive LTSS, the AC should be changed as of the day they leave the AH.*

The ACs are:

- 012 for an aged AG recipient;
- 032 for a blind AG recipient;
- 052 for a disabled AG recipient.

M0320.200 PROTECTED COVERED GROUPS

A. Legal base

Federal law and regulations require that the Medicaid eligibility status of certain groups of persons be protected even though they may not meet current eligibility requirements. These groups, and the applicable eligibility requirements, are described in this section.

B. Procedure

- M0320.201 Former Money Payment Recipients August 1972
- M0320.202 Conversion Cases
- M0320.203 Former SSI/AG Recipients
- M0320.204 Protected Widows or Widowers
- M0320.205 Qualified Severely Impaired Individuals (QSII)-1619(b)
- M0320.206 Protected Adult Disabled Children
- M0320.207 Protected SSI Disabled Children.

M0320.201 FORMER MONEY PAYMENT RECIPIENTS AUGUST 1972

A. Policy

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

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

In August 1972, the individual was entitled to OASDI and

- he was receiving AFDC, Old Age Assistance (OAA), Aid to the Blind (AB), or Aid to the Permanently and Totally Disabled (APTD); or
- he would have been eligible for one of those programs if he had applied and the Medicaid plan covered this optional group. The Virginia plan covered this group; or

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- he would have been eligible for one of those programs if he was not in a medical institution or intermediate care facility and the Medicaid plan covered this optional group. The Virginia plan covered this group.

2. Would Currently Be Eligible If Increase Were Excluded

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

- meets all LIFC requirements or current SSI requirements except for the requirement to file an application; or
- would meet all current LIFC or SSI requirements if he were not in a medical institution or intermediate care facility and the Medicaid plan covers this optional group. The Virginia plan covers this group

B. Nonfinancial Requirements

The protected individual must meet all of the following criteria:

- he was a recipient of OAA, AB, APTD, or AFDC cash assistance as of August, 1972;
- his money payment was subsequently discontinued as a result of the 20% increase in Social Security benefits received in October, 1972;
- his current countable resources are less than or equal to the current resource limit for Medicaid; and
- his current countable income is less than or equal to the F&C income limit or the current SSI income limit, as appropriate, after excluding the 20% increase amount received in 1972. The current SSI standards are in subchapter S0810; *the F&C income limit is available from a Regional Medical Assistance Program consultant.*

Contact a Medicaid Assistance Consultant if you have an applicant you believe meets this covered group.

M0320.202 CONVERSION CASES

A. Policy

42 CFR 435.131, 435.133--Conversion cases are classified as categorically needy and consist of the following individuals:

- blind or disabled individuals eligible in December 1973;
- individuals eligible as essential spouses of aged, blind or disabled individuals in December 1973.

B. Eligibility Determination

The agency must continue the individual's Medicaid if

- the ABD individual continues to meet the December 1973 eligibility requirements of the applicable cash assistance program; and



- the essential spouse continues to meet the conditions that were in effect in December 1973 under the applicable cash assistance plan for having his needs included in computing the payment to the ABD individual.

C. Essential Spouse

The agency must provide Medicaid to any person who was eligible for Medicaid in December 1973 as an essential spouse of an aged, blind or disabled individual who was receiving cash assistance, if the conditions below are met. An "essential spouse" is defined as one who is living with the individual, whose needs were included in determining the amount of cash payment to the individual under OAA, AB, or APTD in December 1973, and who is determined essential to the individual's well-being.

The spouse of the protected conversion person is included in the conversion case if:

- his/her needs were included in the OAA, AB, or APTD grant as of December, 1973, and
- he/she continues to live in the home of the protected individual

D. Blind or Disabled In December 1973

The agency must provide Medicaid to individuals who:

- meet all current Medicaid eligibility requirements except the criteria for blindness or disability;
- were eligible for Medicaid in December 1973 as blind or disabled individuals; and

for each consecutive month after December 1973, continue to meet the criteria for blindness or disability and the other eligibility requirements used under the Medicaid plan in December 1973.

Contact your Regional Medical Assistance Program Consultant if you have an applicant you believe meets this covered group.

M0320.203 FORMER SSI/AG RECIPIENTS

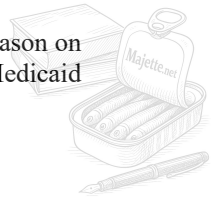
A. Policy

1. Nonfinancial Requirements

The protected former SSI/AG recipient must meet the nonfinancial eligibility requirements in chapter M02. The protected former SSI recipient is one who was eligible for and received **either:**

- SSA and SSI, or
- SSA and AG, or
- SSA, SSI, and AG

concurrently, but who became ineligible for SSI or AG due to any reason on or after April 1, 1977. The individual did not have to be receiving Medicaid at that time.



An individual who concurrently received these benefits does not meet this covered group's requirements if one of the benefit payments was later recouped because the individual was not entitled to the payment.

2. Financial Requirements

The former SSI/AG recipient is eligible for Medicaid if:

a. the individual meets the Medicaid resource requirements currently in effect, and the individual's income, less all SSA cost-of-living adjustments (COLAs) received since the most recent month SSI or AG was cancelled (including the COLA received in the month SSI or AG was cancelled) is within the current SSI income limit; OR

b. the individual meets the AG requirements in effect at the time of application or redetermination, including residing in an approved AG home, and the individual's income less the amount of all SSA COLAs received since the most recent month SSI or AG was cancelled (including the COLA received in the month SSI or AG was cancelled) is within the current AG income limit applicable to a resident of that home.

c. Any change in SSA benefits other than cost-of-living increases are not excluded, such as an increase due to change from disability benefits to widow's benefits.

EXAMPLE #1: Ms. C is age 71. She has never been enrolled in Medicaid before. She applied for Medicaid on February 12, 1997. She received SSA on her own record, in the amount of $280, until March 1, 1994 when she began receiving widow's benefits of $410. She received SSI until March 1, 1994, when SSI was cancelled due to her increased SSA benefit. She received COLA increases in her SSA in January of 1995, 1996, and 1997. Her current SSA is $537. Her countable resources are less than the current Medicaid resource limit.

Ms. C meets the former SSI recipient protected individual criteria because she was eligible for and received SSA and SSI concurrently. Her countable income is her SSA amount prior to the January 1, 1995 COLA - $410 - less the $20 disregard. The result, $390, is compared to the current SSI individual limit.

Because her resources are within the Medicaid limit, and her countable income of $390 is within the current SSI limit, she is eligible for Medicaid as a protected former SSI recipient.

B. Eligibility Procedures

1. Assistance Unit

Use the assistance unit composition and resource deeming procedures policy in chapter M05 to determine when a spouse's resources or income are counted or deemed in determining the individual's eligibility.

If the protected individual lives with his/her spouse (or parent in the case of a blind/disabled child) whose resources and income would be counted or deemed in determining the individual's SSI or AG eligibility, the SSA cost-of-

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living increase(s) (COLAs) received by the spouse (or parent) since the individual lost SSI or AG eligibility is also excluded in determining the protected individual's income eligibility under this section.

2. Resource Eligibility

Resource eligibility is determined by comparing the former SSI recipient's resources to the current Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). Calculate resources according to the assistance unit policy in chapter M05. If current resources are within the limit, go on to determine income eligibility. If current resources are NOT within the limit, the individual is NOT eligible in this protected covered group.

3. Income Eligibility

a. Countable Income

In figuring income to compare to the current SSI or AG income limit, the income exclusions in chapter S08 are applicable including the $20 exclusion.

When the individual meets the above criteria for a protected case and the individual's assistance unit's resources are within the Medicaid resource limit:

1) Identify the individual's, and the individual's spouse's (or parent's when applicable), amount of Social Security Title II benefits at the time of SSI termination.

   If this amount is unknown and cannot be obtained, see item 4. below.

2) When the amount of Social Security Title II benefits at the time of SSI termination is determined:

   - add the Medicare premium amount to the Title II check amount if only the check amount is known (see item 5. below for Medicare premium amounts);
   - determine if any change in benefit had occurred between loss of SSI and the point of application. If questionable, multiply the prior Title II amount by the COLA percentages and compare to current entitlement. If the figures are significantly different, use the procedures in 4. below to obtain the amount of Title II at the time SSI was terminated;
   - if there were no changes, count the Title II amount at the time of SSI loss. Subtract the $20 general exclusion;
   - count all other current sources of income, apply appropriate exclusions, total countable income.

b. Allocation For NBD Child(ren)

When determining the amount of a spouse's or parent's deemable income, the allocation for a non blind or disabled (NBD) child(ren) in the home is the same regardless of locality (see M0530, Appendix 1). On the income worksheet, insert the SSI individual payment limit whenever the worksheet calls for the Medicaid income limit.

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c. Income Limit

Countable income is compared to the AG or SSI income limit for an individual or couple, as appropriate.

The SSI limit for a couple is used whenever evaluating a couple when both meet an ABD definition and both request Medicaid. The SSI limit for an individual is used when only one member of a couple applies or meets an ABD definition.

The SSI income limit reduced by one-third is used whenever an applicant/recipient lives in the home of another person throughout a month and does not pay his/her pro rata share of food and shelter expenses.

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

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

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

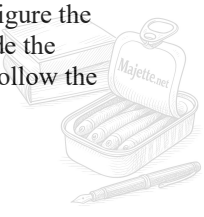
   The non-protected spouse's eligibility is evaluated in another covered group.

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

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

4. COLA Formula

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



Note: There was no COLA in 2010, 2011 or 2016.

The Cost-of-living calculation formula
(The formula is the current Title II Benefit divided by the percentage increase to equal the benefit amount before the COLA change):

a. *Current Title II Benefit = Benefits before 1/25 COLA*

2.8% (1/25 increase)

b. Current Title II Benefit= Benefit Before 1/24 COLA

2.5% (1/24 Increase)

c. Current Title II Benefit= Benefit Before 1/23 COLA

3.2% (1/23 Increase)

d. Current Title II Benefit = Benefit Before 1/22 COLA
1.059 (1/22 Increase)

e. Benefit Before 1/22 COLA = Benefit Before 1/21 COLA
1.013 (1/21 Increase)

f. Benefit Before 1/21/ COLA = Benefit Before 1/20 COLA
1.016 (1/20 Increase)

5. Medicare Premiums

a. Medicare Part B premium amounts:

1-1-26 $202.90
1-1-25 $185.00
1-1-24 $174.70
1-1-23 $164.90
1-1-22 $170.10

Note: These figures are based on the individual becoming entitled to Medicare during the year listed. The individual's actual Medicare Part B premium may differ depending on when he became entitled to Medicare. **Verify the individual's Medicare Part B premium in SVES or SOLQ-I if it is necessary to know the premium amount for Medicaid eligibility or post-eligibility purposes.**

b. Medicare Part A premium amount:

1-1-26 $565.00
1-1-25 $518.00
1-1-24 $505.00
1-1-23 $506.00
1-1-22 $499.00

Contact a Medical Assistance Program Consultant for amounts for years prior to *2022.*

6. Evaluation

Individuals who are eligible when a cost-of-living increase is excluded are eligible.



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

The cost-of-living increase(s) is not excluded when determining income eligibility in ANY other covered group. However, these individuals must be identified for possible future protection as the SSI and AG income limits increase.

C. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

The ACs are:

- 021 for an aged individual;
- 041 for a blind individual;
- 061 for a disabled individual.

D. Eligibility for Non-Protected Family Members

The amount of an SSA cost-of-living increase that must be excluded when determining eligibility for a former SSI recipient **cannot** be excluded when determining Medicaid eligibility of the individual's non-protected spouse and/or children living with the former SSI recipient.

The former SSI recipient is included in his/her non-protected spouse's unit if the non-protected spouse is aged, blind, or disabled.

The former SSI recipient is included as a member of the family unit when determining a child's eligibility in an F&C covered group. All of the protected recipient's income, including the cost-of-living increase(s), is counted.

M0320.204 PROTECTED WIDOWS OR WIDOWERS

A. Policy

Two groups of disabled widow(er)s who lost SSI eligibility because of receipt of or increase in Title II disabled widow(er)s' or Title II widow(er)'s benefits have their Medicaid categorically needy eligibility protected.

The first group consists of disabled widow(er)s who would be eligible for SSI except for the increase in disability benefits resulting from elimination of the reduction factor under P.L. 98-21 in January 1984.

The second group consists of *(1)* disabled widow(er)s age *60* through 64 *years* and *(2) disabled widow(er)s age 50 through 59 years* who would be eligible for SSI except for early receipt of Social Security benefits.

B. July 1989 Protected Widow(er)s

42 CFR 435.137 - A "July 1989 protected widow(er)" is an individual who became entitled to SSA benefits when he/she had attained age 50 but not age 60 years, and

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- who applied for Medicaid before July 1, 1989,
- was entitled to monthly OASDI benefits under Title II of the Social Security Act for December 1983,
- was entitled to and received widow's or widower's disability benefits under section 202(e) or 202(f) of the Social Security Act for January 1984,
- lost SSI and/or AG because of the January 1984 increase in disabled widow(er)'s benefits due to elimination of the reduction factor,
- has been continuously entitled to an SSA widow(er)'s disability benefit under section 202(e) or 202(f) of the Social Security Act since the first month that increase was received, and
- would be eligible for SSI or AG if the amount of the increase and any subsequent COLAs in the widow(er)s' SSA benefits were excluded.

1. Nonfinancial Eligibility

Determine the widow(er)'s eligibility using the procedures below. The widow(er):

a. applied for Medicaid as a protected individual prior to July 1, 1989;

b. was entitled to and received a widow's or widower's benefit based on a disability under Section 202 (e) or (f) of the Social Security Act, for January 1984;

c. became ineligible for SSI and/or AG payments because of the increase in the amount of his/her widow(er)'s benefit and:

- the increase resulted from the elimination of the reduction factor for disabled widow(er)s entitled before age 60,
- he/she became ineligible for SSI and/or AG payments in the first month in which that increase was paid to him/her, and
- a retroactive payment of that increase for prior months was not mad in that month;

d. has been continuously entitled to a widow(er)'s disability benefit under Section 202 (e) or (f) of the Social Security Act from the first month tha the increase in his/her widow(er)'s benefit was received;

e. would be eligible for SSI or AG if the amount of that increase, and any subsequent cost-of-living adjustments (COLAs) in the widow(er)'s benefits, were deducted from his/her income.



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2. Financial Eligibility

a. Assistance Unit

Determine whose resources and income will be counted or deemed available according to the assistance unit policy in chapter M05.

b. Resource Eligibility

Resource eligibility is determined by comparing the widow(er)'s resources to the current Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this protected group; he/she may be eligible as *an MSP* (which has more liberal resource methods and standards).

c. Income Eligibility

1) If the individual received SSI (or SSI and AG) and is not currently residing in an approved AG home, the individual's gross SSA benefit amount that was effective in December 1983 plus other current countable income must be within the current SSI individual limit, or couple limit if the individual is married and living with his/her spouse. Calculate income according to the assistance unit policy in chapter M05. Instead of the protected individual's current SSA benefit amount, use the amount effective in December 1983.

   Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected individual is eligible for Medicaid in this protected covered group.

2) If the individual received AG (or AG and SSI) and is currently residing in an approved AG home, the individual's income must be within the current AG limit (home's rate plus personal care allowance). Instead of the protected individual's current SSA benefit amount, use the amount effective in December 1983.

   Compare the total countable income to the current AG limit (home's rate plus personal care allowance). If countable income is within that limit, the protected individual is eligible for Medicaid in this protected covered group.

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3) If the individual is not income-eligible, Medicaid eligibility may exist in another covered group. However, when determining eligibility in another covered group, count all current income including the current SSA benefit amount. If the individual does not meet an F&C covered group, is not institutionalized, is not receiving CBC or does not have Medicare Part A, he/she must be determined eligible in a medically needy covered group.

C. Protected Disabled Widow(er)

42 CFR § 435.138 specifies that categorically needy eligibility for Medicaid is protected for the group of disabled widow(er)s age 60 through 64 years who meet the criteria specified below. Under 42 USC § 1383c(d), Medicaid protected status was extended to the group of disabled widower(er)s age 50 through 59 years who meet the same criteria.

A protected disabled widow(er) is an individual who:

- is at least age 50 years (and has not attained age 65);
- is **not** eligible for Medicare Part A hospital insurance;
- becomes ineligible for SSI and/or AG because of mandatory application for and receipt of SSA Title II widow(er)'s disability benefits under section 202(e) or 202(f) of the Social Security Act (or any other provision of section 202 if they are also eligible for benefits under subsections (e) or (f) of the Act).
- would be eligible for SSI or AG if the SSA widow(er)'s benefit were excluded from income.

1. Nonfinancial Eligibility

The protected disabled widow(er) must:

a. have received SSI and/or AG for the month before the month in which he/she began receiving SSA Title II disabled widow(er)'s benefits or widow(er)'s benefits;

b. be eligible for SSI or AG if the SSA widow(er)s disability benefit were not counted as income.

2. Financial Eligibility

a. Assistance Unit

Determine whose resources and income will be counted or deemed available according to the assistance unit policy in chapter M05.

b. Resource Eligibility

Financial eligibility is determined by comparing the widow(er)'s resources to the current Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). If current resources are within the limit, go on to determine income eligibility.



If current resources are NOT within the limit, the individual is NOT eligible in this protected group; he/she may be eligible in an MSP covered group (which has more liberal resource methods and standards).

c. Income Eligibility

When determining a protected widow(er)'s eligibility in this covered group, the agency must deduct from the individual's income all of the Social Security benefits that made him or her ineligible for SSI.

1) If the individual received SSI (or SSI and AG) and is not currently residing in an approved AG home, the individual's SSA benefit that made him/her ineligible for SSI must be excluded. Other current countable income must be within the current SSI individual limit, or couple limit if the individual is married and living with his/her spouse. Exclude the protected individual's current SSA widow(er)'s benefit amount.

   Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected individual is eligible for Medicaid in this protected covered group.

2) If the individual received AG (or AG and SSI) and is currently residing in an approved AG home, the individual's countable income must be within the current AG limit (home's rate plus personal care allowance). Exclude the protected individual's current SSA widow(er)'s benefit amount.

   Compare the total countable income to the current AG limit (home's rate plus personal care allowance). If countable income is within that limit, the protected individual is eligible for Medicaid in this protected group.

3) If the individual is not income eligible, the individual must be evaluated for Medicaid eligibility in other covered groups. However, when determining eligibility in another covered group, count all current income including the current SSA benefit amount.

D. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

The ACs are:

- 021 for an aged individual;
- 041 for a blind individual;
- 061 for a disabled individual.

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M0320.205 QUALIFIED SEVERELY IMPAIRED INDIVIDUALS (QSII)-1619(B) STATUS

A. Introduction

42 CFR 435.121 - Under Section 1619(a) of the Social Security Act, a disabled individual who would otherwise lose SSI because of work and the demonstration of the ability to perform substantial gainful activity but continue*s* to have a disabling impairment can continue to receive special SSI benefits if he continues to be financially eligible for SSI benefits based on income.

Section 1619(b) of the Act allows a disabled individual whose income is too high to retain financial eligibility for the special SSI benefit under Section 1619(a) and a blind individual who lost regular SSI payments to continue to receive Medicaid benefits under certain criteria specified in Section 1619(b).

The Social Security Administration (SSA) determines whether an individual who lost SSI because of earned income is eligible for 1619(b) status. The local department of social services determines whether an individual who has a 1619(b) status continues to be Medicaid eligible.

B. Identifying QSII Individuals

To identify a QSII individual, check the "Medicaid Test Indicator" field on the State Verification Exchange System (SVES) WMVE9068 screen *or the* SOLQ-I screen. If there is a code of A, B, or F, the individual has 1619(b) status.

Since eligibility for 1619(b) can change, check the SVES or SOLQ-I at each redetermination and when there is an indication that a change may have occurred.

C. Determining Eligibility

1. Nonfinancial Eligibility

The QSII individual must have been eligible for and receiving Medicaid coverage as an SSI recipient (must have met the more restrictive real property requirement) in the month immediately preceding the first month of the 1619(b) status. The "Current Pay Status Effective Date" field on the SVES WMVE9065 screen shows the first month of the 1619(b) status.

NOTE: If you cannot determine the first month of 1619(b) status, contact SSA.

2. Financial Eligibility

a. Resource Eligibility

Use the following to determine if the QSII recipient has real property resource(s):

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

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

3) ownership (equity value) of an individual's former residence when the QSII recipient is in an institution for longer than 6 months. Determine if the former residence is excluded under policy in section M1130.100 D;

4) equity value in property owned jointly by the QSII recipient and another person who is not the individual's spouse as tenants in common or joint tenants with the right of survivorship at common law. Determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;

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

When a QSII recipient has any of the real property listed in 1) through 5) previously, ALL of the recipient's resources must be verified, evaluated, and counted together to determine if the recipient meets the Medicaid resource requirements. Calculate resources according to the assistance unit policy in chapter M05. If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible for Medicare Savings Program (MSP) limited-benefit Medicaid (which has more liberal resource methods and standards).

When a QSII recipient has no real property resource listed in 1) through 5) previously, do NOT determine the recipient's resources. The QSII recipient meets the Medicaid resource requirements because his resource eligibility for QSII has been determined by SSA and he does not have a real property resource as listed previously.

b. Income Eligibility

There are no income eligibility requirements for QSII individuals once they have been determined eligible as 1619(b).

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D. Entitlement & Enrollment

Eligible individuals are entitled to full Medicaid coverage. The *ACs are:*

- 21 for an aged individual;
- 41 for a blind individual; or
- 61 for a disabled individual.

***E.* Individuals Ineligible as QSII**

Individuals who are ineligible as QSII because they:

- did not receive Medicaid in the month immediately preceding the month in which SSA first determined them eligible under 1619(b) or

- lost 1619(b) status

must be evaluated for Medicaid eligibility in other covered groups.

NOTE: An individual who has 1619(b) status continues to meet the disabled definition. An individual who no longer has 1619(b) status may not meet the disabled definition.

M0320.206 PROTECTED ADULT DISABLED CHILDREN

A. Policy

Section 1634(c) of the Social Security Act was amended in 1987 (P.L. 99-643 §6(b)) to state that if any individual who has attained the age of 18 and is receiving benefits under Title XVI (the Supplemental Security Income program) on the basis of blindness or a disability which began before he or she attained the age of 22

- becomes entitled, on or after the effective date of this subsection (July 1, 1987), to child's insurance benefits which are payable under section 202(d) on the basis of such disability or to an increase in the amount of the child's insurance benefits which are so payable; and

- ceases to be eligible for SSI because of such child's insurance benefits under the title or because of the increase in such child's insurance benefits,

shall be treated as receiving SSI benefits for Medicaid eligibility purposes so long as he/she would be eligible for SSI in the absence of such child's insurance benefits or such increase.

B. Nonfinancial Eligibility

A protected adult disabled child is one who:

- has reached the age of 18 years and receives SSI payments on the basis of blindness or a disability which began before he or she reached the age of 22 years;

- on or after July 1, 1987, becomes entitled to SSA Title II disabled child's insurance benefits on the basis of such disability, or receives an increase in Title II disabled child's insurance benefits;



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- becomes ineligible for SSI on or after July 1, 1987 because of the receipt of, or increase in, Title II disabled child's benefits;
- has resources within the current Medicaid resource limit; and
- has income which, in the absence of the Title II disabled child's benefit, or in the absence of the increase in such benefit, is within the current SSI income limit.

C. Financial Eligibility

Determine whose resources and income will be counted or deemed available according to the assistance unit policy in chapter M05.

1. Resources

Financial eligibility is determined by comparing the protected individual's resources to the current Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). Calculate resources according to the assistance unit policy in chapter M05. If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this protected covered group; he/she may be eligible in an MSP covered group (which has more liberal resource methods and standards).

2. Income

a. Receipt of SSA Child's Benefits Causes SSI Ineligibility

If the individual began receiving adult disabled child's benefits and this receipt caused SSI ineligibility, then the entire adult disabled child's benefit amount and any subsequent increases in the benefit are excluded when determining the individual's countable income.

In determining whether the adult disabled child's income, in absence of the Title II adult disabled child's benefit is within the current SSI income limit, all of the adult disabled child's other current countable income must be within the current SSI individual limit, or couple limit if the individual is married and living with his/her spouse. Calculate income according to the assistance unit policy in chapter M05, including deeming of parent(s)' income when the individual is under age 21 and living with a parent(s). **Exclude all of the protected individual's current SSA adult disabled child's benefit amount.**

Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected individual is eligible for Medicaid in this protected covered group.

If countable income exceeds the SSI limit, determine the individual's eligibility in another Medicaid covered group.

b. Increase In SSA Child's Benefits Causes SSI Ineligibility

If the individual received an increase in disabled child's benefits and this increase caused SSI ineligibility, only the increase which caused SSI



ineligibility is excluded when determining the individual's countable income. Calculate income according to the assistance unit policy in chapter M05, including deeming of parent(s)' income when the individual is under age 21 and living with a parent(s). Exclude the amount of the increase which caused SSI ineligibility.

1) Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected individual is eligible for Medicaid in this protected covered group.

   In this situation, the adult disabled child received SSI and SSA concurrently, and lost SSI because of an increase in SSA disabled child's benefits. The amount of the increase that caused SSI ineligibility is excluded. No subsequent increases in the disabled child's benefit are excluded when reviewing the individual's eligibility as a protected adult disabled child. However, if the protected adult disabled child becomes ineligible for Medicaid, evaluate his/her Medicaid eligibility as a protected former SSI recipient using the policy and procedures in Section M0320.201 of this chapter.

2) If countable income exceeds the SSI limit, determine the individual's eligibility in another covered group. If the individual does not meet an F&C MI covered group, is not institutionalized, is not receiving CBC or does not have Medicare Part A, he/she must be evaluated in a medically needy covered group.

D. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

The ACs are:

- 021 for an aged individual;
- 041 for a blind individual;
- 061 for a disabled individual.

M0320.207 PROTECTED SSI DISABLED CHILDREN

A. Introduction

The Balanced Budget Act of 1997 (P.L. #105-33) created a new covered group which protects Medicaid eligibility for disabled children who received SSI, whose SSI is canceled solely because the children do not meet the SSI definition of childhood disability (revised per section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996), and who would be paid SSI but for the change in the childhood disability definition.

Note: The group of Protected SSI Disabled Children is no longer applicable as all affected children are over age 18; however, it remains in federal regulations.



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B. Nonfinancial Eligibility Requirements

To be eligible in this protected covered group, the protected SSI disabled child must

- have had his/her SSI canceled solely because he/she does not meet the SSI definition of childhood disability (revised per section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996);
- continue to meet the SSI childhood disability definition and regulations that were in effect prior to the effective date of the change in the disability definition (August 22, 1996); and
- be under age 18 years.

Note: All affected children are now over age 18 years.

1. Disability Determination Referral to Disability Determination Services (DDS)

An SSI disabled child is presumed to meet the childhood disability definition in effect prior to August 22, 1996, until he/she reaches age 18 years, unless there is an improvement in the child's condition. If the child's condition improves, complete

- DDS Referral Form, available on SPARK at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*
- the Disability Report Child (SSA-3820-BK), available at http://www.socialsecurity.gov/online/ssa-3820.pdf **and**
- a minimum of 3 signed, original Authorization to Disclose Information to the Social Security Administration forms (SSA-827), available at http://www.socialsecurity.gov/online/ssa-827.pdf **or** a form for each medical provider if more than 3. "General Authorization for Medical Information" (form #032-03-311) for each medical practitioner reported by the individual on the report.

Send the report(s) and authorization forms to the DDS.

2. DDS Decision

If the DDS decides that the child continues to meet the childhood disability definition in effect prior to August 22, 1996, the child continues eligible in the protected group of SSI disabled children, provided the child meets the financial eligibility requirements in item C. below.

If the DDS decides that the child no longer meets the childhood disability definition in effect prior to August 22, 1996, the child no longer meets the protected group of SSI disabled children. Determine the child's eligibility in another covered group. If the child is not eligible in any covered group, send an advance notice to the authorized representative and take action to cancel the child's Medicaid coverage.

C. Financial Eligibility Procedures

1. Assistance Unit

Follow the policy and procedures in M0530.

2. Resource Eligibility

Resource eligibility is determined by comparing the SSI disabled child's countable resources to the current ABD Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). Calculate resources according to the assistance unit policy in subchapter M0530. If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the child is NOT eligible in the protected SSI disabled children covered group; he/she may be eligible as *FAMIS Plus (see M0330.300)* if he/she is under age 19 years.

3. Income Eligibility

Income eligibility is determined by comparing the SSI disabled child's income to the current SSI payment limit for an individual. Determine countable income using policy in Chapter S08. Calculate income according to the assistance unit policy in subchapter M0530. If countable income is within the SSI payment limit, the child is eligible for Medicaid in the covered group of protected SSI disabled children.

D. Entitlement & Enrollment

Children eligible for Medicaid in the covered group of protected SSI disabled children are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible protected SSI disabled children are enrolled with program designation "61."

M0320.300 ABD WITH INCOME ≤ 80% FEDERAL POVERTY LIMIT (FPL)

A. Policy

Section 1902(m) of the Social Security Act allows a State to provide full Medicaid benefits to the categorically needy covered group of aged, blind and disabled individuals whose income is less than or equal to a percentage of the federal poverty limit (FPL).

The 2000 Appropriations Act mandated that effective July 1, 2001, the State Plan for Medical Assistance be amended to add the covered group of aged, blind and disabled individuals with income less than or equal to 80% FPL.

An eligible individual's resources must be within the SSI resource limits.

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B. Financial Eligibility

1. Assistance Unit The assistance unit policy and procedures in chapter M05 apply to ABD individuals with income less than or equal to 80% FPL. If not institutionalized, deem or count any resources and income from the individual's spouse with whom he lives. If institutionalized with a community spouse, go to subchapter M1480.

2. Resources The resource limit is $2,000 for an individual and $3,000 for a couple.

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

All of the individual's resources must be verified and evaluated. All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements.

3. Income The income limits are ≤ 80% of the FPL and are in section M0810.002. The income requirements in chapter S08 must be met.

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

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

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

E. Enrollment The ABD 80% group AC is:

- 029 for an aged individual;
- 039 for a blind individual;
- 049 for a disabled individual; or
- 109 for all incarcerated individuals.

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M0320 Changes

Changed With	Effective Date	Sections Changed
TN #DMAS-35	7/1/25	M0320.400 M0320.500 (formatting only)

Virginia Medical Assistance Eligibility Manual Chapter M03

Section Revision Date July 2025

M0320.000 AGED, BLIND & DISABLED GROUPS

M0320.400 MEDICAID WORKS

A. Policy

The Appropriations Act of 2006 authorized an amendment to the Virginia State Plan for Medical Assistance that allows disabled (including blind) individuals to work and earn higher income while retaining Medicaid coverage. This program is called MEDICAID WORKS and includes individuals:

- at least age 16 and are under age 65, **and**
- who have countable income less than or equal to 138% FPL **and**
- who have countable resources less than or equal to $2,000 for an individual and $3,000 for a couple; **and**
- who are working or have a documented date for employment to begin in the future.
- Current participation in the Social Security Administration (SSA) programs Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) will satisfy the condition for disability. Any applicant without SSA documentation of disability should be evaluated by the state's Disability Determination Services program before eligibility can be established.

These individuals can retain Medicaid coverage as long as they remain employed, and their C*ountable* earned income is less than or equal to $6,250 per month. MEDICAID WORKS is Virginia's Medicaid Buy-In (MBI) program.

B. Relationship Between MEDICAID WORKS and 1619(b) Status

An individual with SSI or eligible for Medicaid as a Qualified Severely Impaired Individual (QSII) (1619(b)) must meet the 138% FPL income requirement for entry into MEDICAID WORKS and should not be discouraged from enrolling in MEDICAID WORKS. An individual who meets the criteria for 1619(b) status *and the 138% income limit* may choose to participate in MEDICAID WORKS because of the higher resource limit. SSI or eligible for Medicaid as a Qualified Severely Impaired Individual (QSII) (1619(b)) individuals are not automatically enrolled in Medicaid Works. They must be evaluated according to the non-financial and financial requirements used for all MEDICAID WORKS applicants and enrollees.



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Individuals may have their Social Security payments stop when their earnings are above the SSI threshold or SGA level. If the client would otherwise be eligible for a cash benefit if not for their earnings and has not had a determination of medical improvement following a Continuing Disability Review (CDR), they are still considered disabled for Medicaid Works purposes. Individuals receiving 1619(b) Medicaid protections who request enrollment in Medicaid Works are considered disabled but must have their income and resources evaluated according to the guidelines for initial eligibility.

C. Nonfinancial Eligibility

The individual must also meet the following additional non-financial criteria:

- The individual must be competitively employed in an integrated setting. Work must occur in a work setting in the community or in a personal business alongside people who do not have disabilities. Work performed in a *supervised* sheltered workshop *designed to provide employment opportunities for individuals with disabilities* or similar setting is not considered competitive employment in an integrated setting. Contact a Regional Medical Assistance Program Consultant if there is a question about whether the employment meets the criteria for MEDICAID WORKS.

- The individual must receive pay at the minimum wage or at the prevailing wage or "going rate" in the community, and the individual must provide documentation that payroll taxes are withheld. Self-employment must be documented according to the policy contained in S0820.210.

- The individual must establish a Work Incentive (WIN) Account at a bank or other financial institution, such as a checking or savings account which can be established prior to the application date. The individual must provide documentation for the case record designating the account(s) as a WIN Account. The account must either be a new account or an existing account with only earned income deposited into it. Increases in an enrollee's Social Security Disability benefits resulting from employment as a MEDICAID WORKS participant OR because of a COLA adjustment to the Social Security Disability benefits may also be deposited into the WIN account and will be excluded as described in M0320.400 D.3.b.3) if the increase is regularly deposited upon receipt into the WIN account. The WIN account cannot contain the individual's other Social Security benefits. The individual must provide statements from the institution where the account is held at application and renewal.

- *If there is only one disabled individual on a jointly held account, we presume that all the funds in the account belong to that individual.* A previously established ABLE account can be used as a WIN account.

- All individuals requesting enrollment in MEDICAID WORKS must also sign a MEDICAID WORKS agreement, available at Medical Assistance Forms or Medicaid Works Agreement. The agreement outlines the individual's responsibilities as an enrollee in the program.

D. Financial Eligibility

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1. **Assistance Unit**

   a. Initial eligibility determination

   To qualify for MEDICAID WORKS, the individual must meet the assistance unit policy and procedures in chapter M05 that apply to ABD non-institutionalized individuals. Individuals receiving SSI or who have 1619(b) status must also meet the income requirement for entry into MEDICAID WORKS.

   Income from a non-ABD spouse, non-applicant/member ABD spouse, or parents is not considered deemable income and is not counted for the initial eligibility determination for individuals requesting to participate in MEDICAID WORKS.

   Resources from the individual's spouse with whom he lives or, if under age 21, the individual's parents with whom he lives, must be deemed available.

   b. Ongoing eligibility

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

   Note: Children and non-spouse dependents are not included in the assistance unit when determining eligibility for MEDICAID WORKS.

2. **Resources**

   a. Initial eligibility determination

   For the initial eligibility determination, the resource limit is $2,000 for an individual and $3,000 for a couple. Resources must be evaluated for all individuals, including SSI recipients and QSII/(1619(b) individuals, who wish to qualify for MEDICAID WORKS. The resource requirements in chapter S11 and Appendix 2 to chapter S11 apply for the initial eligibility determination. The individual's countable, nonexempt resources must be verified. All countable resources, must be added together to determine if the individual's countable resources are within the limit. WIN accounts and other non-countable resources are excluded from the resource determination.

   b. Ongoing eligibility

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

   1) For earnings accumulated after enrollment in MEDICAID WORKS, up to the current 1619(b) income threshold amount will be disregarded if deposited and retained in the WIN Account. The 2024 1619(b) threshold amount is $45,976 (decreased from the 2023 amount). *The 2025 1619(b) threshold amount is $59,755*.
   2) Resources accumulated while in MEDICAID WORKS and held in Internal Revenue Service (IRS)-approved retirement accounts, medical or health savings accounts, medical reimbursement (flex) accounts, education accounts, independence accounts, and other similar State-approved accounts are excluded. Examples of these accounts include Archer Medical Savings Accounts, 401(k)/403(b)/457(b)/503(b) accounts, traditional Individual Retirement Accounts

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(IRAs), Roth IRAs, SEP-IRAs, SIMPLE IRAs, and Thrift Savings Plans. The account must be designated as a WIN Account to be excluded. Resources accumulated while in MEDICAID WORKS and held in IRS-approved accounts that have been designated as WIN Accounts are also excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees. The account must be exclusively used to hold resources accumulated while in MEDICAID WORKS (including interest) for the exclusion to continue. Resources can be spent however the individual chooses. *Transfer of assets policy does not apply to Medicaid Works*.

3) Resources can be spent however the individual chooses. Transfers will be evaluated to determine if a penalty should be calculated if the individual applies for (or is receiving) LTSS.
4) For all other resources, the resource requirements in chapter S11 and Appendix 2 to chapter S11 apply. All of the individual's countable, nonexempt resources must be verified and evaluated. All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements. The resource limit for resources not excluded in 1) or 2) above is $2,000 for an individual. Accounts are also excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees. The account must be exclusively used to hold resources accumulated while in MEDICAID WORKS (including interest) in order for the exclusion to continue.
5) For all other resources, the resource requirements in chapter S11 and Appendix 2 to chapter S11 apply. All the individual's countable, nonexempt resources must be verified and evaluated. All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements. The resource limit for resources not excluded in 1) or 2) above is $2,000 for an individual.

3. Income

a. Initial eligibility determination

For the initial eligibility determination on or after *January 15, 2025*, the limit for total countable income (unearned and earned) is less than or equal to 138% of the FPL (*$1,801* per month for an individual or *$2,434* when the applicant has an ABD spouse who is also applying for or covered by Medicaid). Use the rules in chapter M08 to determine income in the month of application. (see M0320.101).

b. Ongoing eligibility

Once the individual is enrolled in MEDICAID WORKS, the following income policies apply:
1) The income limit for earned income is $6,250 per month ($75,000 per year) (no change for *2025*) *if* the funds are deposited in a WIN Account. The policy for determining countable earned income is contained in subchapter M0820.
If the individual is self-employed, net earnings from self-employment (NESE) must be demonstrated through documentation of Internal Revenue Service (IRS) filings, quarterly estimated taxes, business records, and/or business plans. The individual's signed

allegation of self-employment is acceptable if no other evidence of NESE can be obtained. Follow the policy in M0820.220 *to determine* NESE.

2) The income limit for unearned income remains less than or equal to 138% of the FPL. The policy for determining countable unearned income is contained in subchapter M0830.

3) Any increase in an enrollee's Social Security Disability benefits resulting from employment as a MEDICAID WORKS participant OR because of a COLA adjustment to the Social Security Disability benefits will not be counted as long as the increase is regularly deposited upon receipt into the individual's WIN account.

4. **Income Exceeds 138% FPL at Eligibility Determination**
   Spenddown does not apply to the Medicaid Works covered group. Therefore, admission into MEDICAID WORKS is not available to individuals whose income exceeds 138% of the FPL. Evaluate the individual's eligibility in all other Medicaid covered groups.

G. Safety Net

Resources held in the WIN Account that are accumulated from the enrollee's earnings while in MEDICAID WORKS will be disregarded up to the 1619(b) threshold amount for this eligibility determination.

If found eligible and enrolled in another Medicaid covered group, the individual shall have a "safety-net" period of up to one year from MEDICAID WORKS termination and enrollment in another group to dispose of these excess resources before they are counted toward ongoing eligibility. If the individual resumes working within the safety-net period, he may be re-enrolled in MEDICAID WORKS provided that all eligibility requirements are met, except that the resources in the WIN Account are disregarded up to the 1619(b) threshold amount. If the individual wishes to be re-enrolled in MEDICAID WORKS after the one-year safety net period, any resources retained in the WIN Account remain exempt. **Resources accumulated while in MEDICAID WORKS and retained in an IRS approved account described in M0320.400 D. 2. b. 2) that has been designated as a WIN Account are excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees.**

H. Benefit Package

Individuals enrolled in MEDICAID WORKS are entitled to the standard benefits available to full-benefit Medicaid enrollees (see Chapter M18). Medicaid Works members cannot be enrolled in Developmental Disabilities (DD) waivers *or CCC Plus waivers*, but the waiver slot will be held for up to six months if a DD Waiver recipient wants to try transitioning to Medicaid Works. *Waiver slots are not held for CCC Plus recipients since there is no waiting list for CCC Plus waiver services.* Participants can receive personal care services as a service provided by the assigned MCO plan. ***No medical screening is required, and* MEDICAID WORKS enrollees do not have a patient pay responsibility.** Intensive Behavioral Dietary Counseling is also covered for MEDICAID WORKS enrollees when a physician determines that the service is medically necessary.

I. Entitlement and Enrollment

Entitlement for MEDICAID WORKS is dependent upon meeting the requirements listed

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above. *All requests for Medicaid Works should be evaluated and documented even if a member is currently eligible for Medicaid under another full or limited coverage category.*

There is no retroactive coverage under MEDICAID WORKS. The application date in the Virginia Case Management System (VaCMS) *is the date the signed Medicaid WORKS agreement is received by the LDSS.* Coverage shall begin on the first day of the month following the month in which all requirements are met. If the applicant has a future start date for employment, the effective date of eligibility shall be no earlier than the first day of employment. However, unless employment begins on the first day of the month, MEDICAID WORKS enrollment will begin on the first of the following month. If the person is already enrolled Medicaid, a new application is not required. Appendix D should be completed to gather additional information on resources. If the person is not currently enrolled in Medicaid, a *full* application is necessary.

The *Aid Category* for MEDICAID WORKS is **059**. Use the following procedures to enroll the individual in VaCMS:

New Application – Applicant is Disabled and enrolled in Medicaid

1. For the month of application and any retroactive months in which the person is eligible, enroll the individual in the appropriate AC in a closed period of coverage, beginning the first day of the month in which eligibility exists. The cancel date is the last day of the month in which the MEDICAID WORKS Agreement was signed. Use Cancel Code 042.
2. Reinstate the individual's coverage in MEDICAID WORKS using AC 059 beginning the first day of the following month (the first day of the month following the month in which the MEDICAID WORKS Agreement is *received*). Use the same application date (the actual date of the initial application) that was used for the month of application.

DMAS approval is not required for participation in MEDICAID WORKS; however, information must be sent to DMAS after the individual is enrolled for tracking purposes. Use the MEDICAID WORKS Email Cover Sheet available at Medical Assistance Forms, and **email** it together with the following information to DMAS at **MedicaidWorks@dmas.virginia.gov**:

- the signed MEDICAID WORKS Agreement,
- the Work Incentive Account (WIN) information (a bank account statement or verification from the bank that the account was opened), and
- a pay stub showing current employment or an employment letter with start date or self-employment document(s) to verify employment.

Current Enrollee

1. Cancel current coverage using Cancel Code 042.
2. Reinstate in AC 059 beginning the first day of the following month. **Use the date the MEDICAID WORKS Agreement was signed for the application date.**

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Send a Notice of Action to the applicant/recipient advising him of his eligibility and acceptance into MEDICAID WORKS. Do not send the Advance Notice of Proposed Action when a recipient moves to MEDICAID WORKS, because his Medicaid coverage has not been reduced or terminated.

Eligibility for MEDICAID WORKS continues as long as the enrollee continues to:

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

The MEDICAID WORKS enrollee continues to meet the disability criteria *unless* SSA has completed a Continuing Disability Review and has determined that the individual no longer has a disabling condition. The fact that the MEDICAID WORKS enrollee is earning over the SSA substantial gainful activity amount has no bearing on whether the disability criteria *is met*. *In addition, an individual can still be considered disabled by SSA and not receive a monthly payment. After checking the disability status and termination date by electronic sources and* if the enrollee's disability status *remains* unclear, contact a Regional Medical Assistance Program Consultant for assistance.

The individual's continuing eligibility must be determined at least every 12 months.

If the individual is no longer eligible for MEDICAID WORKS, *evaluate the individual to determine if* the individual remains eligible in any other covered group. **The policy in M0320.400 G above must be reviewed to determine whether the resource exclusion safety net rules apply.** If the individual is not eligible for Medicaid in any other covered group, coverage shall be cancelled effective the first of the month following the expiration of the 10-day advance notice.

Virginia Medical Assistance Eligibility Manual Chapter M03

Section Revision Date July 2025

M0320.000 AGED, BLIND & DISABLED GROUPS

M0320.500 300% of SSI INCOME LIMIT GROUPS

A. Introduction

The 300% of SSI income limit groups are for individuals who meet the definition of an institutionalized individual or have been authorized for long-term *services and supports (LTSS)* services (see M1410. B. 2) and are not eligible in any other full-benefit Medicaid covered group.

B. Covered Groups

- M0320.501 ABD in a Medical Institution, Income < 300% of SSI
- M0320.502 ABD Receiving Medicaid Waiver Services (CBC)
- M0320.503 ABD Hospice

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M0320.501 ABD IN MEDICAL INSTITUTION, INCOME ≤ 300% SSI LIMIT

A. Policy

42 CFR 435.236 - The state plan includes the covered group of aged, blind or disabled individuals in medical institutions who

- meet the Medicaid resource requirements, and
- have income that does not exceed 300% of the SSI individual payment limit (see M0810.002 A. 3).

Individuals who are *authorized* for nursing facility care prior to admittance and are likely to receive the services for 30 days or more consecutive days may also be included in this covered group.

B. Financial Eligibility

1. Asset Transfer

The individual must meet the asset transfer policy in subchapter M1450.

2. Resources

a. Resource Eligibility – Married Individual

If the individual is married, use the resource policy in subchapter M1480. Evaluate countable resources using ABD resource policy in chapter S11.

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

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he may be eligible in an MSP covered group (which has more liberal resource methods and standards).

b. Resource Eligibility - Unmarried Individual

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. Pay close attention to:

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

2) ownership of his/her former residence when the individual is in an institution for longer than 6 months. Determine if the former home is excluded in M1130.100 D.

If the individual is a blind or disabled child, DO NOT DEEM any resources or income from the child's parent; count only actual resources the parent makes available to the child. If current resources are within the limit, go on to determine income eligibility.



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If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible in an MSP covered group (which has more liberal resource methods and standards).

3. Income

To determine if an individual has income within the 300% of SSI limit, use **gross** income, not countable income. Determine what is income according to chapter S08 and subchapter M1460.

DO NOT subtract the $20 general exclusion or any other income exclusions. The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Effective 12/1/2024, Virginia's state Medicaid plan was updated to disregard Social Security Disability Income (SSDI) when determining eligibility for Long Term Services and Supports (LTSS) for approved Developmental Disability (DD) Waiver recipients. This change does not apply to CCC Plus waiver recipients.

The disregard is not applicable to the post-eligibility calculation of patient pay.

- *SSDI over and above the current SSI payment limit (see M0810.002) will be disregarded for Medicaid applicants offered a DD waiver slot dependent upon Medicaid eligibility and enrollment.*

- *SSDI over and above the current SSI payment limit will be disregarded at renewal or change for individuals approved for LTSS through a DD waiver.*

- *SSDI will be countable as applicable for the covered group(s) in which the individual is being re-evaluated if they are no longer approved for a DD waiver, for example no longer meeting the level of care (LOC) requirement.*

VaCMS will automatically disregard the SSDI income of a client who meets the above criteria counting only the SSI maximum income limit for one person. Additionally, the MA institutionalized screen and various elements of the Eligibility summary screen have been updated with this change.

Compare the total gross income to the 300% of SSI limit (see M0810.002 A. 3). If countable income is equal to or less than this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in this covered group. Evaluate his/her eligibility as medically needy.

C. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

If the individual has Medicare Part A, re-calculate the individual's income - subtract appropriate exclusions. Compare the countable income to the QMB and SLMB limits.

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1. Dual-eligible As QMB or SLMB *If the individual is also a Qualified Medicare Beneficiary (QMB) or Special Low Income Medicare Beneficiary (SLMB) - the individual has Medicare Part A and has countable income within the QMB or SLMB income limits - the AC is:*

- *022 for an aged individual also QMB;*
- *042 for a blind individual also QMB;*
- *062 for a disabled individual also QMB;*
- *025 for an aged individual also SLMB;*
- *045 for a blind or disabled individual also SLMB.*

2. Not QMB or SLMB *If the individual is NOT a QMB or SLMB - the individual does NOT have Medicare Part A, OR has countable income over the QMB and SLMB income limits - the AC is:*

- *020 for an aged individual NOT also QMB or SLMB;*
- *040 for a blind individual NOT also QMB or SLMB;*
- *060 for a disabled individual NOT also QMB or SLMB.*

D. Ineligible In This Covered Group *If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy spenddown. If the individual is not eligible for Medicaid in this covered group because of resources, determine the individual's eligibility as QMB, SLMB, QDWI or QI if he/she has Medicare Part A.*

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M0320.502 ABD RECEIVING MEDICAID WAIVER SERVICES (CBC)

A. Policy

42 CFR 435.217 - The state plan includes the covered group of aged, blind or disabled individuals in the community who

- would be eligible for Medicaid if institutionalized;
- are *authorized* to receive Medicaid waiver services and have selected the option to receive Medicaid waiver services in lieu of nursing facility services;
- in the absence of the waiver services would require the level of care furnished in a hospital, nursing facility or ICF-MR; and
- have income that does not exceed 300% of the SSI individual payment limit (see M0810.002 A. 3).

Do not wait until the individual starts to receive the waiver services to determine eligibility in this covered group. Determine eligibility in this covered group if the individual is *authorized* (see subchapter M1420) to receive Medicaid waiver services and has selected the option to receive Medicaid waiver services in lieu of nursing facility services. Presume the individual will receive the services and go on to determine financial eligibility using the policy and procedures in C. below.

If the individual's eligibility was determined as an institutionalized individual prior to the receipt of waiver services, the EW must verify the receipt of Medicaid CBC services within 30 days of the date of the Notice of Action on Medicaid. If Medicaid CBC services did not start within 30 days of the date of the Notice of Action on Medicaid, the individual's continued eligibility must be re-evaluated as a non-institutionalized individual.

B. Financial Eligibility

1. Asset Transfer

The individual must meet the asset transfer policy in subchapter M1450.

2. Resources

a. Resource Eligibility - Unmarried Individual

All of the individual’s resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements in chapter S11 (ABD Resources). Pay close attention to:

1) equity in non-exempt property contiguous to the individual’s home which exceeds $5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property, and
2) ownership of his/her former residence when the individual has been away from his home property for longer than 6 months. Determine if the home property is excluded in M1130.100.

DO NOT DEEM any resources from a blind or disabled child’s parent

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living in the home. Count actual resources the parent makes available to the child.

If current resources are within the limit, then determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible for Medicaid in this covered group.

b. Resource Eligibility - Married Individual

If the individual is married and has a community spouse, use the resource policy in subchapter M1480. If the individual is married, but has no community spouse, use the resource policy in subchapter M1460. Evaluate countable resources using ABD resource policy in chapter S11.

If current resources are within the limit, then determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible in an MSP covered group (which has more liberal resource methods and standards).

3. Income

To determine if an individual has income within the 300% of SSI limit, use **gross** income, not countable income. Determine what is income according to chapter S08 and subchapter M1460.

DO NOT subtract the $20 general exclusion or any other income exclusions. The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Effective 12/1/2024, Virginia's state Medicaid plan was updated to disregard Social Security Disability Income (SSDI) when determining eligibility for Long Term Services and Supports (LTSS) for approved Developmental Disability (DD) Waiver recipients. This change does not apply to CCCPlus waiver recipients.

The disregard is not applicable to the post-eligibility calculation of patient pay.

- *SSDI over and above the current SSI payment limit will be disregarded for Medicaid applicants offered a DD waiver slot dependent upon Medicaid eligibility and enrollment.*

- *SSDI over and above the current SSI payment limit will be disregarded at renewal or change for individuals approved for LTSS through a DD waiver.*

- *SSDI will be countable as applicable for the covered group(s) in which the individual is being re-evaluated if they are no longer approved for a DD waiver, for example no longer meeting the level of care (LOC) requirement.*

VaCMS will automatically disregard the SSDI income of a client who meets the above criteria counting only the SSI maximum income limit for one person. Additionally, the MA institutionalized screen and various elements of the Eligibility summary screen have been updated with this change.

C. Entitlement & Enrollment

Compare the total gross income to the 300% of SSI limit (see M0810.002 A. 3). If countable income is equal to or less than this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in this covered group. Evaluate his/her eligibility as medically needy. Individuals *eligible* in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met. Retroactive coverage does not apply to this covered group because an individual cannot be eligible in this covered group until he/she applies for Medicaid. [The individual cannot have received Medicaid covered waiver services in the retroactive period because he was not receiving Medicaid on or before the date he applied.]

If the individual has Medicare Part A, re-calculate the individual's income - subtract the appropriate exclusions. Compare the countable income to the QMB and SLMB limits.

1. Dual-eligible As QMB or SLMB

If the individual is also a Qualified Medicare Beneficiary (QMB) or Special Low Income Medicare Beneficiary (SLMB) - the individual has Medicare Part A and has countable income within the QMB or SLMB income limits - the AC is:

- 022 for an aged individual also QMB;
- 042 for a blind individual also QMB;
- 062 for a disabled individual also QMB;
- 025 for an aged individual also SLMB;
- 045 for a blind or disabled individual also SLMB.

2. Not QMB or SLMB

If the individual is NOT a QMB or SLMB - the individual does NOT have Medicare Part A, OR has countable income over the QMB and SLMB income limits - the AC is:

- 020 for an aged individual NOT also QMB or SLMB;
- 040 for a blind individual NOT also QMB or SLMB;
- 060 for a disabled individual NOT also QMB or SLMB.

D. Ineligible In This Covered Group

If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy spenddown. Determine the individual's eligibility as QMB, SLMB, QDWI or QI if he/she has Medicare Part A.

M0320.503 ABD HOSPICE

A. Policy

SMM 3580-3584 - The state plan includes the covered group of aged, blind or disabled individuals who are terminally ill and elect hospice benefits.

The ABD Hospice covered group is for individuals who have a signed a hospice election statement in effect for at least 30 consecutive days, and who are not eligible in any other full-benefit Medicaid covered group. Hospice care is a covered service for individuals in all full-benefit covered groups; individuals who need hospice services but who are eligible in another full-benefit covered group do not meet the Hospice covered group.

Individuals receiving hospice services in the ABD Hospice Covered group may also receive services the *Commonwealth Coordinated Care Plus (CCC Plus)* Waiver, if the services are authorized by the Department of Medical Assistance Services (DMAS) (see M1440.101).

The individual must elect hospice care. Election of hospice care is verified either verbally or in writing from the hospice. If the verification is verbal, document the case record. Eligibility in the Hospice covered group is ongoing as long as the individual continues to receive hospice care, subject to a renewal of eligibility at least once every 12 months. The eligibility worker must verify that the hospice agreement is current at the time of the annual Medicaid renewal.

The 30-day requirement begins on the day the hospice care election statement is signed. Once the hospice election has been in effect for 30 consecutive days, the 300% of SSI income limit is used to determine Medicaid eligibility. If the individual's income is within 300% of SSI, eligibility in the Hospice covered group may be determined beginning with the month in which the hospice election was signed.

Individuals who already meet the definition of institutionalization in M1410.010 B.2 at the time of hospice election meet the 30-day requirement, provided there is no break between institutionalization and hospice election.



Individuals who meet the Hospice covered group may have their eligibility determined using the same financial requirements as institutionalized individuals.

B. Financial Eligibility

1. Asset Transfer

The individual in the hospice covered group must meet the asset transfer policy in subchapter M1450.

2. Resources

The hospice services recipient is an assistance unit of 1 person. All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements.

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

If current resources are NOT within the limit, the individual is NOT eligible for Medicaid in this covered group. He/she may be eligible in *an MSP* covered group (which has more liberal resource methods and standards).

a. Unmarried Individual

If the individual is unmarried or is married and has no community spouse, use the resource policy in chapter S11 and subchapter M1460.

b. Married Individuals

If the individual is married and has a community spouse, use the resource policy in chapter S11 and subchapter M1480.

3. Income

To determine if an individual has income within the 300% of SSI limit, use **gross** income, not countable income. Determine what is income according to chapter S08 and subchapter M1460.

DO NOT subtract the $20 general exclusion or any other income exclusions. The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Compare the total gross income to the 300% of SSI limit (see M0810.002 A. 3). If countable income is equal to or less than this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in this covered group. Evaluate his/her eligibility as medically needy.

C. Entitlement

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the month in which all eligibility requirements are met. Retroactive coverage is applicable to this covered group.

If the individual has Medicare Part A, re-calculate the individual's income, applying the appropriate exclusions. Compare the countable income to the QMB *and SLMB* limits.



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D. Enrollment

Eligible individuals must be enrolled in the appropriate AC. If the individual is aged, blind, or disabled as defined in M0310, he is enrolled under the AC *for that covered group*. **AC (054) is used for "deemed-disabled" individuals only**. Use the appropriate Hospice AC when the individual is also authorized to receive CCC Plus waiver services.

For individuals who are ABD and entitled/enrolled in Medicare Part A, income must be recalculated (allowing appropriate disregards) to determine if the individual is dually eligible as a QMB or SLMB.

1. ABD Individual

a. Dual-eligible As QMB or SLMB

If the individual is also a Qualified Medicare Beneficiary (QMB) or Special Low Income Medicare Beneficiary (SLMB) - the individual has Medicare Part A and has countable income within the QMB or SLMB income limits - the AC is:

- 022 for an aged individual also QMB;
- 042 for a blind individual also QMB;
- 062 for a disabled individual also QMB
- 025 for an aged individual also SLMB;
- 045 for a blind or disabled individual also SLMB.

b. Not QMB or SLMB

If the individual is NOT a Qualified Medicare Beneficiary (QMB) the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit – the AC is:

- 020 for an aged individual NOT also QMB or SLMB;
- 040 for a blind individual NOT also QMB or SLMB;
- 060 for a disabled individual NOT also QMB or SLMB.

2. "Deemed" Disabled Individual

An individual who is "deemed" disabled based on the hospice election is enrolled using AC 054. Individuals in this AC who have also been approved to receive services under the EDCD Waiver do not need a disability determination.

E. Post-eligibility Requirements (Patient Pay)

A patient pay must be calculated for individuals who receive hospice services in a nursing facility (see subchapter M1470). Individuals who receive hospice services outside of a nursing facility do not have a patient pay.

Individuals who have elected hospice services and who also receive services available under the CCC Plus Waiver must have a patient pay calculation for the CCC Plus services (see subchapter M1470).

F. Ineligible In This Covered Group

There is no corresponding medically needy hospice covered group. If the individual is aged or has been determined blind or disabled, the individual must be evaluated in a medically needy covered group for medically needy spenddown.



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M0320.600 MEDICARE SAVINGS PROGRAM (MSP)

A. Introductions

The Medicare Saving Program is limited Medicaid coverage for individuals who are eligible for Medicare Part A and have income and resources within specific limits.

B. Covered Groups

- M0320.6*01* QMB
- M0320.6*02* SLMB
- M0320.6*03* QI

M0320.601 QUALIFIED MEDICARE BENEFICIARY (QMB)

A. Policy

42 CFR 435.121 - Qualified Medicare Beneficiaries are a mandatory CN covered group. Medicaid will pay the Medicare Part A premium (as well as the Part B premium) and deductibles and coinsurance for individuals eligible as QMB only.

A QMB is an individual who:

- is entitled to Medicare Part A hospital insurance benefits, but not entitled solely because he/she is eligible to enroll in Part A under section 1818A of the Act (1818A is applicable to QDWI);
- has resources that are within the resource limits for the Medicare Savings Programs (MSPs). See section M1110.003 for the current resource limits; and
- has income that does not exceed 100% of the federal poverty level (FPL).

B. Nonfinancial Eligibility

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1. Entitled to Medicare Part A

The individual must be entitled to or must be enrolled in Medicare Part A. The individual does not have to be aged, blind or disabled. However, Medicare entitlement is limited to individuals who are age 65 or older, or who have received Title II social security benefits because of a disability for 24 months, or who have end stage renal (kidney) disease.

Enrollment in Part A of Medicare is verified by the individual's Medicare card, or by communication (such as SVES) with the Social Security Administration (SSA).

2. Individual Not Currently Enrolled In Medicare Part A

Individuals who are not currently enrolled in Medicare Part A must apply for and enroll in Medicare Part A at the local Social Security Administration (SSA) office, and must present verification of Medicare Part A enrollment to
the local department of social services (DSS) in order to be eligible for

Medicaid as QMB.

If an individual appears to be eligible for Medicare but is not enrolled in Medicare, refer him to the SSA district office to apply for Medicare enrollment.

If an individual must pay a monthly premium for Medicare Part A, and cannot afford the premium, the SSA office will give the individual a bill for the premium when the individual is enrolled. The individual must present this bill and the Medicare Part A enrollment verification to the local DSS worker in order to be eligible for Medicaid as a QMB.

NOTE: A disabled working individual who is enrolled or is eligible to enroll in Medicare Part A under Section 1818A of the Social Security Act **cannot** be enrolled as a QMB; he may be eligible as a Qualified Disabled and Working Individual (QDWI). See M0320.604 below for information on the QDWI covered group.0

3. Verification Not Provided

If the applicant does not provide information documenting enrollment in Medicare Part A within the application processing time standard, he is not eligible for Medicaid as QMB, but may be eligible for Medicaid in another covered group.

C. Financial Eligibility

1. Assistance Unit

The assistance unit policy in chapter M05 applies to QMBs.

If the QMB individual is living with his spouse who is aged, blind, or disabled, but does not have Medicare Part A, and both apply for Medicaid, two different financial calculations must be completed for the unit because of the different income limits used in the eligibility determinations. One is the MSP QMB determination; the other is for the ABD spouse's CN or MN covered group.

2. Resources

The resource requirements in chapter S11 and Appendix 2 to chapter S11 must be met by the MSP Medicare beneficiary. Some of the real and personal property requirements are different for QMBs. The different requirements are identified in Appendix 2.

The resource limit for an individual is the resource limit for the MSPs. See section M1110.003 for the current resource limits.

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3. Income

The income requirements in chapter S08 must be met by QMBs. The income limits are in M0810.002. **By law, for QMBs who have SSA benefits, the new QMB income limits are effective the first day of the second month following the month in which the federal poverty limit is updated.** For QMBs who do NOT have SSA benefits, the new QMB income limits are effective the date the updated FPL is published. Local DSS are notified each year of the new FPL via the broadcast system. Check that system to ascertain when the SSA COLA must be counted in determining QMB income eligibility.

4. Income Exceeds QMB Limit

Spenddown does not apply to the MSP income limits. If the individual's income exceeds the QMB limit, he is not eligible as QMB and cannot spenddown to the QMB limit. Determine the individual's eligibility in the SLMB covered group below in M0320.602.

At application and renewal, if the eligible QMB individual's resources are within the medically needy limit and the individual meets a MN covered group, place the individual on two 6-month spenddown based on the MN income limit.

D. QMB Entitlement

Entitlement to Medicaid coverage for QMB only begins the first day of the month **following** the month in which Medicaid eligibility as a QMB is *determined and approved, **not** the month of application. See M1520.102.A.2.*

Because QMB coverage does not begin until the month following the month in which eligibility is *determined and approved*, an applicant who is eligible for QMB coverage must apply for Extra Help in order to receive the subsidy for the month of QMB approval. See chapter M20 for more information on Extra Help.

Retroactive eligibility does **not** apply to the QMB covered group. To be eligible for Medicaid in the retroactive period, and in the application month, a QMB must meet the requirements of another Medicaid covered group.

E. Enrollment

1. Aid Categories

The following ACs are used to enroll individuals who are only eligible as QMBs; they do not meet the requirements of another covered group:

- 023 for an aged QMB only;
- 043 for a blind QMB only;
- 063 for a disabled or end-stage renal disease QMB only.

2. Enrollee's Covered Group Changes To QMB

If a Medicaid enrollee becomes **ineligible** for full-coverage Medicaid because of an increase in income or resources, but is eligible as a QMB, the agency must send an advance notice of proposed action to the enrollee because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare premiums, deductibles and coinsurance amounts as a QMB.



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Cancel the enrollee's full coverage effective the last day of the month, using cancel reason "007." Reinstate the enrollee's coverage with the begin date as the first day of the month following the cancellation effective date. The AC is QMB-only.

3. QMB *Becomes Eligible For* Full Coverage

When an enrolled QMB-only becomes eligible in another covered group which has full Medicaid coverage, except when he/she meets a spenddown, e.g., a QMB-only individual's resources change to below the MN limits:

- cancel the QMB-only coverage effective the last day of the month immediately **prior** to the month in which he/she became eligible in the full coverage covered group, using cancel reason "024";
- reinstate the enrollee's coverage with the begin date as the first day of the month in which he/she became eligible in the full coverage covered group, with the appropriate full coverage AC.

4. Spenddown Status

At application and redetermination, eligible QMBs who meet an MN covered group and who have resources that are within the lower MN resource limits are placed on two 6-month medically needy spenddowns. All spenddown periods are based on the application or renewal date, as appropriate. See M1370.

In order to be placed on spenddown, QMBs with end-stage renal disease must meet a medically needy covered group.

5. QMB Meets Spenddown

When an eligible QMB meets the spenddown, cancel the QMB-only coverage effective the day before the spenddown was met, using cancel reason "024". Reinstate the enrollee's coverage with the first date the spenddown was met as the begin date of coverage, and enter the end date of the spenddown period as the end date of coverage. The aid category is medically needy dual-eligible:

- 028 for an aged MN individual also eligible as QMB;
- 048 for a blind MN individual also eligible as QMB;
- 068 for a disabled MN individual also eligible as QMB.

6. Spenddown Period Ends

After the spenddown period ends, reinstate the QMB-only coverage using the appropriate QMB-only AC. The begin date of the reinstated coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial QMB eligibility.

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7. QMB Enters Long-term Care

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

M0320.602 SPECIAL LOW INCOME MEDICARE BENEFICIARY (SLMB)

A. Policy

1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act - Coverage of Special Low-income Medicare Beneficiaries is mandated by the federal Medicaid law. Medicaid will only pay the Medicare Part B premium for individuals eligible as SLMB.

An SLMB is an individual who meets all of the eligibility requirements for QMB (M0320.*601* above) EXCEPT for income that exceeds the QMB limit but is less than the higher limit for SLMB. Like QMBs, eligible SLMBs who meet an MN covered group are also placed on a medically needy spenddown if resources are within the medically needy limit.

An SLMB individual

- is entitled to Medicare Part A hospital insurance benefits, but not entitled solely because he/she is eligible to enroll in Part A under section 1818A of the Act (1818A is applicable to QDWI);
- has resources that are within the resource limits for the Medicare Savings Programs (MSPs). See section M1110.003 for the current resource limits; and
- has income that exceeds the QMB limit (100% of the FPL) but is less than 120% of the FPL.

B. Nonfinancial Eligibility

1. Entitled to Medicare Part A

The individual must be entitled to or must be enrolled in Medicare Part A. The individual does not have to be aged, blind or disabled.

Enrollment in Part A of Medicare is verified by the individual's Medicare card, or by communication (such as SVES) with the Social Security Administration (SSA).

2. Individual Not Currently Enrolled In Medicare Part A

Individuals who are not currently enrolled in Medicare Part A must apply for and enroll in Medicare Part A at the local Social Security Administration (SSA) office, and must present verification of Medicare Part A enrollment to the local department of social services (DSS) in order to be eligible for Medicaid as SLMB.

If an individual appears to be eligible for Medicare but is not enrolled in Medicare, refer him/her to the SSA district office to apply for Medicare enrollment.

If an individual must pay a monthly premium for Medicare Part A, and cannot afford the premium, the SSA office will give the individual a bill for the premium when the individual is enrolled. The individual must present this bill and the Medicare Part A enrollment verification to the local DSS worker in order to be eligible for Medicaid as an SLMB.

NOTE: A disabled working individual who is enrolled or is eligible to enroll in Medicare Part A under Section 1818A of the Social Security Act **cannot** be enrolled as SLMB; he/she may be eligible as a Qualified Disabled and Working Individual (QDWI). See M0320.604 below for information on the QDWI covered group.

3. Verification Not Provided

If the applicant does not provide information documenting enrollment in Medicare Part A within the application processing time standard, he/she is not eligible for Medicaid as SLMB, but may be eligible in another covered group.

C. Financial Eligibility

1. Assistance Unit

The assistance unit policy in chapter M05 applies to SLMBs.

If the SLMB individual is living with his/her spouse who is aged, blind, or disabled, but does not have Medicare Part A, and both apply for Medicaid, two different financial calculations must be completed for the unit because of the different income limits used in the eligibility determinations. One is the MSP SLMB determination; the other is for the ABD spouse's CN or MN covered group.

2. Resources

The resource requirements in chapter S11 and Appendix 2 to Chapter S11 must be met by the SLMB. Some of the real and personal property requirements are different for SLMBs. The different requirements are identified in Appendix 2.

The resource limits are the resource limits for the Medicare Savings Programs (MSPs). See section M1110.003 for the current resource limits.

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3. Income

The income requirements in chapter S08 must be met by SLMBs. The income limits for SLMBs are in M0810.002. An SLMB's income must exceed the QMB limit and must be less than the SLMB limit.

By law, for SLMBs who have Title II benefits, the new SLMB income limits are effective the first day of the second month following the month in which the federal poverty limit is updated. For SLMBs who do NOT have Title II benefits, the new SLMB income limits are effective the date the updated federal poverty level is published.

Local DSS are notified each year of the new poverty limits via the broadcast system. Check that system to ascertain when the Title II COLA must be counted in determining SLMB income eligibility.

4. Income Equals or Exceeds SLMB Limit

Spenddown does not apply to the MSP income limits. If the individual's income is equal to or exceeds the SLMB limit, he/she is not eligible as SLMB and cannot spenddown to the SLMB limit. At application and redetermination, if the individual's resources are within the medically needy limit and the individual meets a medically needy covered group, place the individual on two 6-month spenddowns based on the MN income limit.

D. SLMB Entitlement

If all eligibility factors are met in the application month, entitlement to Medicaid as an SLMB begins the first day of the application month.

SLMBs are entitled to retroactive coverage if they meet all the SLMB requirements in the retroactive period. However, coverage under this group cannot begin earlier than January 1, 1993.

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

E. Enrollment

1. Aid Category

The AC for all SLMBs is "053".

2. Enrollee's *Covered Group Changes To SLMB*

If a Medicaid recipient becomes ineligible for full-coverage Medicaid or QMB-only coverage because of an increase in income, but is eligible as an SLMB, the agency must send an advance notice of proposed action to the enrollee because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare Part B premiums as an SLMB.

Cancel the enrollee's full coverage effective the last day of the month, using cancel reason "007." Reinstate the enrollee's coverage with the begin date as the first day of the month following the cancellation effective date. The aid category (AC) is "053."

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3. SLMB *Becomes Eligible for* Full Coverage

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

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

4. Spenddown Status

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

All spenddown periods are based on the application or renewal date, as appropriate. See M1370.

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

5. SLMB Meets Spenddown

When an SLMB meets a spenddown, cancel his AC "053" coverage effective the date before the spenddown was met, using cancel reason "024". Reinstate the enrollee's coverage with the first date the spenddown was met as the begin date of coverage, and enter the end date of the spenddown period as the end date of coverage. The AC is medically needy dual-eligible as SLMB Plus:

- 024 for an aged MN individual also eligible as SLMB;
- 044 for a blind or disabled MN individual also eligible as SLMB.

6. Spenddown Period Ends

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

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

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7. SLMB Enters Long-term Care

- The enrollment of an SLMB who is admitted to long-term care and who becomes eligible for Medicaid in the 300% of SSI covered group is handled like an SLMB who meets a spenddown. Cancel the SLMB-only coverage effective the last day of the month before the month of admission to long-term care, reason "024". Reinstate the coverage with the begin date as the first day of the month of admission to long-term care using the appropriate AC for SLMB Plus.

  - 025 for an aged individual also SLMB;
  - 045 for a blind or disabled individual also SLMB.

M0320.603 QUALIFIED INDIVIDUAL (QI)

A. Policy

P.L. 105-33 (Balanced Budget Act of 1997) mandated Medicaid coverage of Qualified Individuals who would be QMBs except that their income exceeds the QMB income limit. Implemented on January 1, 1998, individuals in the QI covered group receive Medicaid coverage for the payment of their Medicare Part B premium.

Prior to 2015, funding for the QI covered group was subject to annual availability by Congress. QI funding became permanent in 2015, and the QI covered group is subject to the same policies regarding entitlement and enrollment as the SLMB covered group.

A QI

- is entitled to Medicare Part A hospital insurance benefits, but not entitled to Medicare Part A solely because he/she is a QDWI (enrolled in Part A under section 1818A of the Act);
- has resources that are within the resource limits for the Medicare Savings Programs (MSPs). See chapter section M1110.003 for the current resource limits; and
- has income that is equal to or exceeds the SLMB limit (120% of the FPL) but is less than the QI limit (135% of the FPL).

B. Nonfinancial Eligibility

1. Entitled to Medicare Part A

The QI must be entitled to or must be enrolled in Medicare Part A. The individual does not have to be aged, blind or disabled.

Enrollment in Part A of Medicare is verified by the individual's Medicare card, or by communication (such as SVES) with the Social Security Administration (SSA).

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2. Individual Not Currently Enrolled In Medicare Part A

Individuals who are not currently enrolled in Medicare Part A must apply for and enroll in Medicare Part A at the local Social Security Administration (SSA) office, and must present verification of Medicare Part A enrollment to the local department of social services (DSS) in order to be eligible for Medicaid as *a* QI.

If an individual appears to be eligible for Medicare but is not enrolled in Medicare, refer him/her to the SSA district office to apply for Medicare enrollment.

If an individual must pay a monthly premium for Medicare Part A, and cannot afford the premium, the SSA office will give the individual a bill for the premium when the individual is enrolled. The individual must present this bill and the Medicare Part A enrollment verification to the local DSS worker in order to be eligible for Medicaid as a QI.

NOTE: A disabled working individual who is enrolled or is eligible to enroll in Medicare Part A under Section 1818A of the Social Security Act **cannot** be enrolled as *a* QI; he/she may be eligible as a Qualified Disabled and Working Individual (QDWI). See M0320.604 below for information on the QDWI covered group.

3. Verification Not Provided

If the applicant does not provide information documenting enrollment in Medicare Part A within the application processing time standard, he/she is not eligible for Medicaid as *a* QI, but may be eligible in another covered group.

C. Financial Eligibility

1. Assistance Unit

The ABD assistance unit policy in chapter M05 applies to *QIs*.

If the QI is living with his/her spouse who is aged, blind, or disabled, but does not have Medicare Part A, and both apply for Medicaid, two different financial calculations must be completed for the unit because of the different income limits used in the eligibility determinations. One is the QI determination; the other is for the ABD spouse's CN or MN covered group.

2. Resources

The resource requirements for QMBs in chapter S11 and Appendix 2 to Chapter S11 must be met by the QI.

The resource limits for QI are the resource limits for the MSPs. See section M1110.003 for the current resource limits.

3. Income

The income requirements in chapter S08 must be met by the QI. The income limits for QIs are in M0810.002. A QI's countable income must exceed the SLMB limit and must be less than the QI limit.

By law, for QIs who have Title II benefits, the new income limits are effective the first day of the **second** month following the month in which the federal poverty limit is updated. For QIs who do NOT have Title II benefits, the new income limits are effective the date the updated federal poverty limit is published. Local DSS are notified each year of the new poverty limits via the broadcast system. Check that system to ascertain when the Title II COLA must be counted in determining QI income eligibility.

4. Income Within QI Limit

When the individual's countable income is equal to or more than 120% of the FPL and is less than 135% of FPL (the QI limit), the individual is eligible for Medicaid as a QI. Go to subsection D below. If the individual's resources are within the MN limit and the individual meets a MN covered group, place the individual on two (2) 6-month spenddowns based on the MN income limit for his locality. See M0320.603 E.5 below.

5. Income Equals or Exceeds QI Limit

If the individual's income is equal to or exceeds the QI limit (135% of FPL), he/she is not eligible as QI.

D. QI Entitlement

If all eligibility factors are met in the application month, entitlement to Medicaid as a QI begins the first day of the application month. QIs are entitled to retroactive coverage if they meet all the QI requirements in the retroactive period.

D. Enrollment

1. Aid Category

The AC for all QIs is 056.

2. Enrollee's Covered Group Changes To QI

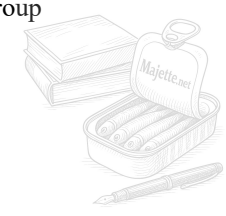
If Medicaid recipient becomes ineligible for full-coverage Medicaid but is eligible as a QI, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare Part B premiums as a QI.

Cancel the recipient's full coverage effective the last day of the month, using cancel reason 007. Reinstate the recipient's coverage with the begin date as the first day of the month following the cancellation effective date. Specify the appropriate QI AC.

3. Spenddown Status

At application and redetermination, eligible QIs who meet an MN covered group and who have resources that are within the lower MN resource limits are placed on two 6-month MN spenddowns. All spenddown periods are based on the application or renewal date, as appropriate. See M1370.

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



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4. *QI Meets Spenddown*

When a QI meets a spenddown, cancel his AC 056 coverage effective the day before the spenddown was met, using cancel reason 024. Reinstate the recipient's coverage with the first date the spenddown was met as the begin date of coverage, and enter the end date of the spenddown period as the end date of coverage, using the appropriate AC:

- *018 for an aged MN individual;*
- *038 blind MN individual*
- *058 for a disabled MN individual.*

5. *Spenddown Period Ends*

After the spenddown period ends, reinstate the QI coverage using AC 056.

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

6. *QI Enters LTC or Otherwise Becomes Eligible for Full Coverage*

When an enrolled QI becomes institutionalized or eligible in another covered group which has full Medicaid coverage, cancel the QI coverage effective the last day of the month immediately prior to the month in which he became eligible in the full coverage covered group, using cancel reason 024. Reinstate the coverage with the begin date as the first day of the month of admission to long-term care using the appropriate AC for the full-coverage group.

H. Covered Service

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

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M0320.604 QDWI (QUALIFIED DISABLED & WORKING INDIVIDUALS)

A. Policy

42 CFR 435.121 - Coverage of Qualified Disabled & Working Individuals is mandated by the federal Medicaid law. Medicaid will only pay the Medicare Part A premium for individuals eligible as QDWI.

B. Nonfinancial Eligibility

1. Definition Requirements

The individual must:

- be less than 65 years of age.
- be employed.
- have been entitled to Social Security disability benefits and Medicare Part A but lost entitlement solely because earnings exceeded the substantial gainful activity (SGA) amount.
- continue to have the disabling physical or mental impairment or be blind as defined by SSI and Medicaid but because he/she is working and earning income over the SGA limit does not meet the disability definition.
- be eligible to enroll or be enrolled in Medicare Part A (hospital insurance) under Section 1818A of the Social Security Act.
- not be eligible for Medicaid in any other covered group.

The above definition requirements must be verified by the Social Security Administration (SSA). The individual must be enrolled in Medicare Part A under Section 1818-A of the Social Security Act. Enrollment in Part A of Medicare is verified by the individual's Medicare card, or by communication (such as SVES) with SSA.

NOTE: Blind individuals who lose SSA and Medicare because of earnings over SGA still meet the blind category for Medicaid purposes. Therefore, a blind individual whose countable income is within the medically needy, or QMB limits cannot be eligible as a qualified disabled and working individual.

2. Verification Not Provided

If the applicant does not provide information documenting enrollment in Medicare Part A within the application processing time standard, he/she is not eligible for Medicaid as QDWI, but may be eligible in another covered group.

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C. Financial Eligibility The assistance unit policy in chapter M05 applies to QDWIs.

1. Assistance Unit If the QDWI individual is living with his/her spouse who is aged, blind, or disabled, but does not have Medicare Part A, and both apply for Medicaid, two different financial calculations must be completed for the unit because of the different income limits used in the eligibility determinations. One is the QDWI determination; the other is for the ABD spouse's covered group.

2. Resources The resource requirements in chapter S11 and Appendix 1 to Chapter S11 must be met by the QDWI Medicare beneficiary. Some of the real and personal property requirements are different for QDWIs. The different requirements are identified in Chapter S11, Appendix 1.

The resource limit for an individual is $4,000 (twice the SSI resource limit for an individual); the resource limit for a couple is $6,000 (twice the SSI resource limit for a couple).

3. Income QDWIs must meet the income requirements in chapter S08. The income limits are in M0810.002. QDWIs do not receive Title II benefits.

4. Income Exceeds QDWI Limit Spenddown does not apply to the MSP income limits. If the individual's income exceeds the QDWI limit, he/she is not eligible as QDWI and cannot spenddown to the QDWI limit. At application and redetermination, if the individual's resources are within the medically needy limit and the individual meets a medically needy covered group, place the individual on two 6-month spenddowns based on the MN income limit.

D. Entitlement Entitlement to Medicaid as a QDWI begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month, including enrollment in Medicare Part A under Section 1818A of the Social Security Act. Retroactive entitlement, up to three months prior to application, is applicable if all QDWI eligibility criteria were met during the period.

If the individual is not enrolled in Medicare Part A under Section 1818A as of the month he/she meets the Medicaid eligibility requirements, the individual's entitlement to Medicaid cannot begin until the first day of the month in which his Medicare Part A enrollment under Section 1818A is effective.

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

E. Enrollment

1. Aid Category The AC for all QDWIs is "055."

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2. Enrollee's AC Changes To QDWI

An enrolled enrollee's AC cannot be changed to AC "055" using a "change" transaction in *VaCMS*. If a Medicaid enrollee becomes ineligible for full-coverage Medicaid, but is eligible as a QDWI, the agency must send an advance notice of proposed action to the enrollee because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare Part A premiums as a QDWI.

Cancel the enrollee's full coverage effective the last day of the month, using cancel reason "007." Reinstate the enrollee's coverage as QDWI with the begin date as the first day of the month following the cancellation effective date. AC is "055."

3. QDWI's AC Changes To Full Coverage AC

When an enrolled QDWI becomes eligible in another covered group which has full Medicaid coverage (except when he/she meets a spenddown); e.g., he/she is no longer able to work and starts to receive SSA and SSI disability benefits:

- cancel the QDWI coverage effective the last day of the month immediately prior to the month in which he/she became eligible in the full coverage covered group, using cancel reason "024;"
- reinstate the enrollee's coverage with the begin date as the first day of the month in which he/she became eligible in the full coverage covered group, with the appropriate full coverage AC.

4. Spenddown Status

Eligible QDWIs who meet an MN covered group and who have resources that are within the lower MN resource limits are also placed on two 6-month medically needy spenddowns.

5. QDWI Meets Spenddown

When a QDWI meets a spenddown, cancel his AC "055" coverage effective the date before spenddown was met using cancel reason "024." Reinstate coverage as medically needy beginning the day the spenddown was met and ending the last day of the spenddown budget period.

The AC is NOT dual-eligible:

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

6. Spenddown Period Ends

After the spenddown period ends, reinstate the QDWI-only coverage using the AC "055."

The begin date of the reinstated AC "055" coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial QDWI eligibility.

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7. QDWI Enters Long-term Care

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

M0320.700 MEDICALLY NEEDY (MN) GROUPS

A. Introduction

1. Medically Needy Individuals

All medically needy covered groups are optional; the federal Medicaid law does not require the state to cover the MN groups in its Medicaid State Plan. Virginia has chosen to cover *individuals who*

- *meet all the nonfinancial requirements in chapter M02,*
- *meet the "Aged," "Blind" or "Disabled" definitions in subchapter M0310,*
- *have countable resources within the MN resource limits,*
- *are not financially eligible in a full-benefit CN covered group; and*
- *have insufficient income to meet their medical care needs.*

2. Spenddown Feature

The major feature of the MN covered groups is a spenddown. An individual who meets the nonfinancial and MN resource eligibility requirements but whose income exceeds the MN income limit may "spenddown" the excess income by deducting incurred medical expenses and become eligible for a limited period of MN Medicaid coverage. An individual who has excess income becomes eligible when he/she has incurred medical expenses equal to the difference between his/her income and the MN income limit.

3. Different Benefit Package

Some medical services that are covered for the CN covered groups are not available to the MN groups. ICF-MR services and IMD services are not covered for MN eligibles. However, the basic services such as inpatient and outpatient hospital, physicians, X-rays, prescription drugs, home health services and Medicare premiums, coinsurance and deductibles are covered for the MN. LTC nursing facility and most *CBC* waiver services are also covered for the MN.

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B. **ABD MN Covered Groups**

The ABD MN covered groups are:

- M0320.701 ABD
- M0320.702 December 1973 Eligibles

M0320.701 ABD MN INDIVIDUALS

A. Legal Base

The federal authority for covering ABD MN individuals is found in 42CFR435.330.

B. Financial Eligibility

1. Assistance Unit

The assistance unit policy and procedures in chapter M05 apply to ABD MN. If married and not institutionalized, deem or count any resources and income from the individual's spouse with whom he/she lives. If married and institutionalized, go to subchapter M1480 for resource and income determination policy and procedures.

2. Resources

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. The resources policy in chapter S11 applies.

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

If the individual is not eligible because of excess real property contiguous to the home, and he/she meets a medically needy Families & Children (F&C) definition, determine if the individual meets an F&C covered group since the F&C home property definition is more liberal for F&C. If the individual is not eligible because of other excess resources, he or she is not eligible as MN.

3. Income

Determine gross income according to chapter S08. Subtract the $20 general exclusion and other exclusions. Compare the total countable income to the MN income limit for the individual's locality group (see section S0810.002) and calculate the MN spenddown amount. See chapter M13 for spenddown policy and procedures.

4. Income Eligibility

An individual becomes eligible in this MN covered group when he/she has incurred medical expenses equal to the difference between his/her income and the MN income limit (spenddown).

C. Entitlement

Individuals who become eligible after meeting a spenddown are entitled to full Medicaid coverage beginning the day the spenddown was met and ending the last day of the sixth month in the spenddown budget period. Retroactive coverage is applicable to this covered group.

Note: Individuals receiving LTC services are placed on monthly spenddowns (see M1460.700).

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D. Enrollment

Eligible individuals in this group are classified as medically needy (MN). If the individual has Medicare Part A, compare the individual's countable income to the QMB and SLMB limits.

The following ACs are used when the individual is ABD MN and QMB or SLMB:

- 028 for an aged individual also QMB;
- 048 for a blind individual also QMB;
- 068 for a disabled individual also QMB;
- 024 for an aged MN individual also SLMB;
- 044 for a blind or disabled MN individual also SLMB.

The following ACs are used when the individual is ABD MN and not QMB or SLMB:

- 018 for an aged individual NOT QMB or SLMB;
- 038 for a blind individual NOT QMB or SLMB;
- 058 for a disabled individual NOT QMB or SLMB.

D. Referral to Health Insurance Marketplace

When an ABD who does not have Medicare is placed on a spenddown, the individual must be referred to the Health Insurance Marketplace (HIM) so that the applicant's eligibility for the APTC can be determined. Individuals with Medicare are not referred to the HIM.

M0320.702 DECEMBER 1973 ELIGIBLES

A. Policy

42 CFR 435.340 - If the State Plan covers the medically needy, the Plan must provide protected medically needy coverage for blind and disabled individuals eligible in December 1973.

B. Blind or Disabled in December 1973

This is an MN covered group of blind and disabled individuals who:

- were eligible as medically needy under the state plan in December 1973 on the basis of the blindness or disability criteria of the AB or APTD plan;
- for each consecutive month after December 1973 continue to meet the December 1973 blindness or disability criteria and the December 1973 financial eligibility requirements; and
- meet the **current** medically needy eligibility requirements except the blindness or disability criteria.

Continuing eligibility is determined on the basis of eligibility requirements in effect as of December, 1973 and current medically needy requirements.

Contact your Regional Medical Assistance Program Consultant if you have an applicant you believe meets this covered group.



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CHAPTER M03
MEDICAID COVERED GROUPS
SUBCHAPTER 30

FAMILIES & CHILDREN GROUPS

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M0330 Changes
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Changed With	Effective Date	Pages Changed
TN #DMAS-35	7/1/25	Pages 1 and 9
TN #DMAS-33	10/1/24	Pages 1a, 24
TN #DMAS-32	7/1/24	Page 1a, 4
TN #DMAS-31	4/1/24	Pages 8, 26-28
TN #DMAS-30	1/1/24	Pages 1, 2, 4, 6, 8, 10, 12, 17, 20, 23, 34, 35, 38, 40
TN #DMAS-26	1/1/23	Page 10
TN #DMAS-24	7/1/22	Pages 1, 2, 15, 18, 29, 31, 32 Page 2a was added as a runover page.
TN #DMAS-23	4/1/22	Table of Contents Pages 1, 2, 5, 7, 8, 29, 37, 39, 40
TN #DMAS-20	7/1/21	Pages 1, 13, 14
TN #DMAS-19	4/1/21	Pages 14, 26
TN #DMAS-14	10/1/19	Pages 1, 2, 10a
TN #DMAS-12	4/1/19	Pages 26, 28
TN #DMAS-11	1/1/19	Pages 1, 2, 12, 14-16, 24, 25
TN #DMAS-10	10/1/18	Table of Contents Page 1-2, 30 Page 10a-b were added as runover pages.

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TN #DMAS-8	4/1/18	Pages 1, 9, 10, 25
TN #DMAS-6	10/1/17	Pages 8, 14
TN #DMAS-5	7/1/17	Pages 9, 14
TN #DMAS-4	4/1/17	Page 5
TN #DMAS-3	1/1/17	Pages 9, 10 Page 9a was removed.
TN #DMAS-2	10/1/16	Pages 8 Page 9b was renumbered to 9a.
TN #DMAS-1	6/1/16	Pages 2, 8, 9, 15, 31, 32-35 Page 9b was added as a runover page.
TN #100	5/1/15	Table of Contents Pages 4-8, 15-22, 24,25 36-38
UP #10	5/1/14	Pages 5, 8, 9
TN #99	1/1/14	Pages 1, 8, 9, 13, 24
TN #98	10/1/13	Table of Contents Pages 1-3, 6-16, 19, 22, 24-29
UP #8	10/1/12	Pages 4, 6
TN #97	9/1/12	Table of Contents Pages 1-40 (all pages)
UP #2	8/24/09	Pages 3, 6, 8, 16, 22
Update (UP) #1	7/1/09	Pages 20, 21
TN #DMAS-4	4/1/17	Page 5
TN #DMAS-3	1/1/17	Pages 9, 10 Page 9a was removed.
TN #DMAS-2	10/1/16	Pages 8 Page 9b was renumbered to 9a.
TN #DMAS-1	6/1/16	Pages 2, 8, 9, 15, 31, 32-35 Page 9b was added as a runover page.
TN #100	5/1/15	Table of Contents Pages 4-8, 15-22, 24,25 36-38
UP #10	5/1/14	Pages 5, 8, 9
TN #99	1/1/14	Pages 1, 8, 9, 13, 24
TN #98	10/1/13	Table of Contents Pages 1-3, 6-16, 19, 22, 24-29
UP #8	10/1/12	Pages 4, 6
TN #97	9/1/12	Table of Contents Pages 1-40 (all pages)
UP #2	8/24/09	Pages 3, 6, 8, 16, 22
Update (UP) #1	7/1/09	Pages 20, 21

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M0330.000 FAMILIES & CHILDREN GROUPS

M0330.001 GENERAL POLICY PRINCIPLES

A. Overview

A State Plan for Medicaid must include the mandatory federal categorically needy (CN) groups of individuals as well as the optional groups a state has elected to cover. This subchapter divides the Families & Children (F&C) covered groups into categorically needy and medically needy (MN) groups.

Enroll children and adults who receive Supplemental Security Income (SSI) in the SSI Medicaid covered group (see M0320.101) *unless Foster Care, Adoption Assistance or Former Foster Care recipient.* Evaluate other disabled children and adults for eligibility in the F&C CN covered groups first because they do not have a resource requirement. **Individuals who are eligible for or entitled to Medicare cannot be eligible in the MAGI Adults covered group.**

A federal mandate requires that as of January 1, 2024, all children under 19 receive 12 months of continuous eligibility unless

- they reach age 19;
- are no longer Virginia residents;
- the child or child's representative requests eligibility be closed;
- the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or
- the child is deceased.

B. Procedure

Determine an individual's eligibility first in a CN covered group. If the individual is not eligible as CN or for the Family Access to Medical Insurance Security Plan (FAMIS), go to the MN groups.

A determination of eligibility for a F&C child should follow this hierarchy:

1. If the child meets the definition of a foster care child, adoption assistance child, adoption assistance child with special needs for medical or rehabilitative care, or an individual under age 21, evaluate in these groups first.
2. If the child meets the definition of a pregnant woman or newborn child, evaluate in the pregnant woman/newborn child group.
3. If the child is under age 18 or is an individual under age 21 who meets the adoption assistance or foster care definition or is under age 21 in an intermediate care facility (ICF) or facility for individuals with intellectual disabilities (ICF-ID), AND is in a medical institution or has been authorized for Home and Community Based Services (HCBS) or has elected hospice, evaluate in the appropriate F&C 300% of SSI covered group.
4. If a child is under the age of 19, evaluate in this group.
5. If a child is a former foster care child under age 26 years, evaluate for coverage in this group.
6. If a child has income in excess of limits individual, evaluate for the Family Access to Medical Insurance Security Plan (FAMIS) eligibility (chapter M21).
7.

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8. If the child is a child under age 1, child under age 18, an individual under age 21 or an adoption assistance child with special needs for medical or rehabilitative care, but has income in excess of the appropriate F&C CN income limit, evaluate as MN.

A determination of eligibility for a F&C adult should follow this hierarchy:

1. If the individual is a former foster care child under 26 years, evaluate in this covered group.

2. If the individual meets the definition of a parent/caretaker relative, evaluate in the LIFC covered group.

3. If the individual has been screened and diagnosed with breast or cervical cancer or pre-cancerous conditions by the Every Woman's Life program and does not meet the definition of for coverage as SSI, LIFC, Pregnant Woman or Child under 19, evaluate in the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) covered group.

4. If the individual is between the ages of 19 and 64 and is not eligible for or entitled to Medicare, evaluate in the MAGI Adults group.

5. If the individual is not eligible as a MAGI Adult, LIFC individual, or pregnant woman but is in a medical institution, has been authorized for Home and Community Based Services or has elected hospice, evaluate in the appropriate F&C 300 % of SSI covered group.

6. If the individual is a parent or caretaker-relative of a dependent child and in a medical institution, the stay must be temporary while receiving treatment, rehabilitation, etc. for him to meet the definition of living in the home with the dependent child. There are no time limits on the amount of time the parent can be in a medical institution as long as he intends to return home. Verify with the parent the reason he is in a medical facility and ask about the intent to return home.

7. If the individual has excess income for full coverage in a Medicaid covered group *and opted in for Plan First*, evaluate for Plan First coverage.

8. If the individual is a pregnant woman but has excess income for coverage in a CN group or FAMIS MOMS evaluate as MN.

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M0330.100 FAMILIES & CHILDREN CATEGORICALLY NEEDY

A. Introduction

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

The F&C covered groups are divided into the categorically needy (CN) and medically needy (MN) classifications. Always evaluate eligibility in the categorically needy groups and FAMIS before moving to MN.

B. Procedure

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

M0330.100 Families & Children Categorically Needy Groups
M0330.105 IV-E Foster Care & IV-E Adoption Assistance;
M0330.107 Individuals Under Age 21;
M0330.108 Adoption Assistance Children With Special Needs for Medical or Rehabilitative Care;
M0330.109 Former Foster Care Children Under Age 26 Years
M0330.200 Low Income Families With Children;

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M0330.250 MAGI Adults Group
M0330.300 Child Under Age 19 (FAMIS Plus);
M0330.400 Pregnant Women & Newborn Children;
M0330.500 300% of SSI Covered Groups
M0330.600 Plan First--Family Planning Services;
M0330.700 Breast and Cervical Cancer Prevention and Treatment Act

C. Eligibility Methodology Used

With the exception of the F&C 300% of SSI covered groups for institutionalized individuals, the F&C covered groups that require a financial eligibility determination use Modified Adjusted Gross Income (MAGI) methodology for evaluating countable income. The policies and procedures for MAGI methodology are contained in chapter M04 unless otherwise specified.

MAGI methodology is not applicable to the F&C 300% of SSI covered groups. See M0330.501 – M0330.503 for information regarding the applicable financial eligibility policies.

D. Aid Categories

Aid Categories (ACs) are used in the eligibility and enrollment systems to denote coverage groups. Some covered groups have multiple ACs for designating disability status, age, income, and other demographic information. These ACs may be used for reporting and funding purposes. The policy sections for each CN covered group contain the assigned ACs.

Exception—F&C individuals who have been determined to be eligible for Medicaid coverage of emergency services only based on the alien status requirement policies in subchapter M0220 will be assigned to the following ACs regardless of their covered group:

- ***AC 112 for individuals in the Modified Adjusted Gross Income (MAGI) Adults covered group;***
- ***AC 113 for all other individuals.***

M0330.105 IV-E FOSTER CARE OR IV-E ADOPTION ASSISTANCE RECIPIENTS

A. Policy

42 CFR 435.145--The federal Medicaid law requires the State Plan to cover children who are eligible for foster care or adoption assistance payments under Title IV-E of the Social Security Act.

B. Children Who Receive SSI

Foster care or adoption assistance children who receive SSI meet the eligibility requirements for IV-E foster care or adoption assistance. They cannot receive both SSI and IV-E payments, so most of them elect to receive the higher SSI payment. These children are enrolled in Medicaid in the appropriate Foster Care or Adoption Assistance AC.

C. Nonfinancial Eligibility Requirements

The child must be under age 21 years and must meet the IV-E foster care or IV-E adoption assistance definition in M0310.115 or M0310.102. The child meets the age requirement until the end of the month in which the child turns age 21.

The child must meet all the nonfinancial eligibility requirements in chapter M02. The IV-E eligibility determination meets the Medicaid requirements for Virginia residency and cooperation in pursuing support.

NOTE: IV-E eligible foster care or adoption assistance recipients meet the Medicaid institutional status requirements when they live in a public residential facility if the facility has less than 25 beds.

D. IV-E Foster Care

42 CFR 435.145---The federal Medicaid law requires the State Plan to cover children who are eligible for foster care maintenance payments under Title IV-E of the Social Security Act.

The child must meet the IV-E foster care definition in M0310.115 and must be receiving IV-E foster care maintenance payments. A child of a IV-E foster care child is also considered to be a IV-E foster care child when the mother's IV-E payment includes an allocation for her child.

The IV-E eligibility determination meets the Medicaid requirements for Virginia residency and cooperation in pursuing support.

NOTE: IV-E eligible foster care maintenance payment recipients meet the Medicaid institutional status requirements when they live in a public child care institution if the facility has less than 25 beds, or if they live in a publicly operated community residence that has no more than 16 beds. See section M0280.100 for definitions of public institutions.

E. IV-E Adoption Assistance

42 CFR 435.145--The federal Medicaid law requires the State Plan to cover children who are eligible for adoption assistance under Title IV-E of the Social Security Act and for whom a IV-E adoption assistance agreement between the LDSS and the adoptive parent(s) is in effect.

The child must meet the IV-E adoption assistance definition in M0310.102. The child does not have to receive a IV-E Adoption Assistance payment in order to meet the IV-E Adoption Assistance definition.

The IV-E Adoption Assistance eligibility determination meets the Medicaid requirements for Virginia residency and cooperation in pursuing support.

F. Financial Eligibility

A separate Medicaid financial eligibility determination is not made for IV-E eligible foster care or IV-E adoption assistance children, regardless of the state that makes the IV-E payment. Verify the child's IV-E foster care payment eligibility, or the child's IV-E adoption assistance eligibility via agency records.



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***G*. Entitlement**

Children under 19 receive 12 months of continuous eligibility unless they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.

1. IV-E Foster Care Child

Entitlement to Medicaid as a IV-E Foster Care child begins the first day of the month of commitment or entrustment if a Medicaid application is filed within 4 months of commitment or entrustment. Retroactive entitlement prior to the month of commitment or entrustment is not allowed.

If the Medicaid application is filed more than 4 months after entrustment or commitment, entitlement may be retroactive up to 3 months prior to application if the child met all Medicaid eligibility requirements in the retroactive months. However, Medicaid entitlement cannot go back to the month of entrustment or commitment when the application is filed more than 4 months after entrustment or commitment.

2. IV-E Adoption Assistance Child

Entitlement to Medicaid as a IV-E Adoption Assistance child begins the first day of the application month if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

***H*. Enrollment**

The aid category (AC) for IV-E foster care children is "076." The AC for IV-E Adoption Assistance children is "072".

M0330.107 INDIVIDUALS UNDER AGE 21

A. Policy

42 CFR 435.222 – The federal Medicaid law allows the State Plan to cover reasonable classifications of individuals under age 21 years who do not receive cash assistance but who meet the income requirements of the state's July 16, 1996 AFDC State Plan. Children under age 19 should be evaluated in the FAMIS Plus covered group if not eligible as individuals under age 21.

Individuals ages 19 and 20 should be evaluated in the Individuals Under Age 21 covered group when they are not eligible for Medicaid in any other full-benefit covered group.

The reasonable classifications of individuals under age 21 are:

- IV-E eligible foster care children who do NOT receive a IV-E maintenance payment,
- Non-IV-E foster care children,
- Department of Juvenile Justice (DJJ) children,
- Non-IV-E Adoption Assistance children,
- Children in intermediate care nursing facilities (ICF), and
- Children in intermediate care facilities for the intellectually disabled (ICF-ID).

B. Nonfinancial Eligibility Requirements

The individual must be under age 21 and meet the nonfinancial requirements in chapter M02.

C. Reasonable Classifications

The individual under age 21 must meet one of the following classifications:



1. Non IV-E Foster Care

Children who meet the foster care definition in M0310.115 but do not receive a IV-E maintenance payment are "individuals in foster homes, private institutions or independent living arrangements for whom a public or private nonprofit child-placing agency is assuming full or partial financial responsibility." This group also includes DJJ children.

a. Children Living In Public Institutions

Non-IV-E foster care recipients meet the Medicaid institutional status requirements when they live in a public child care institution if the facility has less than 25 beds, or if they live in a publicly operated community residence that has no more than 16 beds. See section M0280.100 for definitions of public institutions.

When these children are placed in public residential institutions, the facility must not have capacity for more than 16 children (see M0280).

b. Child in Independent Living Arrangement

A child under age 18 in an independent living arrangement is eligible for Medicaid in this covered group if the child is receiving services from the local social services agency.

A child age 18 and over who is in an Independent Living arrangement with a local department of social services no longer meets the definition of a foster care child and may be eligible for Medicaid in the covered group of Former Foster Care Children Under Age 26 Years group. See M0330.109

2. Non-IV-E Adoption Assistance

Children under age 21 who meet the adoption assistance definition in M0310.102 for whom a Non-IV-E adoption assistance agreement between the local department of social services (LDSS) and the adoptive parent(s) is in effect are "individuals in adoptions subsidized in full or in part by a public agency." If the child receives a Non-IV-E adoption assistance payment, or if the child was adopted under an adoption assistance agreement and is not eligible as a IV-E Adoption Assistance child, then the child meets the "Non-IV-E adoption assistance" definition.

Adoption assistance c*hildren with* special needs *for* medical *or rehabilitative care* have additional requirements. See section M0330.805.

3. In ICF or ICF-ID

Children under age 21 who are patients in either an ICF or ICF-ID meet the classification of "individuals in an ICF or ICF- ID" in the Individual Under Age 21 covered group.

D. Assistance Unit

1. Non-IV-E Foster Care Children (Includes DJJ)

The child is an assistance unit of one effective the date the child is removed from the home and placed in foster care. Each child in foster care is evaluated as a separate assistance unit, even if the child is living with his/her siblings in a foster care home.

The child continues to meet the Individuals Under Age 21 covered group as long as he is under the supervision of the LDSS or DJJ, including during a trial visit in the child's own home. The Modified Adjusted Gross Income (MAGI) household composition methodology contained in Chapter M04 is applicable.



2. Adoptive Placement

While in adoptive placement, the child may continue to be treated as a foster care child. However, once the interlocutory or the final order of adoption is entered, the child must be treated as a Non-IV-E adoption assistance child; see 3. below.

3. Non-IV-E Adoption Assistance-Interlocutory or Final Order Entered

For applications received prior to October 1, 2013 and renewals completed prior to April 1, 2013, financial eligibility is determined using the assistance unit procedures in subchapter M0520, which require the inclusion of the child's adoptive parent(s) and sibling(s). An adoption assistance child must have his/her eligibility determined by counting or deeming (as appropriate) his/her parent's and sibling's income.

For applications received on or after October 1, 2013, use the policies and procedures contained in chapter M04.

4. Child in ICF or ICF- ID

A child in an ICF or an ICF-ID is an institutionalized individual in a medical facility when he meets the definition of "institutionalized individual" in section M1410.010 B.2. When he meets the institutionalized individual definition, he is an assistance unit of one person.

E. Resources

There is no resource test for the Individuals Under Age 21 covered group.

F. Income

1. Income Limits

For the Individuals Under Age 21 covered group, the income limit is the income limit found in M04, Appendix 5.

The foster care or adoption subsidy payment is excluded when determining the unit's income eligibility.

Foster care and Adoption Assistance children in residential facilities do not have a different income limit. For a foster care/adoption assistance child living outside the State of Virginia, the income limit for the assistance unit is the income limit for the Virginia locality which holds custody, pays the adoption subsidy, or signed the adoption assistance agreement.

2. Income Exceeds F&C 100% Income Limit

For foster care (including DJJ) and adoption assistance children whose income exceeds the Individuals Under Age 21 income limit, determine the child's Medicaid eligibility in the Child Under 19 covered group and for FAMIS if the child under 19 or as an MN Individual Under Age 21 if the child is over 19 but under 21 (see M0330.804). Ineligible individuals must be referred to the Health Insurance Marketplace for evaluation for the Advance Premium Tax Credit (APTC).

G. Entitlement & Enrollment

Children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

1. Entitlement

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



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2. Enrollment

The aid category (AC) for individuals in the covered group of Individuals Under Age 21 is:

- 076 for a non-IV-E Foster Care child;
- 075 for a Department of Juvenile Justice child;
- 072 for a Non-IV-E Adoption Assistance child;
- 082 for a child under age 21 in an ICF or ICF-ID.

M0330.108 ADOPTION ASSISTANCE *CHILDREN WITH* SPECIAL NEEDS *FOR* MEDICAL *OR REHABILITATIVE CARE*

A. Policy

42 CFR 435.227 - The federal Medicaid law allows the State Plan to cover an individual under age 21 years:

- for whom a non-IV-E adoption assistance agreement between the state and the adoptive parent(s) is in effect;
- who cannot be placed with adoptive parents without Medicaid because the child has special needs for medical or rehabilitative care; and
- who was enrolled in Medicaid under any covered group before the adoption assistance agreement was entered into OR who would have been eligible for Medicaid before the adoption assistance agreement was entered into if the eligibility requirements and standards of the IV-E foster care program were used, without employing the threshold title IV-A eligibility determination.

If the child was not enrolled in Medicaid or would not have been eligible for Medicaid prior to the adoption assistance agreement being entered into, the child is **not** eligible for Medicaid in the Adoption Assistance *Children With* Special Needs *for* Medical *or Rehabilitative Care* covered group.

The child's eligibility in another covered group must be evaluated. If the child is under age 19, evaluate his eligibility in the FAMIS Plus covered group of Child Under Age 19 (see M0330.300). If the child is over age 19 but under age 21, the child may be eligible as a Non-IV-E Adoption Assistance child in the MN Individuals Under Age 21 covered group. See section M0330.804.

B. Nonfinancial Eligibility Requirements

The child must:

- be under age 21,
- meet the definition of a child *with* special needs *for* medical *or rehabilitative care adopted under a Non IV-E Adoption Assistance agreement* in M0310.102, and
  - meet the nonfinancial requirements in chapter M02.

C. Financial Eligibility Requirements

1. Assistance Unit

The assistance unit consists of only the child if the child was eligible for Medicaid prior to the adoption assistance agreement being entered into. The adoptive parent(s)' income and resources are **not** counted or deemed; only the child's own income and resources are counted.



2. Resources There is no resource test for the Adoption Assistance Children With Special Needs for Medical or Rehabilitative Care covered group.

3. Income Adoption assistance children in residential facilities do not have a different income limit. The income limit for Individuals Under Age 21 for one person in the child's locality is used to determine eligibility in the Adoption Assistance Children With Special Needs for Medical or Rehabilitative Care covered group. See M04, Appendix 4.

For a Virginia adoption assistance child with special needs for medical or rehabilitative care living outside the State of Virginia, the income limit for the unit is the income limit for the Virginia locality that signed the adoption assistance agreement.

The adoption subsidy payment is excluded when determining the child's financial eligibility.

If the child's countable income exceeds the income limit for Individuals Under Age 21, evaluate the child in the Adoption Assistance Children With Special Needs for Medical or Rehabilitative Care MN covered group (see M0330.805). Ineligible individuals must be referred to the Health Insurance Marketplace for evaluation for the APTC.

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

Children under 19 receive 12 months of continuous eligibility unless they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.

The AC for individuals in the Adoption Assistance Children With Special Needs for Medical or Rehabilitative Care covered group is "072."

M0330.109 FORMER FOSTER CARE CHILDREN UNDER AGE 26

A. Policy P.L. 111-148 (The Affordable Care Act) - The federal Medicaid law requires the State Plan to cover individuals who were formerly in Title IV-E or non-IV-E foster care or the Unaccompanied Refugee Minors Program (URM) when the individual:

- was in the custody of a local department of social services in Virginia, another state, or a U.S. Territory, and receiving Medicaid until his discharge from foster care upon turning 18 years or older, or
- was in the URM program in Virginia or another state and receiving Medicaid until his discharge upon turning 18 years or older, *and*
- is under age 26 years.

A child age 18 and over who is in an Independent Living arrangement or in the Fostering Futures Program with a local department of social services may be eligible in this covered group.

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B. Nonfinancial Eligibility Requirements

The individual must meet all the nonfinancial eligibility requirements in chapter M02. If the individual is not a U.S. citizen, he must meet the alien status requirements. These requirements differ depending on the age and pregnancy status of the individual. See subchapter M0220.

C. Financial Eligibility Requirements

There are no resource or income tests for the Former Foster Care group.

D. Entitlement

Entitlement as a former foster care child begins the first day of the month following the month the child was no longer in the custody of a local department of social services or the URM Program if the child was enrolled in Medicaid during the month foster care ended.

Accept the individual's declaration of enrollment in foster care or the URM Program and enrollment in Medicaid at the time turned at least 18.

If Medicaid coverage of a former foster care child was previously discontinued when the child turned 18, he may reapply for coverage and be eligible in this covered group if he meets the requirements in this section. The policies regarding entitlement in M1510 apply.

Individuals in this covered group receive full Medicaid coverage, including long-term care (LTC) services. Do not move enrollees in this covered group who need LTC to the 300% of SSI covered group.

E. Enrollment

The AC for former foster care children is "070."

M0330.200 LOW INCOME FAMILIES WITH CHILDREN (LIFC)

A. Policy

Section 1931 of the Act - The federal Medicaid law requires the State Plan to cover (1) dependent children under age 18 or under the age of 19 and full-time students in a secondary school or in the equivalent level of vocational or technical training, or in a General Educational Development (GED) program IF they may be reasonably expected to complete the secondary school, training or program before or in the month they attain age 19; and (2) parents or caretaker-relatives of dependent children who meet the financial eligibility requirements of the July 16, 1996 AFDC state plan. This covered group is called "Low Income Families With Children" (LIFC).

Public Law 111-148 (The Affordable Care Act) requires that coverage for all children under the age of 19 be consolidated in the Child Under Age 19 (FAMIS Plus) covered group. Virginia has chosen to implement this coverage effective October 1, 2013. Children are not enrolled as LIFC except when the child meets the definition of a dependent child in M0310.111 and his parents are receiving LIFC Extended Medicaid coverage (see M1520.500). In these situations, if the child's household income exceeds the limit for coverage in the Child Under Age 19 group, the child must be evaluated for LIFC Extended Medicaid coverage with his family.

B. Nonfinancial Eligibility

The individual must meet all the non-financial eligibility requirements in chapter M02.



A LIFC child must meet the definition of a dependent child in M0310.111. The adult with whom the child lives must be the child's parent or caretaker-relative, as defined in M0310.107. The presence of a parent in the home does not impact a stepparent's eligibility in the LIFC covered group. Both the parent and stepparent may be eligible in the LIFC covered group. When a parent(s) is in the home, no relative (i.e. caretaker/relative) other than another parent or a stepparent can be eligible for Medicaid in the LIFC covered group.

C. Financial Eligibility

Modified Adjusted Gross Income (MAGI) methodology is applicable to the LIFC covered group. The policies and procedures contained in Chapter M04 are used to determine eligibility for LIFC individuals.

1. Basis For Eligibility ("Assistance Unit")

The basis for financial eligibility is the LIFC individual's MAGI household. See M0430.100.

2. Resources

There is no resource test for the LIFC covered group.

3. Income

The income limits, policies and procedures used to determine eligibility in the LIFC covered group are contained in Chapter M04.

4. Income Exceeds Limit

If the individual's income exceeds the LIFC income limit, the individual is not eligible as LIFC. Individuals should then be evaluated as MAGI. If over the MAGI limit, LIFC families who have been enrolled in Medicaid for at least three of the past six months and who are no longer eligible due to excess earned income must be evaluated for continued eligibility in LIFC Extended Medicaid. See M1520.400.Ineligible individuals must be referred to the Health Insurance Marketplace for evaluation for the APTC. Spenddown does not apply to the LIFC income limits.

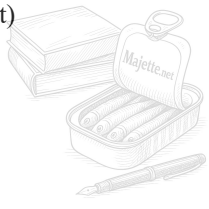
D. Entitlement

Entitlement to Medicaid as an LIFC individual begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period. ***Children under 19 receive 12 months of continuous eligibility unless*** *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

E. Enrollment

The ACs for individuals in the LIFC covered group are:

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



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M0330.250 MAGI ADULTS (EFFECTIVE JANUARY 1, 2019)

A. Policy

The Virginia 2018 Appropriations Act mandated that effective January 1, 2019, the State Plan for Medical Assistance be amended to add a new covered group for adults between the ages of 19 – 64. This mandate is titled "New Health Coverage Options for Virginia Adults" and the new covered group will be known as MAGI (Modified Adjusted Gross Income) Adults.

This new group may be designated in various reports, documentation, or publications of other agencies as New Enrolled Adults, Newly Enrolled Adults, or Medicaid Expansion Adults.

The MAGI Adults Group includes:

- MAGI Parent/Caretaker Relatives (AC 100, AC 101) who meet Medicaid requirements within a MAGI Adult group and must be responsible for a dependent child under age 18 (or less than age 19, still in school and expected to graduate by his 19th birthday);
- MAGI Childless Adults (AC 102, AC 103) who meet Medicaid requirements within a MAGI Adults group and are not responsible for a dependent child or claim such a child on his tax return;
- MAGI Presumptive Eligible Adults (AC 106) who meet Medicaid requirements within a MAGI Adults group and have had a determination made by an authorized PE Hospital; and
- MAGI Incarcerated Adults (AC 108) who would otherwise be eligible for Medicaid as a MAGI Adult except for being incarcerated in a Department of Corrections (DOC) facility or a local / regional jail.

Note: All HPE applications are processed by hospitals and enrolled at Cover Virginia. See M0120.500.D - Hospital Presumptive Eligibility.

B. Procedure

Eligible individuals in the MAGI Adults group must:

- be an individual between the ages of 19 and 64;
- have income at or below 138% *FPL* (133% *FPL* + 5% *FPL* disregard);
- not be entitled to or enrolled in Medicare Part A or B;
- not be eligible in a Medicaid mandatory covered group or the BCCPTA covered group.
- meet any other criteria as outlined in the particular aid categories.

A person in the MAGI Adults covered group may receive long term services and supports (LTSS) in either a facility or home and community based services (waiver) setting. The individual is still required to be assessed and approved for such care.

C. Non-Financial Eligibility

The individual must meet all the nonfinancial eligibility requirements in chapter M02. If the individual is not a U.S. citizen, he must meet the alien status requirements. These requirements differ depending on the age and pregnancy status of the individual. See subchapter M0220.



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D. Resources *Although no resource test is applicable for MAGI Adults coverage, the worker must evaluate certain resources for any individuals seeking Medicaid payment for LTSS. These include asset transfers, trusts, annuities, and the home equity limit. See M1410.050*

E. Financial Eligibility *MAGI methodology is applicable to the MAGI Adults covered group. The policies and procedures contained in Chapters M04 are used to determine eligibility for these individuals.*

1. Basis For Eligibility *The basis for financial eligibility is the individual's MAGI household. See M0430.100.*

2. Income *The income limits, policies and procedures used to determine eligibility in this covered group are contained in Chapter M04.*

3. Income Exceeds Limit *If the individual's income exceeds the MAGI Adults income limit, the individual must be evaluated for eligibility in any other full benefit Medicaid group. If not eligible in a full benefit category, the individual must be evaluated for any limited benefit coverage for which they may be eligible.*

4. Spenddown *Spenddown does not apply to any MAGI Adults covered group.*

F. Referral to Health Insurance Marketplace *If the individual is not eligible for any full benefit Medicaid coverage group due to income over the applicable limit, the individual must be referred to the HIM for evaluation for the APTC.*

G. Entitlement *Entitlement in Medicaid as a MAGI Adult begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period; however, retroactive coverage in the MAGI Adults group is not available for any month prior to January 1, 2019.*

H. Enrollment *The Medicaid aid categories for MAGI Adults are:*

AC	*Meaning*
100	*Parent/caretaker relative; income above the LIFC limit and below 100% FPL (no 5% disregard)*
101	*Parent/caretaker relative; income greater than 100% FPL, but less than or equal to 138% FPL (133% + 5% disregard)*
102	*Childless adult; income at or below 100% FPL (no disregard)*
103	*Childless adult; income greater than 100% FPL, but less than or equal to 138% FPL (133% + 5% disregard)*
106	*Presumptively-eligible MAGI Adult; income at or below 138% FPL (133% + 5% disregard)*
108	*Incarcerated adult*

I. Long Term Services and Supports *Once medical assessment and financial evaluation are approved, a MAGI Adult may receive facility based or home and community based LTSS.*

Patient pay does not apply to MAGI Adults.

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M0330.300 CHILD UNDER AGE 19

A. Policy

The Affordable Care Act requires that all coverage for children under age 19 be consolidated into one covered group. The authority for coverage of these children is found in 42CFR 435.11. 8. Virginia will begin covering children in this group effective October 1, 2013. The income limit for this group is 143% FPL.

Coverage under the Child Under Age 19 covered group is also known as FAMIS Plus in printed materials.

B. Nonfinancial Eligibility

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

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

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

NOTE: a child who has excess income for Medicaid may be evaluated for FAMIS eligibility.

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C. Financial Eligibility

Modified Adjusted Gross Income (MAGI) methodology is applicable to this covered group. The MAGI policies and procedures are contained in Chapter M04.

1. Assistance Unit

The assistance unit for this covered group is the MAGI household.

2. Resources

There is no resource test.

3. Income

MAGI income rules are applicable to this covered group. The income limits for the Child Under Age 19 covered group are contained in M04, Appendix 2.

4. Income Changes

Any changes in a Medicaid-eligible child's income that occur after his eligibility has been established affect eligibility. Recalculate income and compare to the income limits.

5. Income Exceeds Limit

A child under age 19 whose income exceeds the income limit for this covered group may be eligible for FAMIS. The income limit for FAMIS is 200% FPL plus a 5% FPL income disregard. See Chapters M21 and M04 to determine FAMIS eligibility.

If countable income exceeds the limit for Medicaid and FAMIS and the child is under age 18, the opportunity for a Medically Needy (MN) evaluation must be offered (see M0330.803). Ineligible children, other than incarcerated children, must be referred to the Health Insurance Marketplace for evaluation for the APTC.

D. Entitlement

Eligible children are entitled to full Medicaid coverage beginning the first day of the child's application month if all eligibility requirements are met in that month, but no earlier than the date of the child's birth. Retroactive coverage is applicable to this covered group.

Children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

Eligible children are entitled to all Medicaid covered services as described in chapter M18.

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E. Enrollment

The Medicaid ACs for children are:

AC	Meaning
090	child under age 6; income greater than *109*% FPL, but less than or equal to 143% FPL
091	child under age 6; income less than or equal to 109% FPL
092	• child age 6-19; insured or uninsured with income less than or equal to 109% FPL; • child age 6-19; **insured** with income greater than 109% FPL and less than or equal to 143% FPL
094	child age 6-19; **uninsured** with income greater than 109% FPL and less than or equal to 143% FPL

Do not change the AC when a child's health insurance is paid for by Medicaid through the HIPP program.

M0330.400 PREGNANT WOMEN & NEWBORN CHILDREN

A. Policy

The federal Medicaid law requires the Medicaid State Plan to cover categorically needy (CN) pregnant women and newborn children whose family income is within 143% of the federal poverty level (FPL). The law allows the State Plan to cover these pregnant women and newborns regardless of their resources.

B. Nonfinancial Eligibility

1. Pregnant Woman

42CFR 435.116- The woman must meet the pregnant woman definition in M0310.124.

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

Non-citizen pregnant women who meet the lawfully residing policy in M0220.314 meet the citizenship requirements for full coverage in the pregnant woman group.

A pregnant woman who does not meet the lawfully residing policy in M022.314 may be eligible for FAMIS Prenatal Coverage if they apply for coverage no later than the month their child is born. ***Use Chapter M23 to evaluate the pregnant woman for eligibility under FAMIS Prenatal Coverage***

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2. Newborn Child

42 CFR 435.117 - A child born to a woman who was eligible for Medicaid or to an individual covered by FAMIS at the time the child was born (including a newborn child born to an alien eligible for Medicaid payment of emergency services only) is eligible as a newborn child under age 1 year.

Exceptions:

A child born to a women enrolled under Hospital Presumptive Eligibility (HPE); an application must be submitted for the child's Medicaid eligibility to be determined since no Medicaid application was submitted for the child's mother.

An infant born to a woman in FAMIS Prenatal Coverage who is enrolled in AC 111 and/or enrolled in managed care must be evaluated for ongoing coverage. The infant is not considered a deemed-eligible newborn. See Chapter M023.

a. Eligible To Age 1

A child no longer meets this covered group effective the end of the month in which the child reaches age 1, provided he was under age 1 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 1.

Any child born a Medicaid-eligible woman will continue to be eligible up to age 1. If the child's mother was covered by Medicaid as a categorically needy individual in a state other than Virginia at the time of the child's birth, verification of the mother's Medicaid coverage must be provided by the parent or authorized representative.

b. No Other Eligibility Requirements

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

C. Financial Eligibility

Eligibility for CN Pregnant Women is based on the Modified Adjusted Gross Income (MAGI) methodology contained in Chapter M04.

1. Assistance Unit

The unborn child or children are included in the household size for a pregnant woman's eligibility determination. Refer to the procedures for determining the MAGI household in Chapter M04.

2. Resources

There is no resource test.

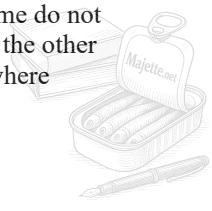
3. Income

Women enrolled as Pregnant Women are not subject to renewals during the pregnancy. The income limits for Pregnant Women are contained in M04, Appendix 2.

4. Income Changes After Eligibility Established

a. Pregnant Woman

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



For example, a married pregnant woman applies for Medicaid on October 10. She received a medical service in the retroactive period. Her expected delivery date is January 15. She and her husband have been unemployed since June 23. Her husband began earning $3,000 a month on October 9; she remains unemployed. Since they had no income during the retroactive period, she is found eligible for retroactive coverage effective July 1.

Because her available income (from her husband) changed after she established eligibility on July 1, the change in income does not affect her eligibility and she remains eligible for Medicaid in October and subsequent months until she no longer meets the pregnant woman definition or other nonfinancial requirements.

b. Newborn

Income changes do NOT affect the certain newborn's eligibility for the first year of the child's enrollment as a certain newborn.

The mother's failure to complete a renewal of her own eligibility and/or the eligibility of other children in the household does NOT affect the eligibility of the certain newborn.

5. Income Exceeds Limit

If the pregnant woman's income exceeds the 143% FPL limit, she is not eligible in this covered group. Determine her eligibility for FAMIS MOMS. If the pregnant woman is not eligible for FAMIS MOMS, evaluate her eligibility as MN (see M0330.801). Ineligible women, other than incarcerated women, must be referred to the Health Insurance Marketplace for evaluation for the APTC.

D. Entitlement

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

The newborn's Medicaid coverage begins the date of the child's birth. A renewal must be completed for the newborn in the last month in which the child meets the Newborn Children Under Age 1 covered group and must include SSN or proof of application, as well as verification of income.

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

After her eligibility is established as a pregnant woman, the woman's Medicaid entitlement continues *for 12 months following the end of the month in which her pregnancy ends,* regardless of income changes. Medicaid coverage ends the last day of *the 12th month*.

If a Medicaid or FAMIS MOMS recipient who applied effective November 1, 2021 [or a CHIPRA214 (lawfully residing individual) who applied effective April 1, 2022] whose pregnancy has ended reapplies for coverage after July 1, 2022, she is entitled to the remainder of the 12 month post-partum period she would have received had her coverage not been canceled.

E. Enrollment

The AC for pregnant women who are not incarcerated is 091. The AC for pregnant women who are incarcerated is 109. The AC for newborns born to women who were enrolled in Medicaid is 093.

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M0330.500 300% of SSI INCOME LIMIT GROUPS

M0330.501 F&C IN MEDICAL INSTITUTION, INCOME ≤ 300% SSI

A. Policy

42 CFR 435.236 - The State Plan includes the covered group of individuals who meet a families & children definition who are in medical institutions and who

- meet the Medicaid resource requirements; and
- have income that does not exceed 300% of the SSI individual payment limit (see M0810.002 A. 3).

B. Nonfinancial Eligibility

An individual is eligible in this covered group if he/she meets the nonfinancial requirements in M02.

The individual must be a child under age 18, under age 21 who meets the adoption assistance or foster care definition or under age 21 in an ICF or ICF-ID, or must be a parent or caretaker-relative of a dependent child, or a pregnant woman as defined in M0310. *If the individual is a parent or caretaker-relative of a dependent child, the stay in the medical institution must be temporary while receiving treatment, rehabilitation, etc. for him to meet the definition of living in the home with the dependent child.*

C. Financial Eligibility

When determining income to compare to the 300% of SSI income limit, use the ABD income policy and procedures, regardless of the individual's definition or covered group. MAGI methodology is not used to determine eligibility for this covered group.

When determining resources, use F&C resource policy in chapter **M06** for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

The individual must also meet the asset transfer policy in M1450.

1. Resources

a. Resource Eligibility – Married Individual Age 18 and Older

When determining resources for a married F&C institutionalized individual with a community spouse, use the resource policy in subchapter M1480. When determining resources for a married F&C institutionalized individual who has no community spouse, use the resource policy in subchapter M1460. Evaluate countable resources using ABD resource policy in chapter S11.

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

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible in a different covered group (which has more liberal resource methods and standards).

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b. Resource Eligibility – Unmarried Individual Age 18 and Older

When determining resources for an unmarried F&C institutionalized individual, use the Medicaid F&C resource requirements in chapter M06. All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the F&C resource limit of $1,000. Pay close attention to ownership of his/her former residence when the individual is in an institution. Determine if the former home is excluded in **M06.**

If current resources are within the limit, go on to determine income eligibility. If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible in a different covered group.

c. Resource Eligibility – Child Under Age 18

Children under age 18 are not subject to a resource test.

2. Income

To determine if an individual has income within the 300% SSI income limit, **use gross income**, not countable income, and **use the ABD income policy and procedures in chapter S08 and subchapter M1460.** Determine what is income according to subchapter S0815, ABD What Is Not Income and subchapter M1460, LTC Financial Eligibility. DO NOT subtract the $20 general exclusion or any other income exclusions.

The individual is an assistance unit of 1 person. DO NOT deem any income from a spouse or parent.

Compare the **total gross income** to the 300% of SSI income limit (see M810.002 A. 3.). If gross income is less than or equal to this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds the 300% of SSI income limit, the individual is not eligible for Medicaid in the covered group of F&C individuals in medical institutions.

D. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

Eligible individuals in this group are classified as **300% SSI.** If the individual has Medicare Part A, re-calculate the individual's income - subtract appropriate ABD income exclusions. Compare the countable income to the QMB limit.

1. Dual-eligible As QMB

If the individual is also a Qualified Medicare Beneficiary (QMB) – the individual has Medicare Part A and has countable income within the QMB income limit - the program designation is "062."

2. Not QMB If the individual is NOT a Qualified Medicare Beneficiary (QMB) - the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - the AC is "060."

E. Ineligible In This Covered Group If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy. For unmarried individuals, redetermine resources using the F&C medically needy policy in chapter M06. Do not recalculate resources of a married individual.

Determine the individual's eligibility as QMB, SLMB, QDWI or QI if *the individual* has Medicare Part A.

M0330.502 F&C RECEIVING WAIVER SERVICES (CBC)

A. Policy 42 CFR 435.217 - The State Plan includes the covered group of individuals who meet a families & children definition who live in the community, who

would be eligible for Medicaid if institutionalized;

are *authorized* to receive Medicaid waiver services and have selected the option to receive Medicaid waiver services in lieu of nursing facility care;

in the absence of the waiver services would require the level of care furnished in a hospital, nursing facility or ICF- ID; and

have income that does not exceed 300% of the SSI individual payment limit (see M0810.002 A. 3).

B. Nonfinancial Eligibility An individual who receives Medicaid waiver services is eligible in this covered group if *the individual*:

1. meets the nonfinancial requirements in M02.
2. is not in a medical institution, may be in a residential institution that meets the institutional status requirements; and
3. is a child under age 18, under age 21 and meets the adoption assistance or foster care definition, a parent or caretaker-relative of a dependent child, or a pregnant woman as defined in M0310.

Verify receipt of Medicaid waiver services; use the procedures in chapter M14.

Do not wait until the individual starts to receive the waiver services to determine eligibility in this covered group. Determine eligibility in this covered group if the *individual* is *authorized* to receive Medicaid waiver services, has not been placed on a waiting list for services, and has selected the option to receive Medicaid waiver services in lieu of nursing facility services. Presume that the *individual* will receive the services and go on to determine financial eligibility using the policy and procedures in C. below. If determined eligible, the individual is not entitled to Medicaid in this covered group unless the policy in item D. below is met. See item D. below for the entitlement and enrollment procedures.

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C. Financial Eligibility

When determining **income** to compare to the 300% of SSI income limit, use the ABD income policy and procedures, regardless of the individual's definition or covered group. MAGI methodology is not used to determine eligibility for this covered group.

When determining **resources**, use F&C resource policy in chapter **M06** for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

The individual must also meet the asset transfer policy in M1450.

1. Resources

a. **Resource Eligibility - Married Individual *Age 18 and Older***

When determining resources for a married F&C institutionalized individual with a community spouse, use the resource policy in subchapter M1480. When determining resources for a married F&C institutionalized individual who has no community spouse, use the resource policy in subchapter M1460. **Evaluate countable resources using ABD resource policy in chapter S11.**

b*.** **Resource Eligibility - Unmarried Individual *Age 18 and Older

When determining resources for an unmarried F&C institutionalized individual, use the Medicaid F&C resource requirements in chapter **M06.** All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the F&C resource limit of $1,000. Pay close attention to

- ownership of his/her former residence when the individual is in an institution. Determine if the former home is excluded in **M06.**

DO NOT DEEM any resources from a child's parent living in the home.

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

If current resources are NOT within the limit, the individual is NOT eligible in this covered group. He/she may be eligible as medically needy in a medically needy covered group.

c. Resource Eligibility – Child Under Age 18

Children under age 18 are not subject to a resource test.

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2. Income

To determine if an individual has income within the 300% SSI income limit, **use gross income**, not countable income, and use the ABD income policy and procedures in **chapter S08** and **subchapter M1460.** Determine what is considered income according to subchapter **S0815, ABD What Is Not Income** and subchapter **M1460, LTC Financial Eligibility**. DO NOT subtract the $20 general exclusion or any other income exclusions.

The F&C waiver services individual is an assistance unit of 1 person. DO NOT deem any income from a spouse or parent.

Compare the **total gross income** to the 300% of SSI income limit (see M0810.002 A.3). If gross income is less than or equal to this limit, the individual is eligible for Medicaid in the CN covered group of F&C individuals receiving Medicaid waiver services.

If the total gross income **exceeds** the 300% of SSI income limit, the individual is **not** eligible for Medicaid in the covered group of F&C individuals receiving Medicaid waiver services.

D. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

Eligible individuals in this group are classified as 300% of SSI. If the individual has Medicare Part A, re-calculate the individual's income - subtract the appropriate ABD income exclusions. Compare the countable income to the QMB limit.

1. Dual-eligible As QMB

If the individual is also a Qualified Medicare Beneficiary (QMB) – the individual has Medicare Part A and has countable income within the QMB income limit - the AC is "062."

2. Not QMB

If the individual is NOT a QMB – the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - the AC is "060."

E. Ineligible In This Covered Group

If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy spenddown. For unmarried individuals, re-determine resources using the F&C medically needy policy in chapter M06. Do not recalculate resources of a married individual.

Determine the individual's eligibility as QMB, SLMB, QDWI or QI if he/she has Medicare Part A.



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M0330.503 F&C HOSPICE

A. Policy

SMM 3580-3584 - The State Plan includes the covered group of children under age 21, pregnant women and parents or caretaker-relatives of dependent children who are terminally ill and who elect hospice benefits. The hospice covered group is for individuals who are not eligible in any other full-benefit Medicaid covered group.

Individuals receiving hospice services in the F&C Hospice Covered group may also receive services under the Elderly and Disabled with Consumer Direction (EDCD) Waiver, if the services are authorized by DMAS (see M1440.101).

To be eligible in the hospice covered group, the individual must file an election statement with a particular hospice which must be in effect for 30 or more consecutive days. Eligibility in the Hospice covered group is ongoing as long as the individual continues to receive hospice care, subject to a renewal of eligibility at least once every 12 months. The eligibility worker must verify that the hospice agreement is current at the time of the annual renewal.

The 30-day requirement begins on the effective date of the hospice care election. Once the hospice election has been in effect for each of 30 consecutive days, the 300% of SSI income limit is used to determine Medicaid eligibility. If the individual's income is within the limit, eligibility begins the effective date of the hospice election.

In situations where the 30-day requirement has already been met, the individual does not have to meet it again when he/she elects hospice care. When there is no break in time between eligibility in a medical facility and the effective date of hospice election, the individual does not have to wait another 30 days for eligibility in the hospice covered group.

B. Nonfinancial Eligibility

A terminally ill individual who elects hospice services is eligible in this covered group if he/she meets the *non-financial requirements in M02, and*:

1. is not in a medical institution, may be in a residential institution that meets the institutional status requirements; and

2. *is a child under age 18, under age 21 and meets the adoption assistance or foster care definition, a parent or caretaker-relative of a dependent child, or a pregnant woman as defined in M0310.*

The individual must elect hospice care. Election of hospice care is verified either verbally or in writing from the hospice. If the verification is verbal, document case record.

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C. Financial Eligibility

When determining **income** to compare to the 300% of SSI income limit, use the ABD income policy and procedures, regardless of the individual's definition or covered group. *MAGI methodology is not used to determine eligibility for this covered group.*

When determining **resources**, use F&C resource policy in *chapter **M06*** for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

The individual must also meet the asset transfer policy in M1450.When determining **resources**, use F&C resource policy for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

1. Resources

a*. Resource Eligibility - Married Individual *Age 18 and Older

When determining resources for a married F&C hospice individual with a community spouse, use the resource policy in subchapter M1480. When determining resources for a married F&C hospice individual who has no community spouse, use the resource policy in subchapter M1460. **Evaluate countable resources using ABD resource policy in chapter S11.**

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

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible as medically needy in a medically needy covered group.

b*. Resource Eligibility - Unmarried Individual *Age 18 and Older

When determining resources for an unmarried F&C hospice individual, use the Medicaid F&C resource requirements in chapter **M06.** All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the F&C resource limit of $1,000.

DO NOT DEEM any resources from a child's parent living in the home.

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

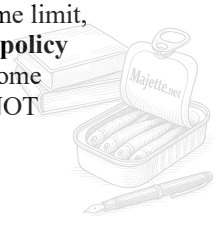
If current resources are NOT within the limit, the individual is NOT eligible in this covered group. He/she may be eligible as medically needy in a medically needy covered group.

c. Resource Eligibility – Child Under Age 18

Children under age 18 are not subject to a resource test.

2. Income

To determine if an individual has income within the 300% SSI income limit, **use gross income**, not countable income, and **use the ABD income policy and procedures in chapter S08.** Determine what is considered income according to **subchapter S0815, ABD What Is Not Income**. DO NOT subtract the $20 general exclusion or any other income exclusions.



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The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Compare the total gross income to the 300% SSI income limit (see M0810.002 A. 3.). If countable income is equal to or less than this limit, the individual is eligible for Medicaid in the hospice covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in the hospice covered group. Evaluate his/her eligibility as medically needy.

D. Entitlement & Enrollment

The hospice services recipient must elect hospice services and the election must be in effect for 30 days. The 30 day period begins on the effective date of the hospice election. Upon 30 days elapsing from the effective date of the hospice election, and the election is in effect for the entire 30 days, eligibility in the hospice covered group begins with the effective date of the hospice election if all other eligibility factors are met.

1. Entitlement

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

Eligible individuals in this group are classified as categorically needy CN. If the individual has Medicare Part A, evaluate his/her eligibility as ABD hospice in M0320.402.

2. Enrollment

If the individual is eligible in any other full-coverage Medicaid covered group, he is enrolled under that aid category (AC) and not the Hospice AC (054). Enroll with AC 054 for an individual who meets an F&C definition, has income within 300% of the SSI limit, but who is not eligible in any other full-coverage Medicaid covered group.

E. Post-eligibility Requirements (Patient Pay)

Individuals who receive hospice services in a nursing facility have a patient pay calculation (see subchapter M1470). Individuals who receive hospice services outside of a nursing facility do not have a patient pay.

Individuals who have elected hospice services and who also receive Medicaid Long-term Care services available under the EDCD Waiver must have a patient pay calculation for the EDCD services (see subchapter M1470).

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M0330.600 PLAN FIRST - FAMILY PLANNING SERVICES

A. Policy

Plan First, Virginia's family planning services health program covers individuals who are not eligible for another full or limited-benefit Medicaid covered group or FAMIS. This optional covered group is available to individuals regardless of their age, gender, disability status, insured status or if they previously had a sterilization procedure. Plan First covers only family planning services, including transportation to receive family planning services.

The income limit for Plan First is 200% FPL. *Plan first is an "opt in" program effective 12/1/2024. If the applicant does not indicate whether they are opting in or out (leaves box blank) they are assumed to be opting out of Plan First.* There are no specific age requirements for Plan First, *so* eligibility for Plan First is determined *for any individual including* children *if* the child's parent or the individual requests an evaluation for Plan First.

Individuals who are eligible for Plan First must be referred to the Federal Health Insurance Marketplace for an evaluation for the APTC, because they are not eligible for full Medicaid coverage.

If the information contained in the application indicates **potential** eligibility in a full-benefit Medicaid covered group (e.g., the applicant has a child under 18 in the home or alleges disability), in another limited benefit covered group (e.g., the individual has Medicare) or in FAMIS, the worker must determine whether eligibility exists in another covered group before the individual(s) can be determined eligible for Plan First.

If additional information is needed to complete the eligibility determination in another Medicaid covered group**,** the applicant must be given the opportunity to provide the additional information needed. If the additional information is not provided by the deadline *and Plan First was requested*, determine the applicant's eligibility for Plan First only.

When an individual is not eligible for Medicaid in any other covered group, evaluate eligibility for Plan First *if* the individual has indicated on the application the desire to opt *in* to *be evaluated for Plan First.*

When a Medicaid enrollee no longer meets the requirements for *the* current covered group, prior to cancelling coverage *the individual* must be evaluated in all *other* covered groups. If the individual is not eligible for full-benefit Medicaid coverage or as a Medicare beneficiary, *eligibility for Plan First* must be evaluated *if* the individual has indicated on the application the desire to opt *in* to *be evaluated for Plan First.*

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B. Nonfinancial Requirements

Individuals in this covered group must meet the Medicaid nonfinancial requirements in chapter M02.

Division of Child Support Enforcement (DCSE*)* services are available to all Medicaid recipients, but cooperation with DCSE is not a condition of eligibility for this covered group.

C. Financial Eligibility

Refer to chapters M05 and M07 for applications submitted before October 1, 2013 and for renewals completed before April 1, 2014. Refer to Chapter M04 for eligibility determinations completed on applications submitted on or after October 1, 2013.

1. Assistance Unit

Use the assistance unit policy in chapter M05 to determine the individual's financial eligibility for applications submitted before October 1, 2013 and for renewals completed before April 1, 2014. Refer to chapter M04 for eligibility determinations completed on applications submitted on or after October 1, 2013.

2. Resources

There is no resource test.

3. Income

The income limit for this group is 200% FPL. The income limits are contained in M04, Appendix 5.

4. Spenddown

Spenddown does not apply to Plan First. However, because an individual enrolled in the Plan First covered group does not receive full Medicaid coverage, if he meets a MN covered group listed in M0320 or M0330, he must be evaluated to determine if he could become eligible for full Medicaid coverage as medically needy (MN) by meeting a spenddown. At application and redetermination, Plan First enrollees who meet the MN covered group and resource requirements are placed on two six-month spenddown budget periods within the 12 month renewal period. They may also be eligible for a retroactive MN spenddown determination. See chapter M13 for spenddown instructions.

D. Entitlement and Enrollment

1. Begin Date

Eligibility in the Plan First covered group begins the first day of the month in which the application is filed, if all eligibility factors are met in the month.

2. Retroactive Coverage

Individuals in this covered group are entitled to retroactive coverage if they meet all the requirements in the retroactive period.

3. Enrollment

The AC for Plan First enrollees is "080."

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M0330.000 FAMILIES & CHILDREN GROUPS	**M0330.700**	**26**

M0330.700 BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT (BCCPTA)

A. Policy

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000 (P.L. 106-354) provides for payment of medical services, including long-term care (LTC) (see Chapter M14) for certain women and men with breast cancer or women with cervical cancer

Individuals eligible for the BCCPTA program must be age 18 through 64. They must have been screened and certified as needing treatment for breast or cervical cancer (including pre-cancerous conditions) by a medical provider operating under the Center for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program (BCCEDP) and referred to LDSS for a Medicaid eligibility determination. These individuals must not have creditable health insurance coverage for treatment of breast or cervical cancer.

Virginia's BCCEDP program, Every Woman's Life, is administered by the Virginia Department of Health. Screening locations can be found at *Free Breast and Cervical Screenings - Free Breast and Cervical Screenings (virginia.gov)*.
Information can also be obtained by calling 1-866-395-4968.

Through an agreement between Virginia and the District of Columbia (D.C.), residents of northern Virginia (the cities of Alexandria, Fairfax, Falls Church, Manassas, Manassas Park and the counties of Arlington, Fairfax, Loudoun and Prince William) are allowed to be screened and diagnosed for breast or cervical cancer and pre-cancerous conditions through the DC Center for Disease Control and Prevention's "Project Wish" program. Individuals who are screened and certified as needing treatment for breast or cervical cancer through Project Wish may be eligible for Virginia Medicaid, provided they meet the requirements of the BCCPTA covered group. These individuals will receive a Virginia BCCPTA Application Form from the DC providers and will be instructed to submit the application directly to the local department of social services in their home locality.

Individuals diagnosed with cancer by a provider who is not operating under the BCCEDP are not eligible in this covered group. Every Woman's Life is responsible for determining if an individual was diagnosed by a BCCEDP provider. Refer individuals who indicate to the local agency that they received a breast or cervical cancer diagnosis but do not provide the BCCPTA Application Form to Every Woman's Life (see above for contact information).

B. Nonfinancial Eligibility

1. Required Nonfinancial Requirements

BCCPTA individuals must meet the Medicaid nonfinancial requirements in chapte M02.

In addition, BCCPTA individuals must not be eligible for Medicaid under the following mandatory categorically needy covered groups:



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- LIFC;
- Pregnant Women;
- Child Under Age 19;
- SSI recipients.
- *Former Foster Care*

2. Creditable Health Insurance Coverage

BCCPTA individuals must not have creditable health insurance coverage. Creditable health insurance coverage includes:

- a group health plan;
- health insurance coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;
- Medicare;
- Medicaid;
- armed forces insurance a medical care program of the Indian Health Service (IHS) or of a tribal organization;
- a state health risk pool.

There may be situations where an individual has creditable health insurance coverage as defined above, but the coverage does not include treatment of breast or cervical cancer due to a period of exclusion or exhaustion of lifetime benefits, or the woman may have a high deductible. The individual is not eligible for Medicaid in the BCCPTA covered group because of the creditable health insurance.

C. Financial Eligibility

There are no Medicaid financial requirements for the BCCPTA covered group. The BCCEDP has income and resource requirements that are used to screen *individuals* for this program.

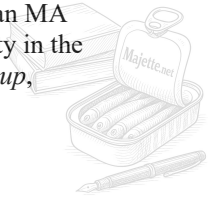
Individuals requesting Medicaid coverage of LTC services must provide verification of their resources and income and must meet all the LTC eligibility requirements in chapter M14.

D. Application Procedures

The application procedures for individuals who meet the BCCPTA non-financial requirements have been streamlined to facilitate the prompt enrollment and immediate access to services for individuals who are in need of treatment for breast or cervical cancer. In addition to the nonfinancial information required to evaluate eligibility in the BCCPTA covered group, the following information is needed for enrollment in Medicaid:

- name,
- address,
- sex and race,
- date of birth,
- country of origin and entry date, if an alien.

Individuals who meet the description of individuals in the LIFC, Pregnant Women, Child Under Age 19, or SSI recipients covered groups must complete the appropriate MA application for the covered group and must have an MA eligibility determination completed prior to determining their eligibility in the BCCPTA covered group. If not eligible in *a mandatory coverage group*,



then determine their eligibility in the BCCPTA covered group.

1. Application Form

This covered group has a special application, BCCPTA Medicaid Application (form #032-03-384), **that must be initiated by a BCCEDP provider**, including those affiliated with Project Wish operating in the District of Columbia. The application includes the BCCEDP certification of the individual's need for treatment and the information needed to determine the nonfinancial eligibility in the BCCPTA covered group. Appendix 7 to subchapter M0120 contains a sample of the BCCPTA Medicaid Application form.

If eligibility in another Medicaid covered group must first be determined, the applicant must be given the appropriate Medicaid application.

2. Application Processing Time Frames

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

BCCPTA Medicaid applications filed by individuals who meet the description of an individual in *one of the mandatory* covered groups must be processed as soon as possible, but no later than 45 calendar days of the agency's receipt of the signed application.

3. Notices

If the BCCPTA Medicaid application is the only application required and no additional information is required, the eligibility decision must be made immediately and applicant must be notified of the decision within 10 working days of the agency's receipt of the application.

If a decision cannot be made within 10 working days of receipt of the BCCPTA application, the worker must send a "Notice of Action on Medicaid", form #032-03-008, on the 10th day stating why action has not been taken, specifying what information is needed and a deadline for submitting the information.

E. Entitlement

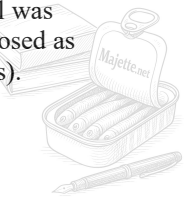
1. Entitlement Begin Date

Eligibility under this covered group is met the beginning of the month the screening is completed if the individual later has a positive diagnosis as a result of the screening and is determined to be in need of treatment for breast and/or cervical cancer.

Eligible BCCPTA individuals are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Coverage is to be provided throughout the person's course of treatment, and no limit is placed upon the number of years an eligible person may be covered as long as physician certifies at renewal that treatment for the breast or cervical condition is still required.

2. Retroactive Entitlement

Retroactive coverage is applicable to this covered group if the individual was screened by a medical provider operating under the BCCEDP and diagnosed as needing treatment for breast or cervical cancer in the retroactive month(s).



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F. Enrollment The aid category for BCCPTA individuals is "066".

G. Benefit Package The BCCPTA group is a full-benefit covered group. All Medicaid-covered services are available to BCCPTA enrollees, including long-term care in a facility or in a community-based care waiver.

H. Renewal Annual renewal requirements are applicable to the BCCPTA covered group. At the time of the annual renewal, the recipient must provide a statement from a medical provider verifying continued treatment for breast or cervical cancer. The BCCPTA Redetermination (form #032-03-653) is used for the renewal. See M1520.200 for renewal requirements.

M0330.800 FAMILIES & CHILDREN MEDICALLY NEEDY GROUPS

A. Introduction An F&C medically needy individual must

- be a child under age 18, or 21, or
- meet the adoption assistance, foster care or pregnant woman definition in subchapter M0310.

B. Procedure The policy and procedures for determining whether an individual meets an F&C MN covered group are contained in the following sections:

- M0330.801 Pregnant Women;
- M0330.802 Newborn Children Under Age 1;
- M0330.803 Children Under Age 18;
- M0330.804 Individuals Under Age 21;
- M0330.805 Adoption Assistance Children With Special Needs for Medical or Rehabilitative Care.

C. Referral to Health Insurance Marketplace When an individual meets an F&C MN covered group is not eligible solely due to excess income and is placed on a MN spenddown, the individual must be referred to the Health Insurance Marketplace (HIM) so that the applicant's eligibility for the APTC can be determined.

Note: Individuals with Medicare are not referred to the HIM.

D. Aid Categories *Aid Categories (ACs) are used in the eligibility and enrollment systems to denote coverage groups. Some covered groups have multiple ACs for designating disability status, age, income, and other demographic information. These ACs may be used for reporting and funding purposes. The policy sections for each MN covered group contain the assigned ACs*

Exception–MN individuals of any age who have been determined to be eligible for Medicaid coverage of emergency services based on the alien status requirement policies in subchapter M0220 will be assigned to AC 113 regardless of their covered group.

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M0330.801 PREGNANT WOMEN

A. Nonfinancial Eligibility

42 CFR 435.301(b)(1)(i)--If the state chooses to cover the medically needy, the State Plan must provide medically needy coverage to all pregnant women during the course of their pregnancy who, except for income and resources, would be eligible for Medicaid as categorically needy.

A pregnant woman's Medicaid eligibility is first determined in the CN pregnant women covered group which has no resource limit and has an income limit that is higher than the medically needy income limit. If a pregnant woman is not eligible as a *CN Pregnant Woman* because her income is too high, evaluate as FAMIS MOMS. If the individual is not eligible for FAMIS MOMS, then evaluate as MN. She may spenddown to the lower MN income limit IF her resources are within the MN resource limit.

A pregnant woman is eligible in this MN covered group if she meets the pregnant woman definition in M0310.119 and meets the nonfinancial requirements in chapter M02.

B. Financial Eligibility

1. Assistance Unit

The assistance unit policy and procedures in chapter M05 apply to medically needy pregnant women. If the pregnant woman is not institutionalized, consider the resources and income of a pregnant woman's spouse with whom she lives and, if the pregnant woman is under age 21, the pregnant woman's parent(s) with whom she lives. If a pregnant woman also applies for other assistance unit members living with her who do not meet an F&C medically needy covered group, separate financial eligibility determinations are done for the unit. One is the F&C medically needy determination for the pregnant woman. The other financial eligibility determination is based on the other individual's(s) covered group(s).

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2. Resources

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

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

a. Resources Within The Limit

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

b. Resources Exceed The Limit

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

3. Income

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

4. Income Exceeds MN Limit

Because the MN pregnant woman's income exceeds the 133% FPL limit, it also exceeds the MN limit. She becomes eligible in this MN covered group when she has incurred medical expenses equal to the difference between her income and the MN income limit (spenddown). See chapter M13 for spenddown policy and procedures.

5. Income Changes

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

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

C. Entitlement

Eligible women in this MN group are entitled to full Medicaid coverage beginning the first day the spenddown is met. The woman is entitled to MN coverage *for 12 months following the end of the month in which her pregnancy ends*. Her MN Medicaid coverage ends the last day of *the 12th month following the month her pregnancy ends,* regardless of when the spenddown period ends, without the need for a new application or an additional spenddown period.

Retroactive coverage is applicable to this covered group.

Example:

A pregnant woman applied for Medicaid on January 5, *2022*. Her estimated date of delivery is May 10, *2022*. Her income exceeds the income limit for 2 persons for Medicaid and FAMIS MOMS. Her resources are within the medically needy resource limit for the retroactive period and ongoing, and she is placed on a retroactive spenddown for the period October 1, *2021,* through December 31, 2021, and a prospective spenddown for the period January 1, *2022* through June 30, *2022*. She delivered the child and met the spenddown on May 20, *2022*. She was enrolled in MN coverage effective May 20, *2022*. Although her spenddown period ends on June 30, her MN Medicaid coverage does not end until May 31, *2023, the last day of the 12th month following the end of the month the child was born.*

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

D. Enrollment

Eligible individuals in this group are enrolled in AC 097.

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M0330.802 NEWBORN CHILDREN UNDER AGE 1

A. Policy

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

B. Nonfinancial Eligibility

A child who meets this covered group:

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

  If the child's mother was covered by Medicaid as a medically needy individual in a state other than Virginia at the time of the child's birth, verification of the mother's Medicaid coverage must be provided by the parent or authorized representative.

1. Continued Eligibility When Mother Becomes Ineligible

Any child born to an eligible pregnant woman will continue to be eligible in this covered group **up to age 1.**

EXAMPLE #4: A pregnant woman applied for Medicaid on October 24, 2008. Her estimated date of conception is March 24, 2008, and her due date is December 20, 2008. Her income exceeds the CN limit for 2 persons. Her resources are within the medically needy resource limit and she is placed on a spenddown for the period October 1, 2008 through March 31, 2009. She meets the spenddown on November 15, 2008, and is enrolled in Medicaid as MN effective November 15, 2008 through March 31, 2009.

Her child is born on November 30, 2008, and is enrolled in Medicaid as an MN newborn. The mother's Medicaid coverage is canceled effective January 31, 2009, the last day of the month in which the 60th day occurred after her pregnancy ended. The newborn's Medicaid coverage continues through November 30, 2009, the end of the month in which he turns one year old. *A renewal of the child's coverage must be completed for his coverage to continue past age one.*

2. Covered Group Eligibility Ends

The child no longer meets this covered group effective:

a. the end of the month in which the child reaches age 1 year; or

b. the end of the month in which the child no longer resides in Virginia.

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B. Financial Eligibility

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

C. Entitlement & Enrollment

Eligible newborns in this MN group are entitled to full Medicaid coverage beginning the date of the child's birth. Retroactive coverage is applicable to this covered group, but coverage cannot begin prior to the date of the child's birth. A renewal must be completed for the newborn before system cut-off in the last month in which the child meets the Newborn Children Under Age 1 covered group and must include SSN or proof of application, as well as verification of income and resources.

Children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

Eligible children in this group are enrolled in aid category 099.

M0330.803 CHILDREN UNDER AGE 18

A. Nonfinancial Eligibility

42 CFR 435.301(b)(1)(ii) - If the state chooses to cover the medically needy, the State Plan must provide medically needy coverage to all children under 18 years of age who, except for income and resources, would be eligible for Medicaid as categorically needy.

A child is eligible in this MN covered group if he/she has not attained age 18 years and meets the nonfinancial requirements in chapter M02.

A child under age 18's Medicaid eligibility is first determined in the Child Under Age 19 covered group and for FAMIS, which have no resource limits and have income limits that are higher than the medically needy income limit. If a child under age 18 is not eligible for Medicaid in the Child Under 19 covered group or for FAMIS because the child's countable income is too high, and the child's resources are within the MN resource limit, evaluate the child's in the MN Children Under Age 18 covered group.

B. Financial Eligibility

1. Assistance Unit

The assistance unit policy and procedures in chapter M05 apply to this covered group. If not institutionalized, count or deem any resources and income from the child's spouse and/or parent with whom he/she lives.

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2. Resources

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

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

a. Resources Within The Limit

If the child's resources are within the MN limit, go on to determine income eligibility.

b. Resources Exceed The Limit

If the child's resources are NOT within the limit, the child is NOT eligible for Medicaid because of excess resources.

3. Income

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

4. Income Exceeds MN and FAMIS Limits

Because the Child Under Age 19 and FAMIS income limits are higher than the MN income limits, the child becomes eligible in the MN children under age 18 covered group when the child has incurred medical expenses equal to the difference between his/her income and the MN income limit (spenddown). See chapter M13 for spenddown policy and procedures.

5. Income is under the MN and FAMIS Limits

Because of the differences between the Child Under 19 covered group/FAMIS (MAGI) and MN (non-MAGI) income-counting rules, such as the treatment of a stepparent's income, a child may be ineligible for Medicaid as a Child Under 19 or for FAMIS coverage but have countable income under the income limit for MN coverage. In this case, the child's spenddown liability is $0.00 (zero dollars). Even if the spenddown liability is $0.00, MN coverage cannot be open-ended. Enroll the child in *one 12 month* period of coverage, without the need for a new application. Complete a renewal following the procedures in M1520 at the end of the second spenddown period. Continue to enroll the child in *one 12 month* period of coverage per year as long as he continues to be eligible as MN at renewal.

C. Entitlement & Enrollment

Children who become eligible after meeting a spenddown are entitled to full medically needy Medicaid coverage beginning the day the spenddown was met. Retroactive coverage is applicable to this covered group.

Children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

Eligible children in this group are enrolled in aid category 088.

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Virginia Medical Assistance Eligibility	**M03**	**May 2015**	
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M0330.000 FAMILIES & CHILDREN GROUPS	**M0330.804**		**36**

M0330.804 INDIVIDUALS UNDER AGE 21

A. Policy

42 CFR 435.308(b) - A state may choose to provide medically needy coverage to reasonable classifications of individuals under 21 years of age who are not eligible for coverage as categorically needy but who meet the medically needy resource and income requirements.

Virginia has chosen to cover the following reasonable classifications of individuals under age 21:

- Non-IV-E Foster Care children
- Department of Juvenile Justice (DJJ) children,
- Non-IV-E Adoption Assistance children,
- Children in intermediate care nursing facilities (ICF), and
- Children in an ICF-*ID*.

NOTE: the ICF- *ID* services are **not** covered for medically needy individuals, but other Medicaid covered services such as prescription drugs, physicians, inpatient and outpatient hospital services are covered for medically needy patients in ICF- *IDs*.

B. Nonfinancial Eligibility

The individual must be under age 21 and meet the nonfinancial requirements in chapter M02. The child meets the age requirement until the end of the month in which the child turns age 21.

C. Reasonable Classifications

The individual under age 21 must meet one of the following classifications:

1. Non IV-E Foster Care

Children who meet the foster care definition in M0310.115 but do not receive a IV-E maintenance payment are "individuals in foster homes, private institutions or independent living arrangements for whom a public or private nonprofit child-placing agency is assuming full or partial financial responsibility." This group also includes DJJ children.

c. Children Living In Public Institutions

Non-IV-E foster care children meet the Medicaid institutional status requirements when they live in a public child care institution if the facility has less than 25 beds, or if they live in a publicly operated community residence that has no more than 16 beds. See section M0280.100 for definitions of public institutions.

When these children are placed in public residential institutions, the facility must not have capacity for more than 16 children (see M0280).

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d. Child in Independent Living Arrangement

A child in an independent living arrangement is eligible for Medicaid in this covered group if the child is receiving services from the local social services agency.

2. Non-IV-E Adoption Assistance

Children under age 21 who meet the adoption assistance definition in M0310.102 for whom a Non-IV-E adoption assistance agreement between the LDSS and the adoptive parent(s) is in effect are "individuals in adoptions subsidized in full or in part by a public agency." If the child receives a Non-IV-E adoption assistance payment, or if the child was adopted under an adoption assistance agreement and is not eligible as a IV-E Adoption Assistance child, then the child meets the "Non-IV-E adoption assistance" definition.

Adoption assistance c*hildren with* special needs *for* medical *or rehabilitative care* have additional requirements. See section M0330.805.

3. In ICF or ICF-ID

Children under age 21 who are patients in either an ICF or ICF- ID meet the classification of "individuals in an ICF or ICF- ID" in the Individual Under Age 21 covered group.

D. Assistance Unit

a. Non-IV-E Foster Care Children (Includes DJJ)

The child is an assistance unit of one effective the date the child is removed from the home and placed in foster care. Each child in foster care is evaluated as a separate assistance unit, even if the child is living with his/her siblings in a foster care home.

A foster care or DJJ child continues to be a single person unit during a trial visit in his own home. A "trial visit" is no longer than six months for this section's purposes.

b. Adoptive Placement

While in adoptive placement, the child may continue to be treated as a foster care child. However, once the interlocutory or the final order of adoption is entered, the child must be treated as a Non-IV-E adoption assistance child; see 3. below.

c. **Non-IV-E Adoption Assistance-Interlocutory or Final Order Entered**

Financial eligibility is determined using the assistance unit procedures in subchapter M0520, which require the inclusion of the child's adoptive parent(s) and sibling(s). An adoption assistance child must have his/her eligibility determined by counting or deeming (as appropriate) his/her parent's and sibling's income.

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d. **Child in ICF or ICF- ID**

A child in an ICF or an ICF- ID is an institutionalized individual in a medical facility when he meets the definition of "institutionalized individual" in section M1410.010 B.2. When he meets the institutionalized individual definition, he is an assistance unit of one person.

E. Resources

The resource limit and requirements are found in chapter M06.

If the resources exceed the limit, the child is not eligible for Medicaid. If the child is under age 19, determine the child's eligibility as FAMIS Plus because that classification has no resource limits.

F. Income

The MN income requirements are found in subchapter M0710.

Income Limits

For the MN Individuals Under Age 21 covered group, the income limit is the medically needy income limit found in chapter M0710, Appendix 5.

The foster care or adoption subsidy payment is excluded when determining the unit's income eligibility.

Foster care or adoption assistance children in residential facilities do not have a different income limit. For a foster care/adoption assistance child living outside the State of Virginia, the MN income limit for the unit is the income limit for the Virginia locality which holds custody, pays the adoption subsidy, or signed the adoption assistance agreement.

2. **Income Exceeds MN Income Limit**

If the unit's resources are within the medically needy limit, but the income exceeds the medically needy income limit, the unit is placed on a spenddown. All medical expenses of the unit members are used to meet the spenddown. Once the spenddown is met, only the child and family members who meet an MN covered group and who applied for Medicaid are enrolled in Medicaid.

G. Entitlement & Enrollment

1. Entitlement

Entitlement to Medicaid begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. If the individual is eligible after meeting a spenddown, entitlement begins the date the spenddown was met and ends after the last day of the spenddown period.

Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

Children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

2. Enrollment

The aid category for medically needy individuals in the MN covered group of Individuals Under Age 21 are:

- 086 for an MN Non-IV-E foster care, MN Non-IV-E adoption assistance,
- 085 for an MN Juvenile Justice Department child;
- 098 for an MN child under age 21 in an ICF or ICF- ID.

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M0330.000 FAMILIES & CHILDREN GROUPS	**M0330.805**		**39**

M0330.805 ADOPTION ASSISTANCE *CHILDREN WITH* SPECIAL NEEDS *FOR* MEDICAL *OR REHABILITATIVE CARE*

A. Policy

42 CFR 435.308(b) - A state may choose to provide medically needy coverage to a child under age 21 years

- for whom a non-IV-E adoption assistance agreement between the state and the adoptive parent(s) is in effect;
- who cannot be placed with adoptive parents without Medicaid because the child has special needs for medical or rehabilitative care; and
- who was enrolled in Medicaid under any covered group before the adoption assistance agreement was entered into OR who would have been eligible for Medicaid before the adoption assistance agreement was entered into if the eligibility requirements and standards of the IV-E foster care program were used, without employing the threshold title IV-A eligibility determination.

If the child was not enrolled in Medicaid and would not have been eligible for Medicaid prior to the adoption assistance agreement being entered into, the child is **not** eligible for Medicaid in the Adoption Assistance *Children With* Special Needs *for* Medical *or Rehabilitative Care* MN covered group. The child may be eligible in the MN Non-IV-E Adoption Assistance classification of Individuals Under Age 21 in section M0330.804.

B. Nonfinancial Eligibility

The child must

- be under age 21,
- meet the definition of a child *with* special needs *for* medical *or rehabilitative care adopted under a Non IV-E Adoption Assistance agreement* in M0310.102, and
- meet the nonfinancial requirements in chapter M02.

C. Financial Eligibility

1. Assistance Unit

The assistance unit consists of only the child if the child was eligible for Medicaid prior to the adoption assistance agreement being entered into. The adoptive parent(s)' income and resources are **not** counted or deemed; only the child's own income and resources are counted.

A child in an ICF or an ICF-MR is an institutionalized individual in a medical facility when he meets the definition of "institutionalized individual" in section M1410.010 B.2. When he meets the institutionalized individual definition, he is an assistance unit of one person. The child's eligibility is determined in the F&C 300% SSI covered group in M0330.501.

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2. Resources

The resource limits and requirements are found in chapter M06.

If the resources exceed the limit, the child is not eligible for Medicaid as medically needy. If the child is under age 19, determine the child's eligibility as F&C CN because that classification has no resource limits.

3. Income

Adoption assistance children in residential facilities do not have a different income limit. The MN income limit for one person in the child's locality is used to determine the child's MN eligibility. For an adoption assistance child living outside the State of Virginia, the income limit for the child is the income limit for the Virginia locality which signed the adoption assistance agreement.

The adoption subsidy payment is excluded when determining the child's financial eligibility.

If the child's countable income exceeds the MN income limit, the child is placed on a spenddown. Only the child's medical expenses are used to meet the spenddown. Once the spenddown is met, the child is enrolled in Medicaid.

D. Entitlement & Enrollment

Eligible individuals in this MN group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Individuals who become eligible after meeting a spenddown are entitled to full Medicaid coverage beginning the day the spenddown was met and ending the last day of the sixth month in the spenddown period. Retroactive coverage is applicable to this covered group.

Children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

The AC for individuals in the Adoption Assistance Children With Special Needs for Medical or Rehabilitative Care MN covered group is "086.**"**

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CHAPTER M04

MODIFIED ADJUSTED GROSS INCOME (MAGI)

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Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Pages 2, 13, 30, 31
TN #DMAS-35	7/1/25	Page 4, 14, 15, 20, 33; Appendices 3, 5, 8
TN #DMAS-34	1/1/25	Pages 16a and 16b, Appendix 1,2,6,7
TN #DMAS-33	10/1/24	Appendix 2
TN #DMAS-32	7/1/24	Pages 2, 4, 5, 8, 16, 16b2, 21, 33, 34, 34a Appendices 3, 5 and 8
TN #DMAS-31	4/1/24	Pages 15 and 16a; Appendices 1, 2, 6 and 7
TN #DMAS-30	1/1/24	Pages 1, 34 Page 34a is a runover page
TN #DMAS-28	7/1/23	Page 37 Appendices 1,2,3,5,6 and 7

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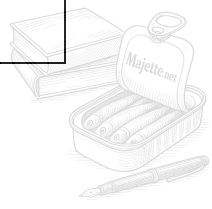
Changed With	Effective Date	Pages Changed
TN #DMAS-27	4/1/23	Pages 5, 6, 16 Definitions renumbered
TN #DMAS-26	1/1/23	Page 34
TN #DMAS-25	10/1/22	Pages 5, 15, 16
TN #DMAS-24	7/1/22	Appendix 3 Appendix 5
TN #DMAS-23	4/1/22	Pages 16b, 18, 32 Appendix 1, pages 1-2 Appendix 2, pages 1-2 Appendices 6 and 7
TN #DMAS-21	10/1/21	Pages 3, 15
TN #DMAS-20	7/1/21	Pages 2, 14, 15, 16a, 16b, 19 Appendix 3 Appendix 5 Appendix 8
TN #DMAS-19	4/1/21	Appendix 1, pages 1-2 Appendix 2, pages 1-2 Appendices 6 and 7
TN #DMAS-18	1/1/21	Pages 7, 16a, 18, 19 Page 16 b was added. Page 18a was added as a runover page.
TN #DMAS-17	7/1/20	Pages 15, 16, 16a, 19 Appendices 3, 5, and 8
TN #DMAS-16	4/1/20	Pages 16a, 20 Appendix 1, pages 1-2 Appendix 2, pages 1-2 Appendices 6 and 7
TN #DMAS-15	1/22/19	Pages 16, 16a, 19
TN #DMAS-14	10/1/19	Pages 1, 3, 4, 5, 14, 16, 32, 33 Appendix 8
TN #DMAS-13	7/1/19	Pages 32-34, 36 Appendices 3 and 5
TN #DMAS-12	4/1/19	Pages 2, 3, 5-8, 15-16, 19, 32-37 Page 16a was added as a runover page. Page 37 was removed. Appendices 1, 2, 6, 7, 8
TN #DMAS-11	1/1/19	Pages 8, 15, 32-35 Pages 36 and 37 were added.
TN #DMAS-10	10/1/18	Table of Contents Pages 1-5, 9, 10, 15, 16, 19, 22, 23, 30-32 Appendix 7 Appendix 8 was renumbered. Pages 6-8, 11-14, 17, 18, 20, 21, 24-29, 33-35 are runover pages.



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TN #DMAS-9	7/1/18	Table of Contents. Pages 5, 6, 11, 14a, 25-27 Appendices 3 and 5 Page 6a is a runover page. Page 28 was added as a runover page.
TN #DMAS-8	4/1/18	Table of Contents Pages 2-6a, 12-14b, 25 Pages 26 and 27 were added. Pages 14c was added as a runover pages. Appendices 1, 2, 6 and 7 Appendix 1, page 2 was added.
TN #DMAS-6	10/1/17	Pages 12, 13, 14b
TN #DMAS-5	7/1/17	Table of Contents Pages 5, 6, 12, 13, 14-14b Appendices 3, 4 and 5 Page 6a was added as a runover page. Page 13a, 14, and 14a were renumbered to pages 14, 14a and 14b.
TN #DMAS-4	4/1/17	Appendices 1, 2 and 6
TN #DMAS-3	1/1/17	Table of Contents Pages 3 -5, 13a, 20 Appendix 6, page 1 Page 20a was added.
TN #DMAS-2	10/1/16	Appendix 2, pages 1, 2 Appendices 3, 5
TN #DMAS-1	6/1/16	Pages 3, 5, 6, 12, 13, 14a Appendices 1, 2, 6 and 7 Appendix 2, page 2 was added. Page 13a is a runover page.
UP #11	7/1/15	Appendices 3 and 5
TN #100	5/1/15	Pages 2, 11, 12, 13, 14 Appendices 1, 2, 3, 5, 6 and 7 Page 1 is a runover page.
Update (UP) #10	5/1/14	Table Contents pages 2, 3, 5, 6, 10-15 Appendices 1, 2 and 6 Appendix 7 was added.
TN #99	1/1/14	Pages 2, 5, 6, 8, 14, 15 Appendix 6



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M0410.000 MODIFIED ADJUSTED GROSS INCOME (MAGI) M0410.100 MAGI GENERAL INFORMATION

A. Introduction

Effective October 1, 2013, determinations of eligibility for most families and children (F&C) Medicaid covered groups and the Family Access to Medical Insurance Security Plan (FAMIS) *were completed* using the Modified Adjusted Gross Income (MAGI) methodology.

Effective January 1, 2019, determination of eligibility for adults age 19-64 without Medicare *were* evaluated using MAGI income methodology. These individuals are referred to as MAGI Adults.

MAGI methodology is also used to determine eligibility for *Premium Tax Credits through Virginia's* Insurance Marketplace. Medicaid, FAMIS and *Virginia's* Insurance Marketplace (VIM) are called insurance affordability programs. Medicaid and FAMIS are collectively referred to as medical assistance (MA) programs.

For all case actions effective October 26, 2019, verification of earned and unearned income *were* evaluated using attested income and reasonable compatibility rules. Whenever possible, income reported on the application *are* verified through electronic data sources.

The goal of using MAGI methodology for all insurance affordability programs is to align financial eligibility rules, provide a seamless and coordinated system of eligibility and enrollment, and maintain the eligibility of low-income populations, especially children.

A federal mandate requires that as of January 1, 2024, all children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

B. Legal Base

The Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111- 152) (collectively referred to as the Affordable Care Act [ACA]) is the legal base for the changes required to be made in the Medicaid and CHIP (FAMIS) eligibility determinations. The 2018 Appropriations Act provided funding for New Health Coverage Options for Virginia Adults. Effective January 1, 2019, determination of eligibility for adults between the ages of 19-64 without Medicare will be evaluated using MAGI income methodology. Adults eligible under the expansion of coverage will be referred to as Modified Adjusted Gross Income (MAGI) Adults. Individuals in the MAGI Adults covered group are not subject to a resource test unless the individual requests Medicaid payment for LTC/LTSS. The resource and home equity requirements for MAGI Adults are contained in M1460.

MAGI and household income are defined in section 36B(d)(2)(A) and (B) of the Internal Revenue Service Code (IRC). The MAGI-based methodology under the Medicaid statute includes certain unique income counting and household (HH) composition rules reflected in the Centers for Medicare and Medicaid Services (CMS) regulations at 42 CFR 435.603 and discussed in section III.B. of the preamble to the eligibility final rule published in the Federal Register on March 23, 2012.

C. Policy Principles

1. What is MAGI?

MAGI is a methodology for how income is counted and how household composition and family size are determined and is based on federal tax rules for determining adjusted gross income (with some modification), and has no resource test (Exception: MAGI Adults requesting coverage of Long Term Care services are subject to certain asset/resource requirements).



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- has no resource test (Exception: MAGI Adults requesting coverage of Long-Term Care services are subject to certain asset/resource requirements)

2. MAGI Rules

- MAGI has an income disregard equal to 5% of the federal poverty level (FPL) for the Medicaid or FAMIS individual's household size. The disregard is only given if the individual is not eligible for coverage due to excess income. It is applicable to individuals in both full-benefit and limited-benefit covered groups.
- If the individual meets multiple Medicaid covered groups (and/or FAMIS) his gross income is compared first to the income limit of the group with the highest income limit under which the individual could be eligible.
- If the income exceeds the limit, the 5% FPL disregard can be allowed, and the income again is compared to the income limit.
- When considering tax dependents in the tax filer's household, the tax dependent may not necessarily live in the tax filer's home.
- Under MAGI counting rules, an individual may be counted in more than one household but is only evaluated for eligibility in his household.
- Use non-filer rules when the household does not file taxes.
- Use non-filer rules when the applicant is claimed as a tax dependent by someone outside the applicant's household.
- Non-filer rules may be used in multi-generational household.

3. Eligibility Based on MAGI

MAGI methodology is used for eligibility determinations for insurance affordability programs including Medicaid, FAMIS, the Advance Premium Tax Credit (APTC) and cost sharing reductions through the Health Insurance Marketplace for the following individuals:

a. Children under 19

b. Parent/caretaker relatives of children under the age of 18 - Low Income Families With Children (LIFC)

c. Pregnant individuals, including *LIFC,* FAMIS MOMS and FAMIS Prenatal Coverage

d. Individuals Under Age 21

e. Adults between the ages of 19 and 64 not eligible or enrolled in Medicare (effective January 1,2019)

f. Individuals in Plan First.

4. Eligibility NOT Based on MAGI

MAGI methodology is NOT used for eligibility determinations for: individuals for whom the eligibility worker is not required to make an income determination:

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- Supplemental Security Income (SSI) recipients.
- IV-E foster care or adoption assistance recipients
- Deemed newborns
- BCCPTA (Breast and Cervical Cancer Prevention and Treatment Act) enrollees
- Auxiliary Grants.

b. individuals who are eligible on the basis of being aged (age 65 or older), blind or disabled;

- individuals eligible for or enrolled in Medicare;

- individuals evaluated as Medically Needy (MN);

5. Adoption Assistance Children *with* Special Needs *for* Medical *or Rehabilitative Care*

An adoption assistance child *with* special needs *for* medical *or rehabilitative care* is subject to MAGI methodology for the child's initial Medicaid eligibility determination. These children are in their own household apart from parents and siblings. Parents' and siblings' income is not counted for these children.

6. MAGI Adults

a. MAGI methodology is used to determine eligibility for the following individuals with income at or below 138% (133% + 5% disregard) of the Federal Poverty Limit:

- Parents and caretaker- relatives with excess income for LIFC

- Disabled individuals not eligible for or entitled to Medicare or individuals alleging disability who have not been determined disabled

- Childless adults ages 19-64

- Incarcerated individuals ages 19-64. Incarcerated individuals are eligible for inpatient hospital services only; inpatient hospitalization may include long-term inpatient services, such as admission to a rehabilitation facility.

- Non-citizens eligible for emergency services only

- Individuals eligible for Long Term Care Services and Support (LTSS) ages 19-64
  Note: See Chapter M14 for LTSS screening requirements.

b. The following individuals are not eligible under the MAGI ADULTS group:

- Individuals pregnant at initial application or redetermination of eligibility

- Individuals under the age of 19 or 65 and over

- Individuals eligible for or enrolled in Medicare Part A or B

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- Individuals eligible in the following covered groups:
  - LIFC (parents and caretaker-relatives)
  - Pregnant Individuals
  - Adoption Assistance and Foster Care Children
  - Former Foster Care Children Under Age 26
  - BCCPTA
- Supplemental Security Income (SSI) recipients and protected individuals.

7. Psychiatric Residential Treatment Facilities (PRTFs) *Children residing in a PRTF (formerly called a Level C PRTF) are not temporarily absent from home. They are indefinitely absent from home and are not living with their parents or siblings for Medicaid purposes, if their stay in the facility has been 30 calendar days or longer.* Long-term *Services and Supports* rules do not apply. See M0520.100 B.*4*.

M0420.100 Definitions

A. Introduction The definitions below are used in this chapter. Some of the definitions are also in subchapter M0310. Some of the definitions are from the IRC.

B. Definitions

1. Advance Premium Tax Credit (APTC) is a tax credit that an individual or family with taxable income of at least 100% FPL but no more than 400% FPL can take in advance to lower their monthly health insurance premium. Eligibility for the APTC is determined by the federal HIM using MAGI rules for tax-filer households. Projected annual household income, rather than monthly income, is evaluated.

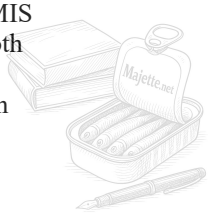
2. Attested Income means the agency must review income information attested by the applicant and utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information, information from SSA through SVES or SOLQ-I and other verified income in the eligibility record or system. Verification of income from available sources, including the VEC, may be used if it is dated within the previous *6* months.

3. Caretaker Relative means a non-parent relative of a "dependent" child by blood, adoption, or marriage with whom the child lives, who assumes primary responsibility for the child's care. When a parent is in the home, no adult relative other than a stepparent can be eligible for Medicaid in the LIFC covered group.

4. Child means a natural, biological, adopted, or stepchild.

5. Childless Adult a childless adult is someone who does not meet the definition of an LIFC parent or caretaker-relative.

6. Coverage Gap and Gap-filling Rule occurs when the difference in eligibility rules between the APTC and Medicaid/FAMIS creates a situation in which an applicant may appear to be financially ineligible for both the APTC (household income is too low) and Medicaid or FAMIS (household income is too high). The gap-filling rule is applied in such cases to help mitigate the coverage gap.



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7. Dependent Child means a child under age 18, or age 18 and a full-time student in a secondary school is expected is to graduate prior to his 19th birthday, and who lives with his parent or caretaker-relative.

8. Family means the tax filer (including married tax filers filing jointly) and all claimed tax dependents.

9. Family Size means the number of persons counted as an individual's household. The family size of a pregnant *individual's* household includes the pregnant *individual* plus the number of children she is expected to deliver. When determining the family size of other individuals who have a pregnant *individual* in their household, the pregnant woman is counted as just one person.

10. Household A household is determined by tax dependency. Parents, children and siblings are included in the same household. A child claimed by non-custodial parent is evaluated for eligibility in the household in which is living and is also counted in the family size of the parent claiming *the child* as a dependent. There can be multiple households living in the home.

This definition is different from the use of the word household in other programs such as the Supplemental Nutrition Assistance Program (SNAP).

11. MAGI Adult is an individual between the ages of 19-64 who is not eligible for or enrolled in Medicare and who has income at or below 138% of FPL.

12. Non-filer Household means individuals who do not expect to file a Federal tax return and/or do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made. A non-filer household can also be a child who lives in the household with his custodial parent who is claimed on his non-custodial parent's taxes.

13. Parent for the purposes of MAGI methodology, means a natural, biological, adoptive, or stepparent. When both the child's parent and stepparent are living in the home with the dependent child, both may be eligible in the LIFC covered group.

14. Reasonable Compatibility means the income attested to (declared) by the applicant is within *2*0% of income information obtained from electronic sources OR that both the attested income and any electronic income verification are below the applicable income limit. If the income from both sources meets the 20% requirement or the income from both sources is below the limit, then the attestation is considered verified.

The applicant's income reported on the application is compared through a match with income verification available from electronic income sources. The eligibility/enrollment system will compare the reported income with the income from the data match and determine if reasonable compatibility exists. If reasonable compatibility exists, the income will be labeled verified, and no further verification of the income is necessary.

If reasonable compatibility does not exist or income data was not available through available electronic sources and the attestation is below the medical assistance income level, additional verification of income is required.

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15. Sibling means a natural, biological, stepsibling or half-sibling.

16. Tax-Dependent means an individual for whom another individual claims a deduction for a personal exemption under section 151 of the Internal Revenue Code of 1986 for a taxable year.

17. Tax-filer Household means individuals who expect to file a Federal tax return and/or who expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made.

18. Tax Filing Threshold is the minimum amount of income an individual must earn in order to be required to file a federal income tax return. The amount varies depending on the individual's age, marital status and number of dependents. The amount generally changes annually.

M0430.100 MAGI HOUSEHOLD COMPOSITION

A. Introduction

The household composition is the basis for the financial eligibility determination for each person in the home who applies for MA. Eligibility is based on the countable income of the household members.

Included in the MAGI household composition are:

- stepparents and stepchildren,
- children/siblings with income,
- children ages 21 and older who are claimed as tax dependents, and
- adult tax dependents.

B. Household Composition Rules

Tax filers and tax dependents use the tax household rules with limited exceptions. In most cases, the household is determined by principles of tax dependency.

- Parents, children and siblings are included in the same household.
- Stepparents and parents are treated the same.
- Children and siblings with or without income are included in the same household as the rest of the family.
- Older children are included in the family if claimed as tax dependent by the parents.
- Married couples living together are **always** included in each other's household even if filing separately.
- Married couples that are separated and not living together but file jointly are not included in each other's household.
- Dependent parents may be included in the household if they are claimed for income tax purposes.

1. Tax Filer Household Composition

The tax filer household is determined based on the rules of tax dependency. Parents, children and siblings are included in the same household. The tax filer's household consists of the tax filer and all tax dependents who **are expected to be claimed for the current year**. This could include non-custodial children claimed by the tax filer, but living outside the tax filer's home and dependent parents claimed by the tax filer, but living outside the tax filer's home.

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The tax filer household is composed of the individual who expects to file a tax return this year and does not expect to be claimed as a dependent by another tax filer. The household consists of the tax filer and all individuals the tax filer expects to claim as a tax dependent.

2. Tax Dependent Household Composition

means all dependents expected to be claimed by another tax filer for the taxable year. Except for adoption assistance children *with* special needs *for* medical *or rehabilitative care* and children who have been in a Level C PRTF for at least 30 consecutive days, the household of a tax dependent who does not meet an exception in M0430.100 B.2 below is the same as the tax filer's household.

If the tax dependent is living with a tax filer other than a parent or spouse or is living separately from the parent claiming him as a dependent, the tax dependent is included in the tax filer household, but the tax filer is NOT included in the tax dependent's household.

An adoption assistance child *with* special needs *for* medical *or rehabilitative care* or a child who has been in a Level C PRTF for at least 30 consecutive days is in his own household with no parents or siblings.

Exceptions to the tax household composition rules apply when:

- individuals other than biological, adopted or stepchildren are claimed as tax dependents,
- children are claimed by non-custodial parents,
- children under age 19 live with both parents and expect to be claimed as a tax dependent by one parent, but parents (married or unmarried) do not expect to file jointly,
- the tax dependent is *an* adoption assistance child *with* special needs *for* medical *or rehabilitative care* or a child who has been in a Level C PRTF for at least consecutive 30 days.

3. Non Filer Household Composition

The Non Tax Filer household rules mirror the tax filer rules to the maximum extent possible.

- The household consists of parents and children under age 19. Exception: An adoption assistance child *with* special needs *for* medical *or rehabilitative care* or a child who has been in a Level C PRTF for at least 30 consecutive days is in his own household with no parents or siblings.
- Non-filer rules are used when a child is claimed as a tax dependent of someone not living in the home.
- Non-filer rules are used in the case of a multi-generational household where the tax dependent is also the parent of a child.
- Spouses, parents, stepparents and children living together are included in the same household. Exception: An adoption assistance child *with* special needs *for* medical *or rehabilitative care* or a child who has been in a Level C PRTF for at least 30 consecutive days is in his own household with no parents or siblings.
- Children under age 19 living with a relative other than a parent are included in a household only with siblings/stepsiblings under age 19 who also live in the home.



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- For non-filers, a "child" is defined as under age 19.

4. Married Couple

In the case of a married couple living together, the spouse is always included in the household of the other spouse, regardless of their tax filing status. This includes a tax dependent living with both a tax filer parent AND the dependent's spouse. The tax dependent's household includes his spouse, the tax filer, any other parent in the home, and any siblings in the home who are also claimed by the same tax filer.

5. Tax Filer is Under Age 19

If the tax filer is under age 19, lives in the home with *the* parent(s) AND is not expected to be claimed as a dependent by anyone, the parent(s) are included in the child's household.

6. Gap-filling Rule

States are required to use household income, as calculated by the federal HIM for the APTC eligibility determination, to determine eligibility for Medicaid or FAMIS if **all** of the following conditions apply:

a. The individual is in a tax filer household (including those who meet a tax dependent household exception in M0430.100 B.2). APTC methodology does not apply to non-filer households.

b. Current monthly household income, using Medicaid/FAMIS MAGI-based methods is over the applicable monthly income limit (including the 5% FPL disregard) for the individual's covered group.

c. The total income already received plus projected income for the **calendar** year in which eligibility is being determined, using MAGI methods applied by the HIM for the purposes of APTC eligibility, is below 100% FPL (i.e. the lower income threshold for APTC eligibility). See M04, Appendix 1.

This requirement is referred to the gap-filling rule. See M0450.400 for gap-filling rule evaluation procedures and examples.

M0430.200 TAX FILER HOUSEHOLD EXAMPLES

A. Married Parents and Their Tax Dependent Children

Sam and Sally are a married couple. They file taxes jointly and claim their two children Susie and Sarah as tax dependents. All of them applied for MA.

The MAGI household is the same as their tax household because the tax filers are a married couple filing jointly and claiming their dependent children. No additional individuals live in the home.

Ask the following questions for each tax dependent to determine if exceptions exist:

- Is Susie the tax dependent of someone other than a spouse or a biological, adopted, or stepparent? No, also applies to Sarah
- Is Susie a child living with both parents, but the parents do not expect to file a joint tax return? No, also applies to Sarah
- Is Susie a child who expects to be claimed by a non-custodial parent? No, also applies to Sarah

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The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Sam	4 - Sam, Sally, Susie, Sarah	Tax-filer & dependents
Sally	4 – Sally, Sam, Susie, Sarah	Tax filer & dependents
Susie	4 – Susie, Sam, Sally, Sarah	Tax dependent, tax-filer parents and other tax dependent
Sarah	4 - Sarah, Sam. Sally, Susie	Tax dependent, tax-filer parents and other tax dependent

B. Parent, Stepparent, and Parent's Child (not child of stepparent)

John and Joan are a married couple. They file taxes jointly and claim Joan's son by a first marriage, JP age 17, as a tax dependent. All of them applied for MA.

The tax household includes John, Joan and JP. Since no one is claimed as a tax dependent by anyone else, the tax household and MAGI household are the same.

Ask the following questions for each tax dependent to determine if exceptions exist:

- Is JP the tax dependent of someone other than a spouse or a biological, adopted, or stepparent? No
- Is JP a child living with both parents, but the parents do not expect to file a joint tax return? No
- Is JP a child who expects to be claimed by a non-custodial parent? No

The following table shows each person's tax filer household:

Person	# - Household Composition	Reason
John	3 – John, Joan, JP	Tax-filer & dependents
Joan	3 – Joan, John , JP	Tax-filer & dependents
JP	3 – JP, Joan, John	Tax dependent and tax-filer parents

C. Husband and Wife (Childless Adults)

Regina and Tyrone, both age 33, are a married couple. Regina is unemployed. The couple file taxes together. Both applied for MA

Person	*#-Household Composition*	*Reason*
Regina	*2-Regina, Tyrone*	*Tax-filers*
Tyrone	*2-Tyrone , Regina*	*Tax-filers*

D. Father and Child

Elyse, age 20, is single and lives with her father. Her father does not claim her on his taxes. Elyse applied for MA.

Person	*# - Household Composition*	*Reason*
Elyse	*1-Elyse*	*Tax-filer*



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M0430.300 NON TAX FILER HOUSEHOLD EXAMPLES

A. Example for non-filer HH with child over age 19

Jill lives with her daughter, Lea, age 24 and her son, Mike, age 15. Lea and Mike's father is deceased. Jill and Mike receive Social Security survivor's benefits. They do not file taxes. All applied for MA. The following table shows each person's MAGI household:

For individuals who neither file a tax return nor are claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, the household consists of the individual and, if living with the individual:

- the individual's spouse
- the individual's natural, adopted and stepchildren under the age 19
- the individual's natural, adopted and stepparents and natural, adoptive and step siblings under the age of 19.

Person	# - Household Composition	Reason
Jill	2 Jill, Mike	Non tax filer household-parent and child under age 19
Mike	2 Mike, Jill	Non tax filer household-child under age 19 and parent
Lea	*1-Lea*	*Non-filer over age 19 (MAGI Adults)*

B. Married Parents and Their Dependent Children

Josh and Penny are a married couple. They live with their children Daisy and Kate, both under age 18. They do not expect to file federal taxes this year so non-filer rules are used. All applied for MA. The following table shows each person's MAGI household.

Person	# - Household Composition	Reason
Josh	Josh, Penny, Daisy, Kate	Non -filer household-married parents living with 2 children in common
Penny (Spouse)	Josh, Penny, Daisy, Kate	Non- filer household-married parents living with 2 children in common
Daisy	Josh, Penny, Daisy, Kate	Non- filer household-married parents living with 2 children in common
Kate	Josh, Penny, Daisy, Kate	Non- filer household-married parents living with 2 children in common

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C. Parent, Stepparent, and Parent's Child (not child of stepparent)

Paul and Pattie are a married couple. They live with Pattie's son by a first marriage, Edgar age 17. They do not plan to file taxes this year. The household for the MAGI determination is the non-filer household which includes Paul (stepparent/spouse), Pattie (parent/spouse) and Edgar (child/stepchild). All of them applied for MA. The following table shows each person's tax filer household:

Person	# - Household Composition	Reason
Paul	3-Paul, Pattie, Edgar	Non filers – spouses, parent, stepparent and child/stepchild under age 19
Pattie	3-Pattie, Paul, Edgar	Non filers - spouses, parent, stepparent and child/stepchild under age 19
Edgar	*3*-Edgar, Paul, Pattie	Non filer lives with parent*s*

M0430.400 TAX FILER AND NON TAX FILER HOUSEHOLD EXAMPLES

A. Parent and Child Claimed by Non-custodial Parent

Linda and her daughter, Liza (age 6), live in the home. Linda works and claims only herself as a tax dependent. Liza is claimed by her father who does not live in the home. Both applied for MA.

Linda is a tax filer claiming only herself. Her tax household and MAGI household are the same. Liza is a tax dependent claimed by a non-custodial parent so a tax dependent exception exists and non-filer rules must be used. The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Linda	1– Linda	Tax-filer with no tax dependent
Liza	2 – Liza, Linda	Non-filer child and parent living in the home

B. Three Generation Household – Grandmother is Tax Filer

Mary is a working grandmother who claims her daughter, Samantha, age 20 and a full-time student, and granddaughter, Joy, age 2 as tax dependents. Although Samantha has a part-time job, she is not required to file taxes. All applied for MA.

The tax household includes Mary (the tax filer), Samantha (Mary's dependent child), and Joy (Mary's tax dependent). Mary's MAGI household is the same as her tax household and includes Mary, Samantha and Joy. Samantha's MAGI household is the same as Mary's because Samantha is a tax dependent and no tax dependent exceptions exist. Joy's is also a tax dependent, but meets an exception because she is not the child of the tax filer. Her MAGI household is a non-filer household and includes just Samantha and Joy; parent and child living in the home.

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The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Mary	3 – Mary, Samantha, Joy	Tax-filer & dependents
Samantha	3 – Samantha, Mary, Joy	Tax-filer & dependents
Joy	2 – Joy, Samantha	Non-filer parent and child

C. Three Generation Household – Second Generation Tax Filer

Rose is a tax dependent of her daughter, Lee, age 18. Lee works and claims her son, Peter, and Rose as tax dependents. All applied for MA.

The tax household includes Lee (tax filer), Rose (tax dependent), and Peter (tax dependent). Rose is not the child of the tax filer so a tax dependent exception exists and non-filer rules are used for her MAGI household. Lee is a tax filer with dependents so her MAGI household is the same as her tax household. Peter is a tax dependent living with his tax filer parent so his MAGI household is the same as the tax household.

The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Rose	2– Rose and Lee	Non-filer, has child under age 19
Lee	3 – Lee, Rose and Peter	Tax-filer with dependents
Peter	3 – Peter, Lee and Rose	Tax dependent lives with tax-filer parent and parent's other tax dependent

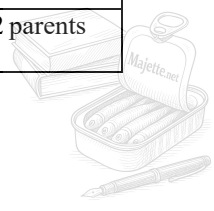
D. Two Parents Not Married To Each Other, One Is Tax Filer With Children, One Is Child Of One Parent And Other Is Child-In-Common

Bob and Ann live together with Bob's son, John age 14, and their child-in-common, Jane age 12. Ann works and files taxes claiming both children as dependents. Bob does not file taxes. All applied for MA.

Bob is a non-filer and is not claimed as a tax dependent of anyone. His MAGI household uses non-filer rules and includes Bob and his children living in the home. Ann is a tax filer with tax dependents; her MAGI household is the same as her tax household. John is a tax dependent of someone other than his parent so non-filer rules are used. John's MAGI household includes John, his father Bob and his sibling Jane. Jane is a tax dependent of her tax filer mother, but her parents are not filing jointly so non-filer rules are used and her MAGI household includes her parents and siblings.

The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Bob	3 - Bob, John and Jane	Non-filer with children
Ann	3 – Ann, John and Jane	Tax filer and her dependents
John	3 - John, Bob, and Jane	Non-filer with parent and siblings-no direct relation to tax filer Ann
Jane	4 – Jane, Bob, Ann and John	Non-filer child with 2 parents and half-sibling



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A. Two Parents Not Married To Each Other, Both File Taxes; 1 Child-In-Common, One Child Not In Common; Mom Is Pregnant

Jill and Max are both tax filers. Also in the home are Max's son, Mark and their child-in-common, May. Jill is pregnant, expecting 1 baby. Max claims both children on his taxes. All applied for MA.

Jill is a tax filer who claims no additional dependents. Her MAGI household is the same as her tax household for Medicaid coverage in the LIFC covered group and includes her unborn child when determining her eligibility as a pregnant woman. Max is a tax filer with two dependent children; his MAGI household is the same as his tax household. Mark is a tax dependent living with his tax filer parent and no exceptions exist; his MAGI household is the same as the tax household. May is a tax dependent, but her parents are not filing jointly so an exception exists and non-filer rules are used for her MAGI household.

The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Jill	2 – Jill and 1 unborn	Tax-filer pregnant woman; no other dependents
Max	3 – Max, Mark and May	Tax filer and two dependent children
Mark	3 – Mark, Max and May	Tax filer rules, tax household rules for person filing for him
May	4 – May, Max, Jill and Mark	Non-filer rules child with parents not filing jointly, non-married parents and half sibling.

B. Tax Filer, Spouse, Their Child, His Child Not Living In the Home

Gerry and Bree are married and file their taxes jointly. Also in the home is their son, Tad age 7, whom they claim as their dependent. They also claim Gerry's daughter, Tansy age 10, who does not live with them. Gerry, Bree and Tad applied for MA.

Gerry and Bree are tax filers who are married, filing jointly claiming two dependent children. Their MAGI household is the same as their tax household.

Tad is a tax dependent child and no tax dependent exceptions exist; Tad's MAGI household is the same as the tax household. The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Gerry	4 – Gerry, Bree, Tad and Tansy	Tax filers and dependent children
Bree	4 – Gerry, Bree, Tad and Tansy	Tax filers and dependent children
Tad	4 – Gerry, Bree, Tad, Tansy	Tax filer and dependents

G. Tax Filer, Her Son and Her Nephew

Daria lives with her son, Jack age 11, and her nephew Billy age 8. All applied for MA.

Daria is a tax filer who claims her son and nephew as dependents. Her MAGI household is the same as her tax household. Jack is a tax dependent and no exceptions exist; his MAGI household is the same as the tax household. Billy is a tax dependent claimed by a tax filer who is not his parent so an exception exists and non-filer rules are used. Billy's MAGI household consists of Billy only because he has no parents or siblings in the home. The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Daria	3 – Daria, Jack and Billy	Tax filer and dependents
Jack	3 – Daria, Jack and Billy	Tax filer and dependents
Billy	1 – Billy	Non filer rules; Daria is not his parent, Jack is not his sibling

H. Tax Filer, Spouse, Their Child, His Parent Not Living In the Home

Dave lives with his wife Jean and their child, Cathy age 8. Dave files taxes separately from his wife who files her own taxes each year. Dave claims their child Cathy and his mother, Becky, as his tax dependents. Dave, Jean and Cathy applied for MA.

Dave's MAGI household includes the individuals in his tax household and his wife, Jean because married spouses are always included in each other's MAGI household. Jean is also a tax filer with no additional dependents. Jean's MAGI household includes Dave because married spouses are always included in each other's MAGI household. Cathy is a tax dependent whose parents are not filing jointly so non-filer rules are used; her MAGI household includes herself and her parents. The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Dave	4 – Dave, Jean, Cathy and Becky	Tax filer, spouse, dependent child and dependent parent
Jean	2 – Dave, Jean,	Tax filer and spouse
Cathy	3 – Cathy, Dave, Jean	Non filer rules; child and parents in home

M0440.100 HOUSEHOLD INCOME

A. General Rule

The income counted under MAGI rules is the income counted for federal tax purposes with few exceptions. All taxable income sources and some non-taxable income sources are counted for the MA eligibility determinations.

Whenever possible, income, including income from self-employment, reported on the application will be verified through available electronic data sources. The agency must utilize online systems that are available to the agency without requiring verifications from the individual or family. If no data sources exist to verify the attestation, and the attestation is below the medical assistance income level, documentation of income is required. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information and information from SSA through SVES or SOLQ-I. Verification of income from available sources, including the VEC, may be used if it is dated within the previous *6* months. The agency must include in each applicant's case record facts to support the agency's decision on the case.

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The reported income of a child must be verified regardless of whether or not the attested income is above or below the tax-filing threshold amount.

If an income calculation must be made, use the information in subchapter M0710 for estimating income, subchapter M0720 for sources of earned income, and subchapter M0730 for sources of unearned income with the exceptions in B. below. The sources of income listed in this section are organized in table form in M04, Appendix 8.

B. MAGI Income Rules

1. Income That is Counted

a. Gross earned income is counted. There are no earned income disregards.

b. Earnings and unearned income, including Social Security benefits, of everyone in the household are counted, except the income of

- a tax dependent of any age regardless of relation to the tax-filer who is not required to file taxes because the tax filing threshold is not met or
- a child under 19 in a non-filer household who is living with a parent or parents

For children and tax dependents, Social Security income only counts toward the total household income if the child or tax dependent is required to file their own federal tax return.

Tax dependents claimed by someone other than a parent have their MAGI household determined using non-filer rules. For these individuals, income excluded from the tax-filer's household income may still be included in the tax-dependent's household income.

c. Income of a tax dependent or of a child under 19 in a non-filer household living with a parent or parents the individual's income is not countable as household income unless the tax dependent is required to file taxes because the tax-filing threshold is met. Any Social Security benefits received by the dependent individual may have do not count in determining whether the tax filing threshold is met.

Effective, January 1, 202*4*, the Tax Filing Threshold for MAGI income counting purposes for individuals under 65 is *$1,300* in unearned income and *$14,600* in earned income. Social Security benefits do not count as unearned income in determining whether the tax filing threshold is met. If the dependent is married, 65 or over or blind, please see 2024 Publication 501 (irs.gov)

d. Interest, including tax-exempt interest, is counted.

e. Foreign income is counted.

f. Stepparent income is counted

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g. Effective January 1, 2019, alimony received is not countable.

Alimony received prior to January 1, 2019, is countable. An individual whose divorce decree was finalized prior to January 1, 2019, has the option with the IRS to adopt the new IRS alimony rule by modifying the divorce agreement. If an individual whose divorce decree was finalized prior to January 1, 2019, does not want alimony received on or after January 1, 2019 to be countable for the MAGI income determination, the individual must provide a copy of the modified divorce agreement to the eligibility worker.

h. An amount received as a lump sum is counted only in the month received

i. *Lottery and gambling winnings of $80,000 or greater, which are received in a single payout, are counted not only in the month received, but over a period of up to 120 months. Lottery winnings paid out in installments would be treated the same as other types of recurring income. Winnings less than $80,000 are counted in the month received;*
- *Winnings of $80,000 but less than $90,000 are counted as income over two months, with an equal amount counted in each month; and*
- *For every additional $10,000 one month is added to the period over which total winnings are divided, in equal installments, and counted as income.*

The maximum period of time over which winnings may be counted is 120 months, which would apply for winnings of $1,260,000 and above. The requirement to count qualified lottery and gambling winnings in household income over multiple months applies only to the individuals receiving the winnings. The determination of household income for other members of the individual's household are not affected. Thus, for example, the total amount of qualified lottery or gambling winnings of a spouse or parent continues to count only in the month received in determining the eligibility of the other spouse and children. If the winner wishes to claim an "undue medical or financial hardship" exemption to counting the income after the first month, send the request to DMASEvaluation@dmas.virginia.gov. Military pay based upon age or years of service (other types of military pay are also counted and excluded; see M0720.290)

j. Census income.

k. RecognizeB5 Initiative and Incentive Payments issued to educators for their ongoing efforts to improve Virginia's early childcare and education structure are counted.

l. Unemployment Compensation is counted as unearned income.
Exception: Additional benefits of $600 per week paid under the under the Federal Pandemic Unemployment Compensation program are not counted. See M0440.100 B.2.n.

2. Income That is Not Counted

a. Child support received is not counted as income (it is not taxable income).

b. Workers Compensation is not counted.

c. When a child or other dependent is included in a parent or stepparent's household, the individual's income is not countable as household income unless they are required to file taxes because the tax-filing threshold is met. Any Social Security benefits the individual may have do not count in determining whether the tax filing threshold is met.

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d. *Veterans benefits which are **not** taxable in IRS Publication 525 are not counted:*

- *Education, training, and subsistence allowances,*
- *Disability compensation and pension payments for disabilities paid either to veterans or their families,*
- *Veterans' insurance proceeds and dividends paid either to veterans or their beneficiaries, including the proceeds of a veteran's endowment policy paid before death,*
- *Grants for homes designed for wheelchair living and motor vehicles for veterans who lost their sight or the use of their limbs,*
- *Interest on insurance dividends left on deposit with the VA,*
- *Benefits under a dependent-care assistance program,*
- *The death gratuity paid to a survivor of a member of the Armed Forces who died after September 10, 2001, or*
- *Payments made under the VA's compensated work therapy program.*

e. *For divorce agreements finalized on or after January 1, 2019, no deduction is allowed for alimony paid. For divorce agreements finalized prior to January 1, 2019, alimony **paid** to a separated or former spouse outside the home is deducted from countable income.*

f. Interest paid on student loans is deducted from countable income.

g. Gifts, inheritances, and proceeds from life insurance are not counted.

h. A parsonage allowance is not counted.

i. Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are not counted.

j. Student loans

Effective January 1, 2019, student loan debt forgiven due to death or disability of student is not counted as income.

Amounts that an employer paid in 2020 for an employee's student loan principal and interest are not counted in the employee's MAGI.

k. Difficulty of Care Payments, which include (1) payments designated by the payer as compensation for providing additional care that is required for a physically, mentally or emotionally disabled qualified foster care individual living in the provider's home and (2) payments to care providers *(including parents providing personal care to a child)* who provide care under a Medicaid home and-community-based Waiver to an individual in the care provider's home. The care provider's home is the residence in which the care provider resides and regularly performs the routines of the care provider's life. If the care provider moves into an individual's home to care for that individual and performs the routines of the care provider's life in that residence, it is considered the care provider's home.

l. General Welfare Payments for Indian Tribes are not countable To qualify under the general welfare exclusion, the payments must be made pursuant to a governmental program for the promotion of the general welfare based on need and not represent compensation for services (See https://www.irs.gov/pub/irs- drop/n-12-75.pdf)

m. Kinship Guardianship Payments are not income. These payments are a stipend paid to a relative caregiver who has assumed custody of a child as an alternative to that child remaining in foster care.

n. Under the Federal Pandemic Unemployment Compensation Program, eligible individuals who are collecting certain Unemployment Compensation, including regular unemployment compensation, will receive an additional $600 in federal benefits per week for weeks of unemployment ending on or before July 31, 2020. **The $600 weekly Pandemic Unemployment Compensation payments (monthly equivalent of $2,580) are not counted as income.**

p. Tax filers who do not itemize their deductions are permitted to deduct from their MAGI up to $300 in charitable contributions made by an eligible individual in tax years beginning in 2020.

q. Under the Federal Pandemic Unemployment Compensation Program, eligible individuals who are collecting certain Unemployment Compensation, including regular unemployment compensation, will receive an additional $600 in federal benefits per week for weeks of unemployment ending on or before July 31, 2020. **The $600 weekly Pandemic Unemployment Compensation payments (monthly equivalent of $2,580) are not counted as income.**

r. COVID-19 relief payments provided under federal law are not counted as income.

3. Income From Self-employment

The agency must utilize online systems that are available to the agency to attempt to verify self-employment income. If the income cannot be verified through online data sources, an individual reporting self-employment income must provide verification of business expenses, income, and applicable adjustments with forms or schedules including but not limited to IRS Form 1040, Schedule 1, Schedule C (business expenses), Schedule E (expenses from rental income) and Schedule F (expenses from farming). If the individual alleges that current income is not accurately represented by tax records, obtain additional information (such as business records) that documents current income.

Business expenses are expenses directly related to producing goods or services and without which the goods or services could not be produced. Allowable business expenses include, but are not limited to, the following:

- payments on the interest of the purchase price of, and loans for, capital assets such as real property, equipment, machinery and other goods of a durable nature;
- insurance premiums;
- legal fees;
- expenses for routine maintenance and repairs;
- advertising costs;
- bookkeeping costs.
- depreciation and capital losses. If the losses exceed income, the resulting negative dollar amount offsets other countable income.

Expenses that are not deducted for MAGI purposes include the following: payments on the principal of the purchase price of, and loans for, capital assets, such as real property, equipment, machinery and other goods of a durable nature; the principal and interest on loans for capital improvements of real property; net losses from previous periods; federal, state, and local taxes; personal expenses, entertainment expenses, and personal transportation; and money set aside for retirement purposes.

4. Private Accident/Health Plan Benefits

Private accident, health plan, and disability benefits are benefits paid from a plan provided by an employer or purchased by the individual. Social Security benefits and Supplemental Security Income (SSI) are not private benefits.

Benefits received for personal injury or sickness through an accident or health plan that is paid for by an employer are countable income.

If the individual pays the entire cost of the accident or health plan, benefits received from the plan are NOT income.

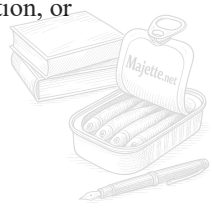
If both the employer and the individual pay for the plan, only the benefits received through the employer's payments are income.

5. American Indian-Alaska Native Payments

In addition, the following payments to American Indian/Alaska Natives are not counted as income:

a. distributions received from the Alaska Native Corporations and Settlement Trusts (Public Law 100-241),

b. distributions from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the Supervision of the Interior,



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c. distribution and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extractions and harvest from:

- rights of any lands held in trust located within the most recent boundaries of a prior Federal reservation or under the supervision of the Secretary of the Interior,
- federally protected rights regarding off-reservation hunting, fishing, gathering or usage of natural resources,
- distributions resulting from real property ownership interests related to natural resources and improvements,
- located on or near a reservation of within the most recent boundaries of a prior Federal reservation, or
- resulting from the exercise of federally-protected rights relating to such property ownership interests.

d. payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or right or rights that support subsistence or a traditional lifestyles according to applicable Tribal Law or custom.

e. Student financial assistance provided under the Bureau of Indian Affairs Education Program.

6. Income from Crowdsourcing

Crowdsourcing or crowdfunding is a practice to raise funds online for donations, fund a project, or underwrite a venture by requesting small amounts of money from a large number of people. Examples of crowdsourcing websites include GoFundME, YouCaring, Kickstarter, or IndieGoGo. The treatment of the funds as income depends on the reason the funds were solicited.

If the individual or someone on his behalf is raising donations to go toward medical costs or bills, money raised is considered a gift and is not countable under MAGI rules.

If there is an exchange of goods or services *between the beneficiary and donor*, money raised is considered earned income and is countable. Platform fees or costs, including the cost per transaction, percentage of donation to the online host site, and costs to a payment processer, are not counted as income.

7. Withdrawals from Retirement Funds

Money that is withdrawn from retirement funds, such as Individual Retirement Accounts (IRAs) and 401K accounts, on an early or emergency basis (i.e. before the individual is eligible to receive periodic payments) is not income. It is the conversion of the individual's resource from one form to another.

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C. Monthly Income Determinations

Medicaid and FAMIS income eligibility is determined using current monthly income. **Sources and amounts of income that are verified electronically and are reasonably compatible do not require additional verification.**

When income cannot be verified electronically **or** the information reported is not reasonably compatible (see M0420.100 for the definition), the individual must be asked to provide current verification of the household income so a point-in-time income eligibility determination can be made.

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C. Steps for Calculating MAGI

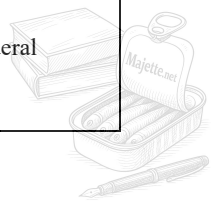
For tax filers whose income is verified in the Hub as being reasonably compatible, no MAGI calculation is required.

For non-filers or any other individuals whose income cannot be verified by the Hub, use the following steps for calculating an individual's MAGI. Subtract or include any deductions listed below as reported by the individual.

Adjusted Gross Income (AGI)	
Include: • Wages, salaries, tips, etc. • Taxable interest • Taxable amount of pension, annuity or Individual Retirement Account (IRA) distributions and Social Security benefits • Business Income, farm income, capital gain, other gains (or loss) • Unemployment Compensation • Ordinary dividends • Rental real estate, royalties, partnerships • S corporations, trusts, etc. • Taxable refunds, credits, or offset of state and local income taxes • Other income	**Deduct:** • Certain self-employment expenses • Student loan interest deduction • Educator expenses • IRA deduction • Moving expenses • Penalty on early withdrawal of savings • Health savings account deduction • Domestic production activities deduction • Certain business expenses of reservists, performing artists, and fee-basis government officials • Alimony paid prior to January 1, 2019 (but not child support paid) • For tax filers who do not itemize and report the deduction, up to $300 in charitable contributions made by an eligible individual in tax years beginning in 2020.
Do Not Include: Veteran's disability payments, Worker's Compensation or child support received. Pre-tax contributions, such as those for child care, commuting, employer-sponsored health insurance, flexible spending accounts and retirement plans such as 401(k) and 403(b), are not included in AGI but are not listed above because they are already subtracted out of W-2 wages and salaries, amounts that an employer paid in 2020 for an employee's student loan principal and interest.	

Note: Check the IRS website for detailed requirements for the income and deduction categories above.

Add (+) back certain income	• Non-taxable Social Security benefits • Tax –exempt interest • Foreign earned income and housing expenses for Americans living abroad
Exclude (-)from income	• Social Security benefits received by a child are not countable for his eligibility when a parent is in the household, unless the child is required to file taxes. • Scholarships, awards, or fellowship grants used for education purposes and not for living expenses • Certain American Indian and Alaska Native income derived from distributions, payments, ownership interests, real property usage rights and student financial assistance • Gifts, inheritances, and proceeds from life insurance • An amount received as a lump sum is counted only in the month received. • Parsonage allowance • Effective January 1, 2019, student loan debt forgiven due to death or disability of student is not counted as income. • Grants for homes designed for wheelchair living and motor vehicles for veterans who lost their sight or the use of their limbs • Difficulty of Care Payments • General Welfare Payments for Indian Tribes • Kinship Guardianship Payments • Pandemic Unemployment Compensation payments paid under the Federal Pandemic Unemployment Compensation Program. • *COVID-19 relief payments provided under federal law*



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M0450.100 STEPS FOR DETERMINING MAGI-BASED ELIGIBILITY

A. Determine Household Composition

1. Does the individual expect to file taxes?

a. If No - Continue to Step 2

b. If Yes - Does the individual expect to be claimed as a tax dependent by anyone else?

1) If No - the household consists of the tax filer, a spouse living with the tax filer, and all persons whom the tax filer expects to claim as a tax dependent. For a tax filer under age 19, parents living in the home are also in the individual's household.

2) If Yes - Continue to Step 2

2. Does the Individual Expect to be Claimed As a Tax Dependent?

a. If No - Continue to Step 3

b. If Yes - Does the individual meet **any** of the following exceptions?

1) the individual expects to be claimed as a tax dependent of someone other than a spouse or a biological, adopted, or stepparent; **or**

2) the individual is a child (under age 19) living with both parents, but the parents do not expect to file a joint tax return; **or**

3) the individual is a child who expects to be claimed by a non-custodial parent; **or**

4) the child is an adoption assistance child with special needs for medical or rehabilitative care.

5) the child has been residing in a PRTF for more than 30 days.

If No to 1) through 4) above - the household is the household of the tax filer claiming her/him as a tax dependent.

If Yes to any of 1) through 4) above - Continue to Step 3.

3. Individual Is Neither Tax Filer Nor Tax Dependent Or Meets An Exception In 2. b Above

For individuals, other than adoption assistance children *with* special needs *for* medical *or rehabilitative care*, who neither expect to file a tax return nor expect to be claimed as a tax dependent, as well as tax dependents who meet one of the exceptions in 2.b above, the household consists of the individual and, if living with the individual:

- the individual's spouse;
- the individual's natural, adopted and step children under the age 19; and
    - In the case of individuals under age 19, the individual's natural, adopted and stepparents and natural, adoptive and stepsiblings under age 19.

The household of an adoption assistance child with special needs for medical or rehabilitative care consists only of the child.



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B. Determine the MA Income for Each Member of the Household

1. Is Any Household Member The Child Or Expected Tax Dependent Of Another Member Of The Household?

a. If yes - is the individual expected to be required to file a tax return?

1) If yes, continue to Step 2 and include child's income in total household income.

2) If no, continue to Step 2, but do not include child's income in total household income.

b. If no, continue to Step 2.

2. Determine MAGI Income For Each Member

Determine MAGI-based income of each member of the individual's household, unless income of such member is flagged as not being counted in step 1. Recall that, for purposes of MA eligibility, the following rules apply:

- An amount received as a lump sum is counted as income only in the month received.
- Scholarships, awards or fellowship grants used for education purposes and not for living expenses are excluded from income.
- Certain distributions, payments and student financial assistance for American Indians/Alaska Natives are excluded from income.
- Child support is not countable income.
- Social Security benefits received by a child are not countable for his eligibility when a parent is in the household, unless the child is required to file taxes.
- Interest paid on student loans is deducted from income.
- Foreign income and interest, including tax-exempt interest, are counted.

3. Using the 5% of FPL Disregard

If the individual's household income is over the income limit for his covered group, subtract an amount equal to 5% of FPL for his household size (see M04, Appendix 1). Compare the countable income against the income limit for the individual's covered group to determine his income eligibility.

If the individual meets multiple Medicaid covered groups (and/or FAMIS) his gross income is compared first to the income limit of the full-benefit covered group with the highest income limit for which the individual could be eligible. If the income exceeds the limit, subtract 5% FPL based on his household size and compare the income again to the income limit. If still not eligible, the same process is followed for Plan First, if the individual is age 19 through 64 years.

C. Household Income

Household income is the sum of the MAGI-based income for every member of the individual's household as determined in step 2 above.



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M0450.200 INCOME EXAMPLES – TAX FILER HOUSEHOLDS

A. Example #1 Tax Filer Single Parent, Two Children (Using *Jan. 18, 2018* figures)

Tom is a single parent living in Henrico County (Group II) with his two children, Jack and Betty, ages 6 and 10, whom he claims as tax dependents. Tom earns $3,000 per month, with projected annual income of $36,000.

The MAGI households are:

Person	# - Household Composition	Reason
Tom	3 – Tom, Jack, Betty	Tax-filer & 2 dependents
Jack	3 – Jack, Tom, Betty	Tax dependent, taxpayer & other tax dependent
Betty	3 – Betty, Tom, Jack	Tax dependent, taxpayer & other tax dependent

Tom (parent) eligibility determination:

Potential covered groups:
LIFC (full-coverage MA)
MAGI Adults (full-coverage-MA)
Plan First (limited coverage)

Monthly Income limits:
LIFC, Group II for HH of 3 = $589
MAGI Adults for HH of 3=$2,391
Plan First 200% FPL for HH of 3 = $3,464
5% FPL Disregard for HH of 3 = $86

Tom's gross HH income of $3,000.00 exceeds the LIFC income limit of $589 for a HH of 3, so he is entitled to a 5% FPL disregard.

$3,000.00 gross household income
- 86.00 5% FPL Disregard for HH of 3
$2,914.00 countable income (after disregard)

His countable income of $2,914.00 is compared to the LIFC income limit for HH of 3 which is $589 ; income exceeds the LIFC limit. Tom is not eligible for full-coverage MA.

His countable income of $2,914 is compared to the MAGI Adult income limit for household of 3 which is $2,391. Toms income exceeds the MAGI Adult, therefore making him ineligible for full coverage MA

Tom's gross HH income of $3,000.00 is then compared to the Plan First 200% FPL income limit for 3 which is $3,464. As his income is under the limit, no disregard is needed; Tom is eligible for Plan First.

Tom is also referred to the Health Insurance Marketplace (HIM)

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Jack (child) eligibility determination:

Potential covered groups:
Child < Age 19
FAMIS

Monthly Income limits:
Child < 19 143% FPL for a HH of 3 = $2,477
FAMIS 200% FPL for HH of 3 = $3,464
5% FPL Disregard for HH of 3 = $86

The gross HH income for Jack of $3,000 (his father's earnings) exceeds the Medicaid Child < Age 19 143% FPL income limit for 3 ($2,477), so Jack is entitled to the 5% disregard.

$3,000.00 gross household income
- 86.00 5% FPL Disregard for HH of 3
$2,914.00 countable income (after 5% disregard)

The countable income of $2,914.00 still exceeds the Medicaid Child < Age 19 143% FPL limit ($2,477), Jack is not eligible for Medicaid.

The gross HH income for Jack of $3,000 is then compared to the FAMIS income limit for a HH of 3 which is $3,404. As the gross HH income is less than the FAMIS income limit ($3,404) Jack is eligible for FAMIS.
If the gross HH income had been over the FAMIS income limit, the 5% disregard would have been used and compared to the FAMIS income limit.

Betty (child) eligibility determination:

Betty's (the other child) income eligibility determination is the same as Jack's; she is eligible for FAMIS too.

B. Example #2 Tax Filer/Three Generation Household

(Using *Jan. 18, 2018* figures)

Mary Lewis is a 52-year-old working grandmother living in Louisa County (Group I). Mary claims her daughter (Samantha), age 20 and a full-time student, and granddaughter Joy (Samantha's daughter), age 2, as tax dependents who both live in the household with her.

Mary earns $4,500/month ($54,000/year).
Samantha earns $300/month ($3,600/year)
Projected annual income for tax household = Mary's income (Samantha not required to file) = $54,000 per year

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Tax household = Mary, Samantha, and Joy.
MAGI Households:

Person	# - Household Composition	Reason
Mary	3 – Mary, Samantha, Joy	Tax-filer & 2 tax dependents
Samantha	3 – Samantha, Mary, Joy	Tax dependent, tax filer, & other tax dependent
Joy	2 – Joy, Samantha	Non-filer child & child's parent with whom child lives

Mary's eligibility determination:

Potential covered groups:
Plan First
MAGI Adult

Monthly Income Limits:
Plan First income limit for HH of 3 = $3,464
MAGI Adult income limit for HH of 3=$2,391
5% FPL Disregard for HH of 3 = $86

HH gross monthly income:
$4,500 Mary's earnings
(Samantha's earnings are excluded because she is a child for tax purposes and is not required to file taxes).

4,500.00 gross household income
- 86.00 5% FPL Disregard for HH of 3
$4,414.00 countable income (after 5% FPL disregard)

Her gross income of $4,500 is compared to the MAGI Adult income limit for household of 3 which is $2,391. Mary's income exceeds the MAGI Adult limit.

After subtracting the 5% FPL disregard, the countable income of $4,414.00 is then compared to the MAGI Adult income limit of $2,391 and her countable income exceeds the MAGI Adult limit, Mary is not eligible for full coverage MA.

The gross HH income of $4,500.00 is compared to the Plan First 200% FPL income limit for 3, $3,490. As the gross HH income exceeds the limit, she is entitled to the 5% FPL disregard.

The countable income of $4,414.00 is then compared to the Plan First income limit of $3,464; but as her countable income exceeds the Plan First limit, Mary is not eligible for Plan First.

Mary is referred to the HIM

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Samantha's eligibility determination:

Potential covered groups:

LIFC
MAGI Adult
Plan First.

Monthly Income limits:

LIFC, Group I for HH of 3 = $484
MAGI Adult income limit for HH of 3=$2,391
Plan First for HH of 3 = $3,464
5% FPL Disregard for HH of 3 = $86

HH monthly income:

$4,500 Mary's earnings
(Samantha's income is not counted in this HH).

As $4,500 exceeds the LIFC limit for 3 ($484) she is entitled to the 5% FPL disregard. Her income eligibility is determined as follows:

$4,500.00 gross household income
- 86.00 5% FPL Disregard for HH of 3
$4,414.00 countable income

Samantha's countable income of $4,414 still exceeds the LIFC income limit for 3 of $484 so she is not eligible for LIFC (full-coverage) MA.

Her countable income of $4,414 is compared to the MAGI Adult income limit for household of 3 which is $2,391. Mary's income exceeds the MAGI Adult limit, therefore, making her ineligible for full coverage MA

The gross HH income of $4,500.00 is compared to the Plan First 200% FPL income limit for 3 which is $3,464, and as Samantha exceeds this amount, the 5% FPL Disregard ($86) can be deducted. The countable income of $4,414 is greater than the Plan First income limit of $3,464. Samantha is not eligible for Plan First, and is referred to the HIM.

An alternate method, which accomplishes the same results, is to compare the Plan First 205% FPL (200% FPL + 5% FPL Disregard) for a HH of 3 which is $3,551. As the countable income amount of $4,500 is greater the income limit of $3,551, Samantha is not eligible for Plan First, and is referred to the HIM.

Joy's eligibility determination

HH gross monthly income:

$300 Samantha's earnings (Mary's income is not counted in this HH).

Potential covered group:

Child < Age 19

The HH income is $300 which is less than the Medicaid Child < Age 19 limit for 2 ($1,936). Joy is eligible for Medicaid in the Child < Age 19 covered group.

The 5% disregard is not necessary since the gross household income is within the Medicaid Child < Age 19 income limit.

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C. Example # 3 Tax Filer with Dependent Outside of the Home (Using *January 18, 2018* figures)

John applies for Medicaid for himself and his child Richard. John files taxes and claims Richard as well as his 17-year-old daughter, Bridget, who does not live with him. John works part time making $800 a month and Bridget works part time making $625 a month. They live in Fairfax County (Group III).

Person	# - Household Composition	Reason
John	3 - John, Richard, Bridget	Tax filer and dependents
Richard	3 - Richard, John, Bridget	Tax dependent, tax filer, and other dependent

Even though Bridget has income over the tax filing threshold ($6,300 in 2016) and is required to file taxes on her own, she is part of John's tax filing household as a dependent, so her income counts toward any HH in which she is included, in this case, the HH of her father John.

John's eligibility determination:

Potential covered groups:
LIFC
MAGI Adult
Plan First

Monthly income limits:
LIFC (Group III) HH of 3 = $807
MAGI Adult income limit for HH of 3=$2,391
Plan First HH of 3 = $3,464
5% FPL Disregard for HH of 3 = $86

John's gross HH income of $1,425.00 exceeds the LIFC income limit for 3 of $807, and he is entitled to the 5% FPL disregard.

$1,425.00 gross household income
- 86.00 5% FPL Disregard for HH of 3
$1,339.00 countable income

His countable income of $1,339 is less that the MAGI Adult limit of $2,304 for 3. John is eligible for full coverage in the MAGI Adult coverage group.

Bridget's eligibility determination
Bridget was not applied for.

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Richards's eligibility determination:

Potential covered groups:
Child < Age 19
FAMIS

Monthly Income limits:
Child < 19 - 143% FPL for a HH of 3 = $2,477
FAMIS 200% FPL for HH of 3 = $3,464
5% FPL Disregard for HH of 3 = $86

Richard's gross HH income of $1,425 (his father's and sibling's earnings) is less than the FAMIS 200% income limit of $3,464. And as the HH income does not exceed the Medicaid Child < Age 19 income of $2,477, the 5% disregard is not needed. Richard is eligible for full-coverage MA.

M0450.300 INCOME EXAMPLES – NON TAX FILER HOUSEHOLDS

A. Example #1

Robb lives in the City of Norfolk (Group II) with his sons, and does not file taxes. He receives of $2,500 per month disability income. His children receive monthly interest on trust accounts their grandparent's setup. Mike is 16 years old and receives $500 per month while Ike is 13 years old and receives $400 per month.

Non Tax Filer Single Parent, Two Children

(Using Jan. 18, 2018 figures)

The MAGI households are:

Person	# - Household Composition	Reason
Robb	3 – Robb, Mike & Ike	Non tax filer & his 2 children < 19
Mike	3 – Mike, Robb & Ike	Non-filer child < 19, his parent & his sibling < 19
Ike	3 – Ike, Robb & Mike	Non-filer child < 19, his parent & his sibling < 19

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HH income:

$2,500.00 Robb's disability benefit income
+ 500.00 Mike's trust income
+ 400.00 Ike's trust income
$3,400.00 gross household income

Robb's gross HH's of $3,400 monthly income exceeds the LIFC income limit for 3 of $589 per month, thus entitled to the 5% disregard. His income eligibility is determined as follows:

$3,400.00 gross household income
- 86.00 5% disregard
$3,314.00 countable income

As his countable income exceeds the LIFC income limit of $589, he is ineligible for full coverage MA.

His gross income of $3,400.00 is compared to the MAGI Adults income limit for household of 3 which is $2,391. After applying the 5% disregard, Robbs's income exceeds the MAGI Adults limit. Robb is ineligible for full coverage MA.

His gross HH income of $3,400.00 is then compared to the Plan First 200% FPL income limit for 3 of $3,464. As the income is less than the Plan First income limit, he is eligible for Plan First. Robb is also referred to the HIM.

Mike's eligibility determination:

Potential covered groups:

Child < Age 19
FAMIS

Monthly Income limits:

Child < Age 19, 143% FPL for a HH of 3 = $2,477
FAMIS, 200% FPL for HH of 3 = $3,464
5% FPL for 3 = $86

HH income:

$2,500.00 Robb's disability benefit income
+ 500.00 Mike's trust income
+ 400.00 Ike's trust income
$3,400.00 gross household income

Mike's gross HH's $3,400 monthly income exceeds the Medicaid Child < Age 19 143% FPL income limit for 3, $2,477, so he is entitled to the 5% disregard. Mike's income eligibility is determined as follows:

$3,400.00 gross household income
- 86.00 5% FPL disregard
$3,314.00 countable income

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Mike's countable income of $3,314.00 exceeds the Medicaid Child < Age 19 143% FPL income limit for 3, $2,477. Mike is not eligible for Medicaid.

His gross HH income of $3,400.00 is then compared to the FAMIS 200% FPL income limit for 3, $3,464. He is eligible for FAMIS because his gross HH income is less than the FAMIS income limit for the household size.

Ike's income eligibility determination:

Potential covered groups:

Child < Age 19
FAMIS

Monthly Income limits:

Child < Age 19, 143% FPL for a HH of 3 = $2,477
FAMIS, 200% FPL for HH of 3 = $3,464
5% FPL for 3 = $86

HH income:

$2,500.00	Robb's disability benefit income
+ 500.00	Mike's trust income
+ 400.00	Ike's trust income
$3,400.00	gross household income

Ike's countable income of $3,314.00 exceeds the Medicaid Child < Age 19 143% FPL income limit for 3, $2,477. Mike is not eligible for Medicaid.

As his gross monthly income exceeded the Medicaid Child < Age 19 143% income limit of $2,477, he is entitled to the 5% disregard. Ike's income eligibility is determined as follows:

$3,400.00	gross household income
- 86.00	5% FPL disregard
$3,314.00	countable income

As his countable income exceeds the income limit of $2,477, he is ineligible for Medicaid child <19, and move to the next step.

His gross HH income of $3,400.00 is compared to the FAMIS 200% FPL income limit for 3 of $3,464. He is eligible for FAMIS because his gross HH income is less than the FAMIS income limit for the household size of 3.

This example also illustrates as even though Mike and Ike had different trust account income, it made no difference in the results, and both eligible for FAMIS coverage.

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A. Example #2

Non Tax Filer Three Generation Household (Using Jan. 18, 2018 figures)

Sally Green is age 64, a grandmother who does not expect to file taxes this year. She is neither blind or disabled. She lives with her daughter Jane, age 20 and a full-time student, and her granddaughter Dee (Jane's daughter), age 2. Sally takes care of Dee while Jane is attending school and working at her part-time job. Jane is pregnant with 1 unborn. They live in Hanover, a Group I locality. Sally doesn't have Medicare.

Income:
Sally receives SSA widow's benefits of $1,000 per month.

Jane earns $300 per month or $3,600 annually and is not required to file taxes.

The MAGI non-filer households are:

Person	# - Household Composition	Reason
Sally	1 – Sally	Non-filer grandmother
Jane (PG)	3 – Jane, Jane's unborn child & Dee	Non-filer, her unborn child & non-filer's child < 19
Dee	2 – Dee, Jane	Non-filer child < 19 & non-filer child's parent

Sally's eligibility determination:
Potential covered groups: Plan
First
MAGI Adult
Monthly Income limits:

MAGI Adult income limit for HH of 1=$1,346
Plan First 200% FPL income limit for HH of 1 = $2,024
5% FPL for 1 = $51

HH gross monthly income = $1,000 Sally's SSA benefits
Her gross income of $1,000 is less than the MAGI Adult limit of $1,346 for 1. Sally is eligible for full coverage in the MAGI Adult coverage group.

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Jane's eligibility determination:

Potential covered groups:
LIFC
MAGI Adult
Medicaid Pregnant Women

Monthly Income limits:
LIFC, Group I for HH of 3 = $381
Pregnant Women 143% FPL for a HH of 3 = $2,477
MAGI Adult income limit for HH of 3=$2,391
5% FPL for 3 = $86

HH monthly income = $300 Jane's income.

Jane is over age 19, not a child and not counted as a dependent for anyone else. Jane's earnings must be counted even though she is not required to file taxes. As her mother (Sally) is not in Jane's tax filing HH, Sally's income is not counted when determining Jane's eligibility. The HH would consist of Jane, *her unborn child* and her daughter Dee.

$300 is less than the LIFC limit for 3 ($381) so the 5% disregard is not applied (it is not necessary). Jane is eligible for Medicaid in the LIFC covered group.

If Jane had been over income for the LIFC covered group, the step to apply the 5% disregard would have been used. If she was found over the LIFC income limit, a review as a Medicaid Pregnant Woman 143% income limit would have been used.

Dee's eligibility determination:
Potential covered groups:
Child < Age 19
FAMIS

Monthly Income limits:
Child < Age 19 143% FPL for a HH of 2 = $1,962
FAMIS, 200% FPL for HH of 2 = $2,585
5% FPL for 2 = $65

HH monthly income:
$300 (Jane's gross earnings)

As HH income $300 is less than the Medicaid Child < Age 19 143% FPL income limit for 2 ($1,962), Dee is eligible for Medicaid. The 5% disregard is not necessary since she qualified in this aid category.

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Dee's eligibility determination:

Potential covered groups:

Child < Age 19
FAMIS

Monthly Income limits:

Child < Age 19 143% FPL for a HH of 2 = $1,962
FAMIS, 200% FPL for HH of 2 = $2,585
5% FPL for 2 = $65

HH monthly income:

$300 (Jane's gross earnings)

$300 is less than the Medicaid Child < Age 19 143% FPL income limit for 2 ($1,962) so Dee is eligible for Medicaid in the Child < Age 19 covered group. The 5% disregard is not applied because it is not necessary; her gross HH income is within the Medicaid Child < Age 19 income limit.

M0450.400 GAP-FILLING RULE EVALUATION

A. When to Complete Gap- Filling Evaluation

Complete a gap-filling evaluation to determine eligibility for Medicaid or FAMIS whenever **all** of the following conditions apply:

- The individual is in a tax filer household (regardless of whether or not a tax dependent exception in M0430.100 B.2 is met). APTC methodology does not apply to non-filer households or if married parents file separately and live in the same home.

- Current monthly household income, using Medicaid/FAMIS MAGI-based methods is over the applicable monthly income limit (including the 5% FPL disregard) for the individual's covered group.

- The total of income already received plus projected income for the **calendar** year in which eligibility is being determined, using MAGI methods applied by the HIM for the purposes of APTC eligibility, is below 100% FPL (i.e. the lower income threshold for APTC eligibility). See M04, Appendix 1. The individual's prior income for the calendar year, or lack of income, is included in the calculation of annual income when determining financial eligibility.

Note: The individual does not need to apply for the APTC prior to applying for Medicaid or having the gap-filling evaluation completed.

The gap-filling evaluation is applicable to the eligibility determination for retroactive and ongoing coverage.

If the eligibility and enrollment system is unable to determine eligibility using the gap-filling evaluation, the evaluation must be completed outside the system and documented in the electronic record. If the individual is eligible, the coverage must be entered directly into *the Medicaid Enterprise System (MES—formerly the Medicaid Management Information System* [MMIS]), and the renewal date must be updated for January of the following year.



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B. Non-financial Requirements

The individual must meet a MAGI covered group (Children under 19, LIFC, Pregnant Individuals, Individuals Under Age 21, Adults age 19-64, Plan First).and all non-financial eligibility criteria for that covered group.

C. Household Income Calculation

Under the gap-filling rule, the individual's household income must be calculated according to the MAGI rules used for APTC purposes and compared to the APTC 100% FPL annual income limit for the household size in M04 listed in, Appendix 1. If the annual income at or below the APTC 100% FPL amount, the income is then compared to the Medicaid annual income limits for the individual's covered group or to the FAMIS or FAMIS MOMS income limits to determine the individual's eligibility.

Only tax-filer rules are used for determining household composition for gap-filling determinations. Neither the tax dependent exceptions used for Medicaid/FAMIS MAGI-specific household composition nor non-filer rules are applicable. For example, if a child lives with both parents, and the parents are unmarried, the child is in the tax-filer household of the parent who claims the child as a tax dependent.

Financial eligibility is based on income already received and projected income for the calendar year in which benefits are sought. If the local agency knows the determination of annual income made by the HIM, it may use that information for the purposes of applying the gap-filling rule. Otherwise, the worker must obtain income information from the individual or authorized representative.

1. Verification of Income

Income reported as received for the calendar year in which benefits are sought as well as current monthly income must be verified.

If the information provided is reasonably compatible with information obtained by the worker from electronic sources such as the VEC, or documentation is available from other social services program, such as TANF or SNAP, and the systems information is dated within the past *6* months, the agency must determine eligibility based upon the information available. If there is a discrepancy between what is stated on the application and the information obtained from online systems/agency knowledge, contact the enrollee to obtain clarification of reported income.

2. Countable Income

Income that is listed in M0440.100 B as countable for the Medicaid/FAMIS MAGI evaluation is also countable for the gap-filling evaluation. Additionally, the following income **is counted** for the gap-filling evaluation only if it is countable for taxes:

- Payments made to American Indian/Alaska Natives as described in M0440.100 B.5.
- Scholarships/Awards and fellowship income, regardless of its intended use
- Lump sum payments received in the calendar year for which benefits are sought are included in the annual income calculation only

3. Income Evaluation

If the annual income as determined by the HIM is not known, the eligibility worker must calculate the annual income. Do not convert this income

- First, add together income already received for the year. Do not convert the income.
- Next, calculate the projected income for the remainder of the year based on the current monthly income, unless the individual's income is expected to change (e.g. current employment is terminating).
- Add income already received to projected income to obtain the **annual** projected income for the current calendar year.
- Compare the **annual** projected income to the 100% FPL **annual** income limits for the MAGI household size in M04, Appendix 1.
- If the **annual** income is less than or equal to 100% FPL, compare the **annua**l income to the **annual** income limit for the individual's covered group.
- For the individual to be eligible for Medicaid as a result of applying the gap-filling rule, the countable income must be no more than the **annual i**ncome limit for the individual's covered group. The 5% income disregard used for the Medicaid MAGI determination does not apply. See M04 Appendices 2-6 for income limits.

3. Renewals

A renewal of eligibility must be completed in January of the following year and annually thereafter. At the time of initial enrollment, change the renewal date to January of the following year. Evaluate the individual's eligibility using Medicaid/FAMIS MAGI methodology before applying gap-filling methodology. A gap-filling evaluation may not be necessary for future eligibility determinations/renewals since tax dependency status and/or income may have changed.

For a pregnant *individual* determined eligible based on gap-filling methodology, coverage ends the last day of the 12th month after the end of the month in which the pregnancy ends. Complete a renewal 30 days prior to the end of coverage.

For a child with 12 months continuous eligibility, coverage ends the last day of the 12th month after the first month of eligibility (not including retroactive coverage). Complete a renewal 30 days prior to the end of coverage.

4. Individual Not Eligible Using Gap-filling Methodology

If the individual's household income is determined to be over the Medicaid and FAMIS income limits after the gap-filling rule evaluation **and** he meets a MN covered group, he must be offered the opportunity to be placed on a MN spenddown. If the individual does not provide the necessary verifications for the gap-filling evaluation the application should be denied.

A. Example Situation – Coverage Gap and Gap-Filling Rule

A 10-year-old child lives with both parents, who are not married, and the child is expected to be claimed as a tax dependent by one parent. His parents apply for the APTC through the Virginia Insurance Marketplace, which uses tax filers income methodology. The child is determined to not be eligible for the APTC because his countable income is below the lower income threshold (it is too low) for APTC eligibility.

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Virginia's Health Insurance Marketplace refers the application to Virginia for a Medicaid/FAMIS eligibility determination. The child meets a tax dependent exception in M0430.100 B.2 (lives with both parents, is claimed as a tax dependent by one parent, and the parents do not expect to file jointly). The child's eligibility for Medicaid or FAMIS is determined using non-filer methodology.

Because *the child* is under 19 and both parents are in *the* household, the income of both parents is counted. Household income with the 5% FPL disregard is over the limit for both Medicaid and FAMIS.

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E. Example – Gap-Filling Evaluation ***Unmarried Couple and Child in Common***

Maria and Tony are an unmarried couple who live with their 12-year-old daughter, Anita. Maria and Tony are both employed. Anita is claimed as a tax dependent by Maria, who works part time. Maria applies for Medicaid only for Anita. Because Anita lives with both parents, but the parent's file taxes separately and only one parent claims her as a tax dependent, Anita meets a tax dependent exemption. Her eligibility must be evaluated using non-filer rules.

Because she is under age 19, Anita's MAGI household consists of Anita and both parents. Both Maria's and Tony's income is counted for Anita's eligibility. Her countable income, including with the 5% FPL disregard, is over the limits for both Medicaid and FAMIS.

The eligibility worker notes that a potential gap-filling situation exists. The worker evaluates Anita's eligibility for Medicaid or FAMIS using the APTC rules. Under the APTC rules, Anita's household consists of Anita (tax dependent) and Maria (tax filer); Tony is not in Anita's household because he does not claim Anita on his taxes. Maria's income from her part time job is *under the APTC* 100% FPL annual income limit *and under the Medicaid annual income limit for a Child Under 19 (143% FPL). Therefore, Anita is eligible for Medicaid under the gap-filling rule.*

The following tables show the household formation and income used.

For the Medicaid/FAMIs evaluation:

Person	# - MAGI Household Composition Non-filer rules	Income to count for Medicaid/FAMIS eligibility
Anita	3 – Anita, Maria, Tony	Maria, Tony

For the gap-filling evaluation

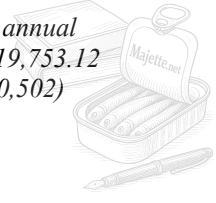
Person	# - ATPC Household Composition	Income to count for Medicaid/FAMIS eligibility
Anita	2 – Maria, Anita	Maria, and (non-excluded) income from Anita

F. ***Example – Gap-Filling Evaluation— (Using 2019 Income Limits)***

An application was filed on 7/4//18 by Tom (tax-filer) for his two children Tia (age 8) and Tony (age 10). The household size is 3 (Tom, Tia and Tony) Tom was unemployed from January –June and started a new job in July. Tom earns $1750 bi-weekly. Only one pay was received in July ($940.62). The income is calculated as $1,750 x 2.15 =$3,762.50. The 5% FPL disregard amount of $89 is deducted ($3,762.50- 89=$3,673.50) and income exceeds the monthly FPL limits for FAMIS ($3,555). The worker requests income already received during the current tax year and Tom's employer verifies the following:

January- June	*$0*
July 23	*$940.62*
August – December (projected)	*$18,812.50*
Total Projected Annual Income	*$19,753.12*

The total annual projected income is of $19,753.12 is under the 100% annual FPL for household size 3 ($21,330). The projected annual amount of $19,753.12 is compared to the 143% annual FPL limit for household size of 3 ($30,502) and both children are eligible for Medicaid.



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Since the child's countable income is under the lower financial threshold for the APTC and he has excess income using non-filer rules, the child's eligibility must be evaluated using gap-filling rules.

G. Example – Gap-Filling Evaluation— Childless Adult (Using 2019 Income Limits)

Lee, age 27, is a tax-filer and applies for Medicaid on June 1. He is attending graduate school and works part-time as a teaching assistant. His income for June is $1,625. The 5% FPL disregard amount of $53 is deducted ($1,625 - $53 =$1,572) and income exceeds the limit for the MAGI Adults covered group for a HH of 1 ($1,436). Lee is not eligible for Medicaid using MAGI methodology.

Lee calls the worker when he receives the denial notice and tells the worker that his income is higher in the summer and less during the remainder of the year *and requests to be evaluated for retroactive coverage for March- May.* A potential gap-filling situation exists, so the worker requests verification of Lee's income from January through May. He provides his paystubs for January ($710), February ($720), March ($697), April ($752), and May ($715). His total year to date income is $3,594.

Lee also provides a letter from his employer that states his teaching income for September thru December will be a guaranteed amount of $715 per month. The worker uses a projected amount for September – December of $715 per month, which totals *$2,860*.

January - May	$3,594
June- August	$4,875
September- December (projected)	*$2,860*
Total Projected Annual Income	*$11,329*

The total annual projected income of *$11,329* is under the 100% annual FPL of $12,490 for household size of 1. The projected annual amount of *$11,329* is compared to the 133% annual FPL limit for household size of 1 ($16,612). *Lee is eligible for retroactive Medicaid coverage and ongoing coverage as a MAGI Adult.*

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5% FPL INCOME DISREGARD AMOUNTS
ALL LOCALITIES

EFFECTIVE *1/15/25*

Household Size	Monthly Amount
1	*$66*
2	*89*
3	*112*
4	*134*
5	*157*
6	*180*
7	*203*
8	*226*
Each additional, add	*23*

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GAP-FILLING RULE EVALUATION
100% FPL
INCOME LIMITS

EFFECTIVE *1/15/25*

Household size	Annual (Use for Gap-filling Evaluation)	Monthly
1	*$15,650*	*$1,305*
2	*21,150*	*1,763*
3	*26,650*	*2,221*
4	*32,150*	*2,680*
5	*37,650*	*3,138*
6	*43,150*	*3,596*
7	*48,650*	*4,055*
8	*54,150*	*4,513*
Each additional, add	*5,500*	*459*

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PREGNANT WOMEN
143% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/15/25*

Household Size	143% FPL Yearly Amount	143% FPL Monthly Amount	148% FPL (143% FPL + 5% FPL Disregard)
*2	*$30,245*	*$2,521*	*$2,609*
3	*38,110*	*3,176*	*3,287*
4	*45,975*	*3,832*	*3,966*
5	*53,840*	*4,487*	*4,644*
6	*61,705*	*5,143*	*5,322*
7	*69,570*	*5,798*	*6,001*
8	*77,435*	*6,453*	*6,679*
Each additional, add	*7,865*	*656*	*679*

*A pregnant woman's household is at least two individuals when evaluated in the Pregnant Women covered group.

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CHILD UNDER AGE 19
143% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/15/25*

# of Persons in House-hold	109% FPL (for Determining Aid Category)	143% FPL		148% FPL (143% FPL + 5% FPL Disregard)
	Monthly Limit	Annual Limit	Monthly Limit	Monthly Limit
1	*$1,422*	*$22,380*	*$1,865*	*$1,931*
2	*1,922*	*30,245*	*2,521*	*2,609*
3	*2,421*	*38,110*	*3,176*	*3,287*
4	*2,921*	*45,975*	*3,832*	*3,966*
5	*3,420*	*53,840*	*4,487*	*4,644*
6	*3,920*	*61,705*	*5,143*	*5,322*
7	*4,420*	*69,570*	*5,798*	*6,001*
8	*4,919*	*77,435*	*6,453*	*6,679*
Each add'l, add	*500*	*7,865*	*656*	*679*

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LIFC Income Limits Effective *7/1/2025*

Group I

Household Size	Monthly Amount	Annual Amount
1	*$329*	*$3,948*
2	*495*	*5,940*
3	*632*	*7,584*
4	*764*	*9,168*
5	*896*	*10,752*
6	*1010*	*12,120*
7	*1142*	*13,704*
8	*1276*	*15,312*
Additional	*139*	*1,668*

Group II

Household Size	Monthly Amount	Annual Amount
1	*$429*	*$5,148*
2	*609*	*7,308*
3	*767*	*9,204*
4	*913*	*10,956*
5	*1,075*	*12,900*
6	*1,209*	*14,508*
7	*1,355*	*16,260*
8	*1,510*	*18,120*
Additional	*155*	*1,860*

Group III

Household size	Monthly Amount	Annual Amount
1	*$642*	*$7,704*
2	*859*	*10,308*
3	*1,048*	*12,576*
4	*1,226*	*14,712*
5	*1,452*	*17,424*
6	*1,613*	*19,356*
7	*1,793*	*21,516*
8	*1,983*	*23,796*
Additional	*188*	*2,256*

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GROUPING OF LOCALITIES EFFECTIVE *7/01/17*

GROUP I		GROUP II	GROUP III
Counties	Louisa	Counties	Counties
	Lunenburg		
Accomack	Madison	Albemarle	Arlington
Alleghany	Mathews	Augusta	Fairfax
Amelia	Mecklenburg	Chesterfield	Montgomery
Amherst	Middlesex	Henrico	Prince William
Appomattox	Nelson	Loudoun	
Bath	New Kent	Roanoke	
Bedford	Northampton	Rockingham	Cities
Bland	Northumberland	Warren	
Botetourt	Nottoway		Alexandria
Brunswick	Orange		Charlottesville
Buchanan	Page	Cities	Colonial Heights
Buckingham	Patrick		Falls Church
Campbell	Pittsylvania	Chesapeake	Fredericksburg
Caroline	Powhatan	Covington	Hampton
Carroll	Prince Edward	Harrisonburg	Manassas
Charles City	Prince George	Hopewell	Manassas Park
Charlotte	Pulaski	Lexington	Waynesboro
Clarke	Rappahannock	Lynchburg	
Craig	Richmond County	Martinsville	
Culpeper	Rockbridge	Newport News	
Cumberland	Russell	Norfolk	
Dickenson	Scott	Petersburg	
Dinwiddie	Shenandoah	Portsmouth	
Essex	Smyth	*Poquoson*	
Fauquier	Southampton	Radford	
Floyd	Spotsylvania	Richmond	
Fluvanna	Stafford	Roanoke	
Franklin	Surry	*Salem*	
Frederick	Sussex	Staunton	
Giles	Tazewell	Virginia Beach	
Gloucester	Washington	Williamsburg	
Goochland	Westmoreland	Winchester	
Grayson	Wise		
Greene	Wythe		
Greensville	York		
Halifax			
Hanover			
Henry	Cities		
Highland			
Isle of Wight	Bristol		
James City	Buena Vista		
King George	Danville		
King & Queen	Emporia		
King William	Franklin		
Lancaster	Galax		
Lee	Norton		
	Suffolk		

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INDIVIDUALS UNDER AGE 21 INCOME LIMITS

EFFECTIVE *7/1/25*

Group I

Household Size	Monthly Income Limit	Annual Income Limit
1	*$315*	*$3,780*
2	*481*	*5,772*
3	*618*	*7,416*
4	*747*	*8,964*
5	*880*	*10,560*
6	*986*	*11,832*
7	*1,114*	*13,368*
8	*1,253*	*15,036*
Each additional person add	*135*	*1,620*

Group II

Household Size	Monthly Income Limit	Annual Income Limit
1	*$424*	*$5,088*
2	*611*	*7,332*
3	*765*	*9,180*
4	*914*	*10,968*
5	*1,079*	*12,948*
6	*1,209*	*14,508*
7	*1,355*	*16,260*
8	*1,509*	*18,108*
Each additional person add	*153*	*1,836*

Group III

Household Size	Monthly Income Limit	Annual Income Limit
1	*$560*	*$6,720*
2	*752*	*9,024*
3	*907*	*10,884*
4	*1,062*	*12,744*
5	*1,256*	*15,072*
6	*1,383*	*16,596*
7	*1,534*	*18,408*
8	*1,689*	*20,268*
Each additional person add	*154*	*1,848*

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PLAN FIRST
200% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/15/25*

Household Size	200% FPL Yearly Amount	200% FPL Monthly Amount	205% FPL (200% FPL + 5% FPL Disregard) Monthly Amount
1	*$31,300*	*$2,609*	*$2,674*
2	*42,300*	*3,525*	*3,614*
3	*53,300*	*4,442*	*4,553*
4	*64,300*	*5,359*	*5,493*
5	*75,300*	*6,275*	*6,432*
6	*86,300*	*7,192*	*7,372*
7	*97,300*	*8,109*	*8,312*
8	*108,300*	*9,025*	*9,251*
Each additional, add	*11,000*	*917*	*940*

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MAGI ADULTS
133% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/15/25*

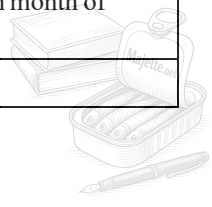
Household Size	133% FPL Yearly Amount	133% FPL Monthly Amount	138% FPL (133% FPL + 5% FPL Disregard)
1	*$20,815*	*$1,735*	*$21,597*
2	*28,130*	*2,345*	*29,187*
3	*35,445*	*2,954*	*36,777*
4	*42,760*	*3,564*	*44,367*
5	*50,075*	*4,173*	*51,957*
6	*57,390*	*4,783*	*59,547*
7	*64,705*	*5,393*	*67,137*
8	*72,020*	*6,002*	*74,727*
Each additional, add	*7,315*	*610*	*7,590*

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TREATMENT OF INCOME FOR FAMILIES & CHILDREN COVERED GROUPS

INCOME	MAGI COVERED GROUPS	MEDICALLY NEEDY; 300% SSI; F&C COVERED GROUPS
Difficulty of Care Payments	*Not counted*	*Counted with appropriate earned income disregards*
Earnings	Counted with no disregards	Counted with appropriate earned income disregards
Social Security Benefits Adult's MAGI household	Benefits received by a parent or stepparent are counted for his eligibility determination, as well as the eligibility determinations of his spouse and children in the home.	Counted if anyone in the Family Unit/Budget Unit receives
Social Security Benefits Child's MAGI household	If the child lives with a parent, only counted if the child is required to file a federal tax return..	Counted if anyone in the Family Unit/Budget Unit receives
Child Support Received	Not counted	Counted – subject to $50 exclusion
Child Support Paid	Not deducted from income	Not deducted from income
Alimony Received	Counted if divorce agreement was finalized prior to January 1, 2019, and the agreement has not been modified.	Counted – subject to $50 exclusion if comingled with child support
Alimony Paid	Deducted from income if divorce agreement was finalized prior to January 1, 2019	Not deducted from income
Worker's Compensation	Not counted	Counted
Veteran's Benefits	Not counted if they are **not** taxable in IRS Publication 525	Counted
Scholarships, fellowships, grants and awards used for educational purposes	Not counted	Not counted
Student Loan Debt	Effective January 1, 2019, student loan debt forgiven due to death or disability of student is not counted as income	Not applicable
Foreign Income (whether or not excluded from taxes)	Counted	Counted
Interest	Counted	Counted
Lump Sums	Income in month of receipt	Income in month of receipt
Lottery & Gambling Winnings	Lottery and gambling winnings of $80,000 or greater, received in a single payout, are counted in the month received and over a period of up to 120 months. Income in month of receipt for other HH members.	Income in month of receipt
Gifts, inheritances, life insurance proceeds	Not counted	Counted as lump sum in month of receipt
Parsonage allowance	Not counted	Counted



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Pandemic Unemployment Compensation Payments	Not counted (regular Unemployment Compensation is counted.)	Not counted (regular Unemployment Compensation is counted.)
Federal COVID-19 relief payments	Not counted	Not counted

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CHAPTER M05

MEDICAID ASSISTANCE UNIT

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M05 Changes

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CHAPTER M05
MEDICAID ASSISTANCE UNIT
SUBCHAPTER 10

GENERALS RULES AND PROCEDURES

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M0510 Changes

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TN #DMAS-16	4/1/20	Page 5
TN #98	10/1/13	Pages 1-3

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M0510.000 GENERAL RULES & PROCEDURES

M0510.001 ASSISTANCE UNIT GENERAL PRINCIPLES

A. Introduction

Medicaid is an assistance program which pays medical service providers for services rendered to eligible needy individuals. An individual's need is based on his financial eligibility--the amount of his resources and income.

Financial eligibility is determined in relation to specific resource and income limits. The income and resource limits are established in relation to the number of persons in the assistance unit. The assistance unit is the basis for the financial eligibility determination. Eligibility is based on the countable income and resources of the assistance unit members and of legally responsible relatives who are not included in the assistance unit and who live in the home. All of the resources and income which the individual has available to him, including resources and income "deemed" to be available to him, are counted.

B. Procedures

This subchapter contains the general policy and procedure for determining *the composition of* an individual's assistance unit for the financial eligibility determination.

- The Legal Base is contained in M0510.002;
- Definitions are contained in M0510.100;
- General Procedures are contained in M0510.200.

The detailed family/budget unit policy and procedures for individuals in *all Families & Children* (F&C) *Medically Needy (MN)* covered groups are contained in M0520.

Chapter M04 contains the procedures for determining the household size for the following F&C covered groups for all ***eligibility determinations for applications submitted on or after October 1, 2013*** *and* ***renewals made after April 1, 2014****:*

- *CN Pregnant Women & Newborn Children;*
- *Plan First;*
- *Child Under Age 19 (FAMIS Plus);*
- *Low Income Families With Children (LIFC);*
- *Individuals Under Age 21;*
- *Special Medical Needs Adoption Assistance.*

The detailed assistance unit policy and procedures for individuals in an ABD covered group are contained in M0530.

M0510.002 LEGAL BASE

A. Federal Law

The federal Medicaid law in Title XIX, section 1902(a)(17)(D), requires that a state plan for medical assistance include reasonable standards for determining



eligibility for and the extent of medical assistance under the state plan. These standards must provide for reasonable evaluation of resources and income. The standards must:

- take into account only such income and resources as are available to the applicant or recipient;
- take into account only such income and resources as would not be disregarded under the Supplemental Security Income (SSI) program for aged, blind and disabled individuals, or the title IV-A program (AFDC program in effect on 7-16-96) for all other individuals;
- NOT take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21.

B. Federal Regulations

Federal regulations in 42 CFR 435.601 state that when determining Medicaid eligibility, the agency must apply the financial methodologies and requirements of the cash assistance program that is most closely categorically related to the individual's covered group, EXCEPT:

- when determining the financial responsibility of relatives, and
- when using more restrictive or more liberal resource methodologies than those of the cash assistance program, as specified in the State Plan.

Federal regulations in 42 CFR 435.602 state that, except for a spouse of an individual or a parent for a child who is under age 21, the agency must not consider income and resources of any relative as available to an individual.

C. Virginia Medicaid Policy

When determining whose resources and income to count available to the individual applicant or recipient, Medicaid must take into account the resources and income of the individual's spouse or parent (if the individual is under age 21) with whom the individual lives. For the aged, blind and disabled (ABD) covered groups, Medicaid must use the SSI program methods for counting and "deeming" spouses' and parents' resources and income to an individual, except where they would result in "illegal" deeming of resources or income from a relative or person who is not legally responsible for the individual according to the federal Medicaid regulations. For the (F&C) *MN* covered groups, Medicaid must use the 7-16-96 AFDC program methods for counting and "deeming" spouses' and parents' resources and income to an individual, except where they would result in "illegal" deeming of resources or income from a relative or person who is not legally responsible for the individual according to the federal Medicaid regulations.

Subchapter M0520 explains how to count the resources and income of a spouse or parent for the F&C *MN* covered groups. Subchapter M0530 explains how to count the resources and income of a spouse or parent for the ABD covered groups.

M0510.100 DEFINITIONS

A. Introduction

The terms used in this subchapter are defined below in this section.

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B. Assistance Unit

The Medicaid assistance unit is the individual or family who applies for Medicaid and whose financial eligibility is determined. The assistance unit for the F&C *MN* covered groups is called the "family unit" or the "budget unit."

The assistance unit for an ABD individual is just the individual, unless the individual is married, living with his/her spouse and the spouse is also ABD. In this situation, the assistance unit is the married ABD couple.

C. Budget Unit

The budget unit (BU) is the term used for the assistance unit for F&C *MN* individuals in a family when specific circumstances exist. The BU is a sub-unit of the family unit (FU). It contains some, but not all, members of the family unit.

D. Family Unit

The family unit is the name for the assistance unit when determining eligibility for an F&C individual or family. The family unit consists of all individuals listed on the application form as living in the household and among whom legal responsibility for support exists.

Federal Medicaid law and regulations prohibit deeming resources or income from anyone other than a parent to a child under age 21 or from spouse to a spouse. An individual cannot be ineligible or have his spenddown liability increased because of counting income and resources of non-legally responsible individuals living in the household.

The family unit must be further divided into "budget units" when the family unit does not meet the resource or income limit, and

- the family unit contains a stepparent, an acknowledged father not married to the mother, a married Medicaid minor or a Medicaid minor parent in the home, or
- a child in the family unit has resources or income of his/her own.

The unit must include the legally responsible relative(s) with whom the individual lives (parent for child under age 21 and spouse for spouse) unless the spouse or the parent receives an SSI or IV-E foster care/adoption subsidy payment. Spouse refers to a person who would be defined as married to the individual under applicable state law. Parent refers to the natural or adoptive parent of the child.

E. Deeming

Deeming is the process of considering the income and resources of another person, who is not included in the assistance, family or budget unit, to be the income and resources of the individual who is applying for or receiving Medicaid. Deemed income and resources are counted available to the eligible individual whether or not they are actually made available to him/her.

The federal Medicaid regulations require that the income and resources of certain individuals other than the applicant be included (deemed available) when determining an individual's Medicaid eligibility. These individuals



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are the individual's responsible relatives--the individual's parent when the individual is under age 21 and the individual's spouse, except when the parent or spouse receives SSI or IV-E assistance payments. Except for a spouse of an individual, or a parent for a child who is under age 21, the agency must not consider resources and income of any relative as available to an individual.

Resources and income deemed **to** an individual are not considered resources or income in subsequent deeming calculations of the individual's resources or income.

F. Deemor

A deemor is an individual whose income and resources are subject to deeming. Such individuals include ineligible parents and ineligible spouses. It does not matter whether these individuals have sufficient income or resources to deem, they are still considered to be deemors. The type of income such an individual receives (e.g., public income maintenance payments such as TANF, VA pension based on need, etc.) does not exclude him/her from this definition for an ABD determination. For F&C determinations, recipients of SSI or IV-E payments are NOT deemors.

G. Illegal Deeming

Illegal deeming is a procedure which results in counting or deeming resources or income to an individual from a person who is not the individual's spouse, or who is not the individual's parent if the individual is under age 21.

M0510.200 GENERAL PROCEDURES

A. Introduction

This section contains the general policy and procedure for determining the individual's assistance unit for the financial eligibility determination.

B. Institutionalized Individuals

When an individual is institutionalized in a medical facility or Medicaid waiver services, the individual is an assistance unit of one person. *Go to chapter M14 to determine eligibility for institutionalized individuals.*

C. Non Institutionalized Individuals

1. Child Under Age 19

a. Does Not Receive SSI

Determine the child's F&C MI eligibility first (if pregnant, use the 133% pregnant woman limits), even if child is also foster care or adoption assistance. If the child has excess income for MI, then determine the child's MN eligibility for spenddown. Use the F&C family/budget unit policy in M0520.

If the child is also blind or disabled and does NOT receive SSI, determine F&C MI eligibility first. Use the F&C family/budget unit policy in

M0520. If the child has excess income for MI, then determine the child's ABD MN eligibility for spenddown, using the ABD assistance unit policy in M0530.

b. Receives SSI

If the child receives SSI, determine the child's eligibility as an SSI recipient. If the child is not eligible for Medicaid as an SSI recipient (e.g. because of excess resources), determine the child's eligibility as F&C. *If* the child is pregnant or under age 19, use the F&C family/budget unit policy in M0520.

2. Individual Age 19 but Under 21

a. Receives SSI

If the child is age 19 or 20 and is not eligible for Medicaid as an SSI recipient, e.g., because of excess resources, determine his/her F&C eligibility IF he/she also meets an F&C covered group because the F&C real property requirements are different from the ABD requirements. Use the F&C family/budget unit policy in M0520.

If he/she does NOT meet an F&C covered group, he/she is not eligible for Medicaid.

b. Disabled or Blind Child

If the child is disabled or blind, first determine the child's ABD eligibility using the ABD assistance unit policy in M0530. If not eligible as ABD and the child meets an F&C covered group, use the F&C family/budget unit policy in M0520.

c. Pregnant Woman

If the individual is pregnant, determine F&C MI eligibility first. Use the family/budget unit policy in M0520. If the individual is not eligible as MI, she should meet the MN pregnant woman group. Use the F&C family/budget unit policy in M0520 when determining her MN eligibility.

3. Individual Age 21 and Older

a. Pregnant Woman

If the individual is pregnant, determine F&C MI eligibility first. Use the family/budget unit policy in M0520. If the individual is not eligible as MI, she should meet the MN pregnant woman group. Use the F&C family/budget unit policy in M0520 when determining her MN eligibility.

b. Other Individuals

If the individual is aged, disabled or blind, first determine the individual's ABD assistance unit in M0530. If the individual is not eligible as ABD and he/she meets an F&C covered group, use the F&C family/budget unit policy in M0520.



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CHAPTER M05
MEDICAID ASSISTANCE UNIT
SUBCHAPTER 20

FAMILIES & CHILDREN (F&C) *MEDICALLY NEEDY (MN)* FAMILY/BUDGET UNIT

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TN #DMAS-10	10/1/18	Page 2
TN #DMAS-3	1/1/17	Table of Contents Pages 3, 5-35 Pages 36-38 were removed.
TN #100	5/1/15	Page 2
TN #98	10/1/13	Title Page Table of Contents Pages 1,2,9
UP #7	7/1/12	Table of Contents Pages 2-5
Update (UP) #4	7/1/10	Pages 2, 2a

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M0520.000 FAMILIES & CHILDREN (F&C) MEDICALLY NEEDY FAMILY/BUDGET UNIT

M0520.001 OVERVIEW

A. Introduction

This subchapter contains the policy and procedures for determining the assistance unit for certain individual or families who meet an F&C MN covered group. Refer to M0510.001 for information and instructions on when to use the policies in M0520.

For F&C MN and Extended Medicaid, financial eligibility determination purposes, the assistance unit is called the "family" unit. A household is divided into one or more family units.

The family unit's financial eligibility is determined first for F&C MN eligibility determinations. If the family unit has resources or income that cannot be verified or that exceeds the limit for the individual's covered group, the family unit is divided into "budget" units if certain requirements are met.

B. Policy

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

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

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

1. Member In One Unit

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

2. May Exclude A Child

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

3. *Child* Living Away From Home

A parent, or a child under age 21 who has not been emancipated, is considered living in the household for family unit composition purposes if the absence is temporary and the parent or child intends to return to the home when the purpose of the absence (such as employment, military service, education, rehabilitation, medical care, vacation, visit) is completed.

Children living in foster homes/institutions are NOT temporarily absent from home. They are indefinitely absent from home and are NOT living with their parents or siblings for Medicaid purposes.



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4. Psychiatric Residential Treatment Facilities (PRTFs)

Children residing in a PRTF *(formerly called a Level C PRTF)* are not temporarily absent from home. They are indefinitely absent from home and are not living with their parents or siblings for Medicaid purposes, if their stay in the facility has been 30 calendar days or longer. Long-term care rules do not apply to these children.

If the child is placed in a PRTF, verify *that the facility is* on the Magellan website at https://www.magellanofvirginia.com/for-providers/residential-program-process. Click on **Medicaid Contracted Residential Treatments Service Providers**. *PRTFs are denoted as Provider Type = 077 and Provider Specialty = blank.* If the facility is not a *PRTF* facility, the child is NOT considered living away from his parents.

5. Medical Facilities

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

6. Parent/ Caretaker-Relative Living in the Home

A parent/caretaker-relative who is absent from the home is considered living with a child in the household if the absence is temporary and the parent/caretaker-relative intends to return home when the purpose of the absence (such as military service, vacation, education, medical care or rehabilitation) is complete.

C. Procedure

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

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

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M0520.010 DEFINITIONS

A. Introduction

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

B. Acknowledged Father

In Virginia, a man who is legally married to the mother of a child on the child's date of birth is considered to be the legal father of the child **UNLESS** another man has been determined by DCSE or a court to be the child's father. The man listed on the application form as the child's father is considered to be the child's acknowledged father when:

- the mother was not married to another man on the child's birth date, or
- the mother was married to another man on the child's birth date but DCSE or a court determined that the man listed on the application is the child's father,

unless documentation, such as the child's birth certificate, shows that another man is the child's father.

NOTE: Her declaration on the application of the child's father's name is sufficient unless there is evidence that contradicts the application. The mother's marital status at the time of the child's birth does not require verification; her declaration of her marital status is sufficient. See M0310.123 for the definition of a parent.

C. Household

For this subchapter's purposes, the "household" is everyone living in the residence and who is listed on the Application for Benefits as living in the residence.

D. Legal Emancipation

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

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

E. Legally Responsible Relative

A legally responsible relative is a person who is related to the individual applicant or recipient and who has a legal obligation under federal and state law to support the individual applicant/recipient.

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

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



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

M0520.100 FAMILY UNIT RULES

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

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

- MN Pregnant Women ;
- MN Newborn Children;
- MN Children Under Age 18;
- MN Individuals < 21 in foster care, adoption assistance, and ICF or an ICF-MR.

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

1. Member In One Unit At A Time An applicant/recipient's Medicaid eligibility can only be determined in one F&C family unit at a time.

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

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

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

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

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

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

3. Child Under 21 Living Away From Home

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

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

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

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

If the child is placed in a PRTF, verify that it is a Level C facility on the Department of Medical Assistance Services web site at *arts-prtf-rates-web-file-sfy25_20240701.pdf (virginia.gov),* If the facility is not a Level C facility, the child is considered not to be living away from his parents.

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4. Pregnant Woman

An individual who meets the pregnant woman definition is counted as at least **two persons** when her eligibility is being determined in the MI Pregnant Woman or MN Pregnant Woman covered group. The unborn child (or children, if medical documentation verifies more than one fetus) must be included in the unit with the pregnant woman when determining her eligibility. A separate calculation is required for the other family unit members who do not meet a pregnant woman covered group. This calculation does NOT include the unborn child(ren) as part of the family unit and/or budget unit (BU).

5. Cohabitant

A cohabitant is not the child(ren)'s parent and is not legally responsible for anyone in the family unit. Therefore, the cohabitant is not included in the family unit. Do not count a cohabitant's income or resources.

C. *Family Unit* Examples *for MN Eligibility Determinations*

1. Household With Excluded Child

EXAMPLE #1: Household listed on application consists of applicant, her disabled spouse, her 15-year old son, and husband's 20-year old daughter. The 20-year old daughter is employed full-time. Medicaid is requested for applicant, her spouse, and her son. She specifies in writing that she wishes to exclude her husband's 20-year old daughter. *It is determined that the applicants are not eligible for Medicaid in any categorically needy covered groups due to excess income; however, the 15-year old son meets a MN Children Under 18 covered group and his mother requests that he be evaluated for a spenddown.*

The family unit consists of:

- the applicant
- her husband, and
- her 15-year old son.

The family unit's income is determined using the F&C income policy and procedures.

2. Household With Acknowledged Father

EXAMPLE #2: Household listed on the Medicaid application consists of pregnant woman applicant, her 5-year old son and her boyfriend, who is the acknowledged father of the 5-year old. They all request Medicaid. *It is determined that the applicants are not eligible for Medicaid in any categorically needy covered groups due to excess income; however, the pregnant woman and her son both meet MN covered groups, and the pregnant woman requests that they be evaluated for a spenddown.*

The family unit for the Medicaid eligibility determination for the 5-year old child consists of:

- the woman,
- the 5-year old child and
- the child's acknowledged father.

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The family unit for the Medicaid eligibility determination for the pregnant woman consists of:

- the pregnant woman,
- her unborn child,
- the 5-year old child, and
- the child's acknowledged father.

The family unit's income is determined using the F&C income policy and procedures.

M0520.101 MULTIPLE FAMILY UNITS

A. Policy Multiple family units exist in a household in the following situations:

1. Non-parent Caretaker When the individual is applying for Medicaid as a non-parent caretaker of a dependent child, multiple family units exist.

2. Child--No Responsible Relative In Home When the individual applying is a child under age 21 but has no responsible relative living in the household and is not a sibling of another child(ren) in the household, multiple family units exist.

***3*. Adult--No Responsible Relative In Home** When the individual applying is age 21 or older and is not legally responsible for the other applicant(s) in the household, multiple family units exist.

***4*. Foster Care Child** When the individual applying is a foster care child whose parent(s) live in the household and who is placed in his/her home for a trial visit (see M0520.701 below), multiple family units exist.

***5*. Siblings** Siblings under age 21 are included in the same family unit.

6. SSI Child A child receiving SSI is always a separate family unit of one person.

B. Procedures When an applicant applies for a child in the household, begin forming the family unit by identifying the child(ren) who applies and meets an F&C covered group. Divide the household into multiple family units when:

- the household contains an individual(s) who applies for Medicaid but who is not a legally responsible relative of the other individual(s) who has applied; or

- the household contains a foster care child under age 21 who is placed in the home for a trial visit.

Each family unit must contain only those individuals among whom legal responsibility for financial support exists.



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M0520.200 BUDGET UNIT RULES

A. Policy

BUs are formed to assure that only the individual's resources and income and the resources and income of those persons legally responsible for the individual are used to determine the individual's Medicaid financial eligibility. If the individual's family unit has resources or income which cannot be verified or which exceed the limit for the individual's covered group, determine if the family unit can be broken into BU. Forming BUs based on resources is only applicable to the F&C MN covered groups. A family unit must be broken into BUs when:

1. a child in the family unit has his/her own income;
2. a child in the family unit has his/her own resources (applicable only for F&C MN covered groups);
3. the child's stepparent is in the family unit;
4. the child's parent with whom he/she lives is a Medicaid minor (under age 21) and they live with the minor parent's parent(s);
5. the child is married and living with his/her spouse and his/her parent(s);
6. the child(ren)'s acknowledged father lives in the household and is not married to the child(ren)'s mother.

All members of a family unit must be placed in a BU when the family unit can be divided into BUs. Although they will be included in a BU, persons found eligible at the family unit level do NOT have their eligibility redetermined at the BU level.

B. Budget Unit Rules

The rules that apply to BU composition are:

1. Member In One Unit

An applicant/recipient can be a member of only one F&C BU.

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2. Children With Own Resources (F&C MN Only) or Income

The child(ren) with his or her own resources or income is in a separate BU. Deem resources and income from parents. Resources are deemed and/or counted only when determining eligibility for F&C MN covered groups.

The parent(s) is/are included in the unit with child(ren) who has no resources or income.

If all of the children have resources or income, the parent(s) is/are in a separate BU. If there is more than one child with resources or income, the resources or income deemed from the parents are divided evenly among the children.

3. Medicaid Minor Caretaker Applicant

When the Medicaid minor parent is not married and lives with his/her parent(s), he or she is included in a BU with his/her parent(s), NOT with his or her child(ren).

When the Medicaid minor parent is married and lives with his/her parent(s) and spouse, he or she is in a BU by himself/herself, NOT with his/her parent(s) and NOT with his or her child(ren) and spouse.

A married Medicaid minor parent is in a separate BU when living with his/her spouse and the minor's parent(s).

4. Married Medicaid Minor

When the Medicaid minor is married and lives with his/her parent(s) and spouse, he or she is in a BU by himself/herself, NOT with his/her parent(s) and NOT with his or her child(ren) and spouse. A married Medicaid minor is in a separate BU when living with his/her spouse and the minor's parent(s).

5. Stepparent In Household

A stepparent is not included in a BU with his/her stepchild(ren). A married parent **(except a Medicaid minor parent who lives with his/her parents)** is included in a BU with his/her spouse and their child(ren)-in-common. The parent's other child(ren) who are not the child(ren) of his/her spouse are in a separate BU.

6. Deeming From Parents

When determining how much of the child's parent's income or resources are deemed available to the child's BU, any income or resources deemed to the parent from the parent's spouse who is not the child's parent, is NOT counted in the deeming calculation.

No income or resources deemed from the parent(s) of a minor child are deemed to the minor child's spouse or the minor's child.

7. Acknowledged Father

An acknowledged father who lives in the household and is not married to the child(ren)'s mother is in a BU separate from the mother. Their child(ren)-in-common is NOT included in the BU with the father; the child(ren)-in-common is in a separate BU.

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8. Spenddown Expenses

If a BU is ineligible because of excess income, only the unit's member's medical expenses will count toward the unit's spenddown, unless a BU member is legally liable to pay the medical expenses of another person in the household, whether or not that other person is in another Medicaid BU. If a BU member is legally liable for another person in the household, the other person's medical bills can count toward the BU member's spenddown.

A medical expense can only be used once to meet only one unit's spenddown. A child's medical expenses are first deducted from the child's unit. If the child's unit spenddown is not met, the child's medical expenses can be deducted from the parent's spenddown. If the child's unit's spenddown is met, then the child's medical expenses that were not used to meet the child's spenddown can be deducted from the parent's spenddown, if the medical expenses are not covered by Medicaid or other health insurance.

M0520.201 CHILD(REN) WITH RESOURCES AND/OR INCOME

A. Policy

The child(ren) with his or her own resources (F&C MN covered groups only) or income is in a separate BU. Forming BUs based on resources is only applicable to F&C MN covered groups. Deem income and resources from the parents if the child is living with the parents; and from the child's spouse if the child is married and living with the spouse.

B. Forming Budget Units *for the MN Eligibility Determination*

Place the child who has his/her own resources or income in a BU by himself.

EXAMPLE #6: Household listed on application consists of a woman, her disabled spouse, their 15-year old son, and their 20-year old daughter. *The son's MN eligibility is being determined.*

The family unit consists of:

- the mother,
- her husband, and
- their two children under age 21.

Because the son receives unearned income from a trust fund, the family unit is broken into BUs:

- BU #1 = son
- BU #2 = mother, her husband, and their daughter

The parent's BU's countable income is calculated to determine how much income is deemed to the son's BU. The parent's deemed income is added to the son's income to determine the son's BU's countable income for *MN* eligibility.

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M0520.202 MARRIED MEDICAID MINOR OR MEDICAID MINOR CARETAKER LIVING WITH PARENT

A. Policy

The Medicaid minor parent (caretaker) is included in a BU with his/her parent(s), NOT with his or her child(ren), unless the Medicaid minor caretaker has resources (F&C MN covered groups only) or income of his/her own, or is married and living with his/her spouse.

If the Medicaid minor parent (caretaker) has resources or income, or is married and living with a parent(s)and his/her spouse, place the Medicaid minor caretaker in a BU by himself/herself and deem the parents' resources and income (and the spouse's resources and income, when the Medicaid minor caretaker is married and living with his/her spouse) to the Medicaid minor caretaker.

B. Forming Budget Units

1. Medicaid Minor Caretaker

Place the Medicaid minor parent caretaker in a BU with his/her parents when the Medicaid minor parent:

- is not married, or is married but not living with his/her spouse, and
- has no resources or income of his/her own.

EXAMPLE #7: Household listed on application consists of woman applicant, her disabled spouse, their 17-year old daughter and her 2-year old son (woman's grandson). *The daughter's MN eligibility is being determined.*

The family unit consists of :

- the mother,
- her husband,
- their daughter, and
- the daughter's son.

The family unit's income is determined using the F&C income policy and procedures. Because the daughter is a Medicaid minor parent, the family unit is broken into BUs:

- BU #1 = 2-year old grandson
- BU #2 = the mother, her husband and the 17-year old Medicaid minor parent

The mother and her husband's countable income is calculated to determine the Medicaid minor parent's eligibility as *MN*.

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2. Married Medicaid Minor

Place the married Medicaid minor in a BU by himself/herself when the Medicaid minor:

- is married and living with his/her spouse, or
- has resources or income of his/her own, AND
- lives with his/her parent(s).

Deem a portion of the married Medicaid minor's parent's resources and income to the married minor, and deem a portion of the married minor's spouse's resources and income to the married minor.

EXAMPLE #8: Household listed on application consists of the married Medicaid minor applicant age 17, her spouse age 25 and her parents. *The minor's MN eligibility is being determined.*

The family unit consists of:

- the married Medicaid minor,
- her husband, and
- her parents.

Because the daughter is a married Medicaid minor who lives wth her parents and her spouse, the family unit is broken into BUs:

- BU #1 = the married Medicaid minor
- BU #2 = her husband
- BU #3 = her parents

The parent's BU's countable income is calculated to determine the amount deemed to the married Medicaid minor. Her husband's countable income is calculated to determine the amount deemed to the married Medicaid minor. The income deemed from the married Medicaid minor's parents and the income deemed from her husband are added to the married Medicaid minor's income to determine her total countable income.

***1.* Medicaid Minor Parent Caretaker Has Resources or Income**

Place the Medicaid minor parent caretaker in a BU by himself/herself when the Medicaid minor caretaker has resources or income of his/her own.

EXAMPLE #9: Household listed on application consists of woman applicant, her spouse, their 17-year old daughter and the 17-year old's 2-year old son. *The daughter's MN eligibility is being determined.*

The family unit consists of:

- the mother,
- her husband,
- their daughter, and
- their daughter's 2-year old son.

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The family unit's income is determined using the F&C income policy and procedures. Because the Medicaid minor parent caretaker has unearned income from a trust fund, the family unit is broken into BUs:

- BU #1 = the 2-year old
- BU #2 = the Medicaid minor parent
- BU #3 = the mother and father of the minor parent

The mother and father's BU's countable income is calculated to determine the amount of income to deem to their daughter.

The Medicaid minor parent's BU's countable income is first calculated to determine her income. Her income then is added to the amount of income deemed from her parents to determine her eligibility. A separate calculation must be done to determine the amount of the Medicaid minor parent's own income (not including income deemed from her parents) that must be deemed to her 2-year old.

The 2-year old's BU's countable income is the amount of income deemed from his mother since he has no other source of income.

M0520.203 STEPPARENT IN HOUSEHOLD

A. Policy

A stepparent is in a BU separate from his/her stepchild(ren). A married parent (except a minor married parent) is included in a BU with his/her spouse and their child(ren)-in-common. The parent's(s') other child(ren) who are not the child(ren) of his/her spouse are in a separate BU.

Deem resources and income from the parent to his/her child's BU. Do not deem any of the stepparent's resources or income to the parent's child.

B. Forming Budget Units

Place a married parent in a BU that is separate from the parent's child(ren); include the married parent's spouse (the child's stepparent) in the BU with the parent. Include the parent's and stepparent's child(ren)-in-common in the BU with the parent and stepparent.

EXAMPLE #10: Household listed on application consists of mother, her spouse, their 6-year old son, and her 8-year old son from another relationship. *The children's MN eligibility is being determined.*

The family unit consists of:

- the mother,
- her 8-year old son,
- her spouse (stepparent to her son), and
- their 6-year old son.

The family unit's income is determined using the F&C income policy and procedures. BUs are *applicable* because there is a stepparent in the home:

- BU #1 = 8-year old child
- BU #2 = mother, stepparent, their 6-year old child

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M0520.204 ACKNOWLEDGED FATHER IN HOUSEHOLD

A. Policy

An acknowledged father who lives in the household and is not married to the child(ren)'s mother is in a BU separate from the mother. Their child(ren)-in-common is NOT included in the BU with the father; the child(ren)-in-common is in a separate BU.

The mother's own children (who are not the acknowledged father's children) are included in a BU with the mother (unless the child(ren) has resources or income of his/her own).

B. Forming Budget Units

When an acknowledged father lives in the household and is not married to the child(ren)'s mother, place the child(ren) and the acknowledged father in separate BUs.

EXAMPLE #11: Household listed on application consists of mother, her boyfriend who is the acknowledged father of their 4-year old son, their 4-year old son and her 8-year old daughter. *The children's MN eligibility is being determined.*

The family unit consists of:

- the mother,
- her 8-year old daughter,
- the acknowledged father, and
- their 4-year old son.

Because there is an acknowledged father, BUs are formed:

BU #1 = mother, her 8-year old child
BU #2 = their 4-year old child
BU #3 = acknowledged father

M0520.300 DEEMING FROM SPOUSE

A. Policy

The spouse is included in the F&C spouse's budget unit UNLESS:

- the spouse is an SSI or IV-E recipient (do NOT deem any resources or income from an SSI or IV-E recipient spouse to the F&C spouse);

- the F&C spouse is a Medicaid minor parent and they are living with his/her parent(s);

the F&C spouse's spouse is under age 21 and they are living with the spouse's parent(s).

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B. SSI or IV-E Recipient Spouse

If eligibility is being determined in an F&C covered group that has a resource test, the income and resources owned **solely** by an SSI or IV-E recipient are not considered available to his/her spouse. The pro-rata share of resources owned **jointly** by the F&C spouse and his/her SSI or IV-E recipient spouse is counted available to the F&C spouse when they are living together.

When **not** living together, resources owned jointly with the SSI or IV-E recipient are available only if the SSI or IV-E recipient agrees to sell or liquidate the resource. If the SSI or IV-E recipient agrees, then only 1/2 of the resource's value is counted as available to the F&C spouse.

C. Married Medicaid Minor Living With Parents

Determine how much of the deemor spouse's resources and income to deem to the F&C spouse (Medicaid minor) using the following procedures:

1. Deem Resources

a. Determine Countable Resources

Determine the value of the deemor spouse's countable resources owned solely and jointly, according to policy in chapter M06.

b. Subtract Resource Deeming Standard

From the total of the deemor spouse's share of jointly held resources and resources held in his/her name only, subtract the $1,000 resource deeming standard.

c. Deem Remaining Resources

The remaining value, if any, is deemed available to the F&C spouse.

d. Deeming Does Not Reduce Resources

If any of the deemor spouse's resources that are over the resource limit are deemed, this does not make the spouse resource-eligible. Deeming resources does not reduce the deemor's countable resources.

2. Deem Income

To determine how much of the deemor spouse's income to deem to the F&C spouse, use the following procedures:

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a. Determine Countable Income

Determine the deemor spouse's gross monthly countable unearned and earned income according to chapter M07.

b. Subtract Earned Income Exclusions

Subtract the applicable earned income exclusions listed in section M0720.500:

- Standard work exclusion of $90 (M0720.520), and
- Child/incapacitated adult care exclusion (M0720.540).

c. Subtract Deeming Standard

Subtract the deeming standard. The deeming standard is the F&C 100% income limit for the locality for

- the number of persons in the deemor spouse's BU, **plus**
- the number of deemor's child(ren) under age 21 in the household who are excluded from the Medicaid application (are not included in **any** Medicaid BU) and who are or can be claimed as dependents on the deemor's federal income tax return. If the deemor has not previously filed a return or states that he/she will claim a different number of dependents for the current year, use the number of dependents he/she intends to claim for the current year.

See M0710, Appendix 3, for the F&C 100% income limit.

NOTE: For the deeming calculation, a pregnant woman is only 1 person.

d. Subtract Support Payments Made

Subtract actual support paid to individuals NOT in the home, who are or could be claimed as dependents on the **deemor's** federal tax return.

Subtract actual alimony and/or child support payments made to individuals NOT in the home and not claimed as dependents on the **deemor's** federal income tax return.

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e. Deem Remainder

Deem the remaining balance to the eligible F&C spouse (plus the spouse's F&C child(ren), if any, who is not in the spouse's BU) as unearned income.

NOTE: Deeming income does not reduce the deemor's countable income for his Medicaid eligibility determination.

D. Example--Married Minor Living With Parents

EXAMPLE #12: (Using 1999 figures)
A Medicaid minor pregnant woman lives with her husband, their 1-year old child, his 14-year old child from a previous marriage, and her parents. They live in Group I. Her husband earns $3,200 monthly. She has no income. She and her husband own a joint savings account with a balance of $1,600. Her father earns $2,000 monthly; her mother has no income. *MN eligibility is being determined for the minor pregnant woman.*

1. Family Unit

The Medicaid minor pregnant woman's family unit consists of herself, her unborn child, her husband, their 1-year old child, his 14-year old child, and her parents (a family unit of 7).

2. Budget Units

Because there is a Medicaid minor parent and a stepparent in the household, the family unit is divided into BUs:

- BU #1 = the minor PG woman and unborn child (2);
- BU #2 = her spouse, their 1-year old child (2);
- BU #3 = her spouse's 14-year old child (1);
- BU #4 = her parents (2).

Due to excess income at the BU level, a MN eligibility determination is required. Portions of her spouse's resources (for F&C MN only) and income are deemed to her BU according to the spouse deeming procedures.

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BU #1 spouse deeming calculations:

a. Resource Deeming

$ 800	husband's ½ of joint savings
-1,000	resource deeming standard
0	excess (no resources deemed to F&C spouse)

b. Income Deeming

$3,200	husband's earnings
- 90	standard work exclusion
3,110	countable income
- 229	deeming standard for deemor's BU (2 persons in Group I)
2,881	excess
÷ 2	PG woman (spouse) and 14-year-old child
$1,440.50	deemed to each

The parents' deemed resources and income to the pregnant woman's BU are calculated according to M0520.400 below. The parents' deemed income is added to the spouse's deemed income to determine the minor PG woman's income eligibility.

M0520.400 DEEMING FROM PARENT

A. Policy

A parent's resources and income are considered available (either counted in the unit or deemed) to a child under age 21 living with a parent. The parent's resources and income are deemed to the child when the child is in a separate BU from the parent, unless

- the parent is an SSI recipient or has a 1619b status,
- the parent receives IV-E foster care or adoption assistance,
- the child is living away from home per M0520.001 B.3, or
- the child is a foster care child placed in the home for a trial visit of 6 months or less.

***1.* Deeming Standard**

The deeming standard is the portion of the parent's countable resources or income that is not considered available to the child who is in a separate BU from the parent. The resource deeming standard is $1,000. The income deeming standard is the locality F&C 100% income limit for the deemor parent's BU plus any excluded children.

***2.* Single Parent or Parent and Stepparent with No Child in Common**

When each child in the home has only one parent in the home and the parent is in a separate BU, subtract the whole deeming standard from the parent's countable resources and income.

Note: A stepparent is not a "parent" for deeming purposes.

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3. Both Parents In Same BU- Married With Child in Common

a. No Stepchildren

When both parents (at least one child in common) are in the same BU and there are no stepchildren, subtract the whole deeming standard from the parents' resources and income.

b. Stepchildren

When both parents (at least one child in common) are in the same BU and they have at least one child in common in the home who is included in the family unit, subtract one-half of the deeming standard for the parents' BU from deemor parent's resources and income.

When both parents are in the same BU and all their children-in-common are excluded from the family unit, subtract the whole deeming standard for the parents' BU from the deemor parent's resources and income.

4. Both Parents In Different BUs

When both parents (at least one child in common) are in separate BUs, subtract the whole deeming standard from the deemor parent's countable resources and income.

B. Deeming Resources

To determine how much of the deemor parent’s resources to deem to the child, use the following procedures:

1. Determine Countable Resources

Determine the value of countable resources owned solely by the parent and the value of countable resources owned jointly with the parent’s spouse or another person, according to policy in chapter M06. All resources that are in the deemor parent’s name only plus the deemor's share of jointly held resources are counted.

2. Subtract Resource Deeming Standard

a. Single Parent or Parent and Stepparent with No Child in Common

Subtract the whole resource deeming standard of $1,000 from the deemor's total countable resources (those in the deemor’s name only plus the deemor's share of jointly held resources).

Separate deeming calculations for each deemor parent must be done to ensure stepparent resources are not deemed.

b. Both Parents In Same BU With Child in Common

1) Subtract the whole deeming standard of $1,000 from the parents' countable resources when there are children in common and no stepchildren in the home.

When both parents are deeming only to children in common, their resources are combined and only one deeming calculation is done.



2) Subtract one-half of the resource deeming standard ($500) from each deemor parent's countable resources, when there are children in common **and** stepchildren in the home, and at least one child-in-common in the home is included in the family unit.

Separate deeming calculations for each deemor parent must be done to ensure stepparent resources are not deemed.

c. Both Parents In Different BUs

When both parents are in the home but in different budget units, subtract the whole resource deeming standard of $1,000 from the deemor's total countable resources (those in the deemor's name only plus the deemor's share of jointly held resources).

Separate deeming calculations must be completed for each deemor parent.

3. Deem Resources Remainder

The remaining value, if any, is deemed available to the non-excluded F&C child(ren) who are not in the parent's BU. If the parent has more than one non-excluded child in the household who is not in the parent's BU, divide the remaining resource value by the number of non-excluded children who are not in the parent's BU.

NOTE: Deeming resources does not reduce countable resources for the deemor's eligibility determination.

4. Example--Resource Deeming From Parent

EXAMPLE #13: A woman lives with her husband, their 5-year old child, her 11- year old and 12-year old children from a previous marriage, and his 14-year old child from a previous marriage. They live in Group I. *The children's MN eligibility is being determined.*

The family's resources consist of a savings account of $1,050 owned jointly by the woman and her spouse, one car owned by the husband with an equity value of $1,000 and a second car (owned jointly by the woman and her spouse) with an equity value of $50. Each child owns a U.S. savings bond valued at $100.

The Medicaid family unit is broken into budget units to determine resource eligibility.

- budget unit #1 = her husband's 14-year old child;
- budget unit #2 = their 5 year old child;
- budget unit #3 = her 11 year old child;
- budget unit #4 = her 12 year old child;
- budget unit #5 = the woman, her husband.

Each parent has a child who is not the child of his/her spouse; therefore, separate deeming calculations are used.

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a. Mom's Resource Deeming Calculation

The mother's resources are deemed available to each of her children who are not in her BU (including her child-in-common with her husband):

$ 525	½ savings account
+ 25	her ½ equity in the second car (not excluded)
550	countable resources
- 500	½ resource deeming standard (parents in same BU, child in common)
50	deemable resources
÷ 3	number of her children not in her BU
$16.67	deemed to each of her children not in her BU

b. Dad's Resource Deeming Calculation

The Dad's resources are deemed available to each of his children who are not in his BU (including his child-in-common with his wife):

$ 525	½ savings account
+ 25	his ½ equity in the second car (not excluded)
550	countable resources
- 500	½ resource deeming standard (parents in same BU, child in common)
50	deemable resources
÷ 2	number of his children not in his BU
$ 25	deemed to each of his children not in his BU

c. Budget Units #3 and #4

$ 100.00	child's savings bond
+ 16.67	deemed from Mom
$ 116.67	child's countable resources

Each child has total resources of $116.67. Each child's resources are less than the MN resource limit; each is resource-eligible and is placed on an MN spenddown.

d. Budget Unit #1

$ 100.00	child's savings bond
+ 25.00	deemed from Dad
$ 125.00	child's countable resources

The child has total resources of $125. Dad's child's resources are less than the MN resource limit, so the child is resource-eligible and is placed on an MN spenddown.

e. Budget Unit #2

$100.00	child's savings bond
+ 16.67	deemed from Mom
+ 25.00	deemed from Dad
$141.67	child's countable resources

Their child's countable resources are less than the MN resource limit, so their child is resource-eligible and is placed on an MN spenddown.

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Manual Title	Chapter	Page Revision Date
Virginia Medical Assistance Eligibility	**M05**	**January 2017**
Subchapter Subject	Page ending with	Page
M0520.000 F&C MN FAMILY/BUDGET UNIT	**M0520.400**	**21**

C. Deeming Income

To determine how much of the deemor parent's income to deem to the F&C child(ren), use the following procedures:

1. Determine Countable Income

Determine the deemor parent's gross monthly countable unearned and earned income according to chapter M07.

2. Subtract Earned Income Exclusions

Subtract the applicable earned income exclusions listed in section M0720.500:

- standard work exclusion of $90 (M0720.520), and
- child/incapacitated adult care exclusion(M0720.540).

3. Subtract Income Deeming Standard

a. Single Parent or Parent and Stepparent with No Child in Common

Subtract the whole income deeming standard. The income deeming standard is the F&C 100% income limit for the locality (see M710, Appendix 3) for

- the number of persons in the deemor's BU, **plus**
- the number of children under age 21 in the household who are excluded from the Medicaid application (not included in **any** Medicaid assistance unit) and who are or can be claimed as dependents on the deemor's federal income tax return. If the deemor has not previously filed a tax return or states that he/she will claim a different number of dependents for the current year, use the number of dependents he/she intends to claim for the current year. Do not count children who receive SSI when determining the income deeming standard.

A deeming calculation must be done for each deemor parent.

NOTE: For the deeming calculation, a pregnant woman is only 1 person.

b. Both Parents In Same BU and Child-in-Common

1) Subtract the whole income deeming standard from the parents' income when there is a child(ren)-in-common and no stepchildren in the home.

When both parents are deeming only to child(ren)-in-common, only one deeming calculation is done.

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2) Subtract one-half of the income deeming standard from the parent's countable income when there are children in common **and** stepchildren in the home, and at least one child-in-common in the home was included in the family unit.

   Separate deeming calculations for each deemor parent must be done to ensure stepparent income is not deemed.

3) When both parents are in the same BU and ALL their children-in-common are **excluded** from the family unit, subtract the whole income deeming standard for the parents' BU from the deemor parent's income.

   Separate deeming calculations for each deemor parent must be done to ensure stepparent income is not deemed.

c. Both Parents In Different BUs

Subtract the whole income deeming standard from the deemor parent's countable income.

Separate deeming calculations must be done for each deemor parent.

4. Subtract Support Payments Made

Subtract actual alimony and/or child support payments made to individuals not in the home, regardless of whether or not the individuals are claimed as dependents on the deemor's federal income tax return.

5. Deem Remainder

Deem the remaining income as unearned income to the non-excluded F&C child(ren) in the household who are not in the parent's BU. If the parent has more than one non-excluded F&C child in the household who is not in the parent's BU, divide the remaining income by the number of non-excluded children who are not in the parent's BU (plus the parent's minor spouse, if any, who is not in the parent's BU).

NOTE: Deeming income does not reduce the deemor's countable income for the deemor's eligibility determination.

6. Example—Income Deeming From Parent; Stepchildren In Home

EXAMPLE #14: (Using July 2002 figures)
An application is filed for a woman who lives with her husband, their 5-year-old child, her 11-year-old and 12-year-old children from a previous marriage, and his 14-year-old child from a previous marriage. They live in Group I. Her husband earns $2,200 monthly. She earns $800 monthly. Her children each receive $150 monthly child support. They have no resources. *The children's MN eligibility is being determined.*

The Medicaid family unit is broken into budget units because there are stepparents in the home and some of the children have their own income.

- budget unit #1 = Dad's 14-year old child
- budget unit #2 = Mom's 11-year old child
- budget unit #3 = Mom's 12-year old child
- budget unit #4 = Mom, Dad, and their child

Each parent has a child who is not the child of his/her spouse; therefore, separate deeming calculations are used.

a. **Mom's Income Deeming Calculation**

Mom's countable income is deemed to each of her children who are not in her BU.

$ 800.00	Mom's earnings
- 90.00	standard work exclusion
710.00	countable income
- 156.63	½ deeming standard for 3 in Group I ($313.25)
553.37	deemable income
÷ 2	number of her children not in her BU
$ 276.69	deemed to each child

b. Dad's Income Deeming Calculation

Dad's countable income is deemed to his child.

$2,200.00	Dad's earnings
- 90.00	standard work exclusion
2,110.00	countable income
- 156.63	½ deeming standard for 3 in Group I ($313.25)
$1,953.37	= deemable income

c. **BU #1**

$1,953.37 = countable income (deemed from Dad).

d. **BUs #2 and #3**

$ 276.69	deemed unearned income from Mom
+ 150.00	child's own income
- 50.00	child support disregard
376.69	= countable income for both BUs

e. **BU #4**

$2,200	husband's earnings
+ 800	woman's earnings
- 180	standard work exclusions ($90 x 2 = 180)
2,820	= countable earned income *for the child in common*.

7. Example—Income Deeming From Parent; All Children-in-Common Excluded

EXAMPLE #14a: (Using July 2005 figures)
A woman lives with her husband, their 5-year old child, her 11-year old and 12 year-old children from a previous marriage, and his 14-year old child from a previous marriage. They exclude their child, and apply for the other three children. They live in Group III. Her husband earns $2,200 monthly. She earns $800 monthly. Her children each receive $150 monthly child support. They have no resources. *The three children's MN eligibility is being determined.*

The Medicaid family unit is broken into budget units because there are stepparents in the home and Mom's two children have their own income.

- budget unit #1 = Dad's 14-year old child
- budget unit #2 = Mom's 11-year old child
- budget unit #3 = Mom's 12-year old child
- budget unit #4 = Mom and Dad

Their excluded child is not included in the parents' BU, but is counted when determining the deeming standard. Each parent has a child who is not the child of his/her spouse; therefore, separate deeming calculations are used.

a. Mom's Income Deeming Calculation

Mom's countable income is deemed to each of her children who are not in her BU.

$ 800.00	Mom's earnings
- 90.00	standard work exclusion
710.00	countable income
- 437.58	whole deeming standard for 3 in Group III
272.42	deemable income
÷ 2	number of her children not in her BU
$136.21	deemed to each child

b. Dad's Income Deeming Calculation

Dad's countable income is deemed to his child.

$2,200.00	Dad's earnings
- 90.00	standard work exclusion
2,110.00	countable income
- 437.58	whole deeming standard for 3 in Group III
$1,672.42	= deemable income

***c.* BU #1**

$1,672.42 = countable income (deemed from Dad)

d. **BUs #2 and #3**

$ 136.21 deemed income from Mom
+ 150.00 child's own income
- 50.00 child support disregard
236.21 = countable income

e. **BU #4**

$2,200 Dad's earnings
+ 800 Mom's earnings
- 180 standard work exclusions ($90 x 2 = 180)
2,820 = countable income

Mom and Dad *do not meet a MN covered group.*

M0520.500 CHANGES IN STATUS

A. Policy — When the household composition changes, or the circumstances of the household members change, the F&C family and budget unit may change, and the requirements to deem a spouse's or parent's resources and income may change.

B. Procedure — See M0520.501 for Family/Budget Unit Changes.
See M0520.502 for Deeming Changes.

M0520.501 FAMILY/BUDGET UNIT CHANGES

A. Introduction — Some changes in the household composition which require changes in the family unit or budget units are listed and described in this section.

B. Spouses Separate or Divorce — If a married F&C individual and his/her spouse separate or divorce and no longer live together, the spouse is not included in the F&C individual's family or budget unit beginning the month after the month in which the separation or the divorce occurred. If a married F&C individual and his/her spouse divorce but they remain living in the same household, the divorced father is considered an acknowledged father beginning the month after the month in which the divorce occurred.

C. Individual Begins Living With A Spouse — For applicants, if an F&C individual or deemor begins living with a spouse, the spouse is included in the family or budget unit beginning with the month in which they begin living together.

For recipients, if an F&C individual or deemor begins living with a spouse, the spouse is included in the family or budget unit beginning with the month after the month they begin living together.

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D. Parent and Child Begin Living in Same Household

For applicants, if an F&C child begins living with a parent in the same household (e.g., a child comes from aunt's home to live in mother's home), the child and parent are included in the family unit for purposes of determining eligibility beginning the month in which they begin living together.

For recipients, if an F&C child begins living with a parent in the same household (e.g., a child comes from aunt's home to live in mother's home), the child and parent are included in the family unit for purposes of determining eligibility beginning the month **after** the month they begin living together.

NOTE: A newborn child is considered living with the parent(s) as of the date the child is born, unless the child is entrusted into foster care on that date.

E. Spouse or Parent Dies

If a spouse or parent dies, the spouse or parent is deleted from the family or budget unit effective with the month following the month of death.

F. Individual Becomes Institutionalized

If an F&C individual becomes institutionalized, either in a medical facility or in Medicaid CBC waiver services, the individual is a separate family unit effective with the first month in which the individual is institutionalized.

G. Individual Leaves Home

If an F&C individual leaves the household, the individual is deleted from the family or budget unit beginning with the month following the month in which he left the household.

NOTE: If a spouse, parent or child was temporarily absent from the household, this rule applies effective with the month after the month the spouse's, parent's or child's absence is no longer considered temporary.

H. Child Attains Age 21

Effective the month following the month in which a child attains age 21, the child is removed from the family or budget unit. An individual attains age 21 on the day preceding the anniversary of his/her birth.

M0520.502 DEEMING CHANGES

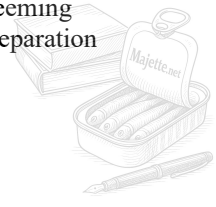
A. Introduction

Some changes in the circumstances of the household members which require changes in the deeming procedures are listed and described in this section.

B. Spouses Separate or Divorce

If a married F&C individual and his/her spouse separate or divorce and no longer live together, or their marriage ends in divorce but they remain living in the same household, the spouse's resources (F&C MN only) and income are not deemed to the F&C spouse's family or budget unit beginning the month after the month in which the separation or the divorce occurred. The divorced father who lives in the household with his child(ren) and ex-wife is treated like an acknowledged father.

NOTE: If an application is filed in the month of separation or divorce, deeming applies that month even if the application is filed on or after the date of separation or divorce.



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C. Individual Begins Living With A Spouse

If an F&C individual begins living with a spouse, deeming of the spouse's resources (F&C MN only) and income to the F&C spouse's BU begins effective with the month after the month they begin living together.

D. Spouse Or Parent Dies

If a spouse or parent dies, deeming stops for purposes of determining eligibility effective with the month following the month of death. If the child lives with two parents and one dies, deeming continues from the surviving parent to determine eligibility.

E. Individual Becomes Institutionalized

If an F&C individual becomes institutionalized, either in a medical facility or in Medicaid CBC waiver services, deeming stops for purposes of determining eligibility effective with the first month in which the individual is institutionalized.

F. Individual Leaves Home

If a spouse, parent or child no longer live in the same household, deeming of that spouse's or parent's resources (F&C MN only) and income stops effective the month after the month the spouse, parent or child leaves the household for purposes of determining eligibility, except for a foster care child. When a child is removed from the home and placed in foster care, the child becomes an FU of 1 person effective the date of commitment or entrustment or non-custodial foster care agreement. The child is deleted from the family's FU effective the end of the month during which the child was placed in foster care.

NOTE: If a spouse, parent or child was temporarily absent from the household, this rule applies effective with the month after the month the spouse's, parent's or child's absence is no longer considered temporary.

G. Parent and Child Begin Living in Same Household

If an F&C child begins living with a parent in the same household (e.g., a newborn child comes home from a hospital), the parent's income is deemed to the child's BU for purposes of determining eligibility beginning the month after the month they begin living together.

H. Child Attains Age 21

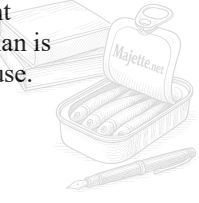
Deeming stops effective the month following the month in which a child attains age 21. An individual attains age 21 on the day preceding the anniversary of his/her birth. Eligibility is determined using only the individual's own income after the child attains age 21. The individual's income for the current month and subsequent months must include any income in the form of cash provided by the parents.

M0520.600 PREGNANT WOMAN BUDGET UNIT

A. Policy

A pregnant woman's family or budget unit always consists of at least 2 persons--herself and the unborn child, or children when it is medically verified that there is more than one fetus.

The other members of the household who are included in the pregnant woman's family or budget unit depend on whether the pregnant woman is under age 21 years, is married and is living with her parent(s) or spouse.



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B. Budget Unit

The BU includes her spouse who lives with her unless the spouse receives SSI, or she and/or her spouse are Medicaid minors living with her or his parent(s).

The BU also includes her child(ren) under age 21 living in the home unless:

- the child(ren) has his or her (their) own income (child is separate BU);
- she specifically excludes the child(ren);
- the child(ren)'s acknowledged father is living in the home and is not married to the pregnant woman;
- she is a Medicaid minor and lives with her parent(s);
- she is a married Medicaid minor and lives with her spouse and parent(s); or
- she is married and living with her spouse who is not the father of the child(ren). If she is married, living with her spouse who is not the father of her child(ren), and she does not exclude her child(ren) under age 21 living in the home, the child(ren) is a separate BU and the pregnant woman's own income and resources deemed available to the child.

M0520.601 UNMARRIED PG WOMAN OVER AGE 21 BUDGET UNIT

A. Policy

An unmarried pregnant woman's family or budget unit always consists of at least 2 persons--herself and the unborn child, or children when it is medically verified that there is more than one fetus. It includes her minor child(ren) under age 21 who live with her unless

- the child has his/her own resources or income,
- the child's acknowledged father lives in the home, or
- she excludes the child.

B. Example--Unmarried PG Woman Over Age 21

EXAMPLE #15: (Using February 2000 figures) Group II locality. An unmarried pregnant woman age 25 applies for Medicaid for herself and her 10-year old child. She lives with her parents, her 20 year old brother and her 10-year old child. They have no resources. She earns $1,200 per month and her 10-year old child receives $200 monthly child support from his father. Her family unit consists of herself (pregnant woman counts as two persons for her eligibility) and her 10-year old, 3 persons. The 10-year child's family unit consists of the 10-year old and his mother, 2 persons.

$1,200	PG woman's earnings
- 90	standard work exclusion
1,110	countable earning

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$ 200 monthly child support
- 50 support disregard
150 countable unearned
+1,110 countable earned
1,260 = countable monthly income

M0520.602 MARRIED PG WOMAN BUDGET UNIT

A. Policy

A married pregnant woman's BU includes her spouse with whom she lives, unless

- she is under age 21 and they live with her parent(s),
- her spouse is under age 21 and they live with his parent(s),
- she has a minor child(ren) living in the household who is not her spouse's child, or
- her spouse has a minor child(ren) living in the household who is not the PG woman's child.

1. PG Woman Is Medicaid Minor Living With Her Parents

When the married PG woman is a Medicaid minor (under age 21 years old) and they live with her parent(s), the BU consists of the Medicaid minor pregnant woman and her unborn child (or children if medically verified). Her spouse and their child(ren) are in a separate BU.

2. PG Woman's Spouse Is Medicaid Minor Living With Spouse's Parents

When the married PG woman's spouse is a Medicaid minor and they live with her spouse's parent(s), the BU consists of the pregnant woman, the unborn child(ren) and their child(ren)-in-common, if any. Her Medicaid minor spouse is in a separate BU and her spouse's parents are in a separate BU.

3. PG Woman And/Or Spouse Have Other Children

When the married PG woman and/or her spouse are age 21 or older, or are under age 21 but do not live with either's parent(s), and have other children in the household who are not their children-in-common, the BU consists of the pregnant woman, her unborn child(ren) and her spouse. Her child(ren) is in a separate BU and his child(ren) is in a separate BU.

B. Example—Married PG Woman Over Age 21, Other Children In Household

EXAMPLE #16: A Medicaid application is filed for a pregnant woman and everyone in her family. She lives with her husband who is not aged, blind, or disabled, her 10-year old child by a former marriage, and his 15-year old child from a former marriage. They have no resources. The family unit's income exceeds the MI pregnant woman income limit for 5 persons, the MI child income limit for 4 persons, and the LIFC 185% standard of need for 4 persons, so BUs are formed because there is a stepparent in the household. Three BUs exist:

- BU #1 = the pregnant woman, her unborn child, and her husband (3);
- BU #2 = her husband's 15-year old child (1);
- BU #3 = her 10-year old child (1).

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C. Example—Married PG Woman Under Age 21, Living With Spouse's Parents

EXAMPLE #17: A minor pregnant woman age 19 lives with her husband who is age 19, her 2-year old child by a former relationship, and his parents (6 persons). Budget units are formed because there are a stepparent and a minor spouse in the household. Four budget units exist:

- #1 = the pregnant woman and her unborn child (2);
- #2 = her 2-year old child (1);
- #3 = her husband (1);
- #4 = his parents (2).

M0520.603 UNMARRIED MINOR PG WOMAN BUDGET UNIT

A. Policy

When the Medicaid minor (under age 21 years old) pregnant woman is not married, the budget unit consists of the Medicaid minor pregnant woman and her unborn child (or children if medically verified) and the minor pregnant woman's child(ren) who live with her, unless

- she lives with her parent(s), or
- her child(ren) has resources or income of his/her own.

If the unmarried Medicaid minor pregnant woman lives with her parent(s), the budget unit consists of the Medicaid minor pregnant woman and her unborn child (or children if medically verified) and the Medicaid minor pregnant woman's parent(s). Her child(ren) are in a separate budget unit.

1. Her Stepparent In Household

If the Medicaid minor pregnant woman's parent is married and the spouse lives in the household, the Medicaid minor pregnant woman's parent is NOT included in the budget unit with her. A portion of her parent's own resources and income is deemed to the Medicaid minor pregnant woman.

2. Siblings In Household

If the Medicaid minor pregnant woman has a minor (under age 21) sibling(s) in the household who is listed on the application form, that sibling is included in the unit with her parent(s) unless

- the sibling(s) has his/her own resources or income, or
- a stepparent or acknowledged father lives in the home.

If the sibling(s) has resources or income, the parent(s) must be advised of the opportunity to exclude that sibling from the family unit.

3. Medicaid Minor PG Woman Is Also Medicaid Minor Caretaker

If the Medicaid minor pregnant woman lives with her parents and also has a child(ren) of her own living with her for whom Medicaid is requested, she is also a Medicaid minor caretaker. Her child(ren) is in a separate budget unit. The pregnant woman is in a separate budget unit with her parent(s) and minor siblings who live at home, if the Medicaid minor PG woman and her siblings have no income or resources of their own. If the



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Medicaid minor PG woman has resources or income of her own, she is in a separate BU and a portion of the pregnant woman's own income and resources is deemed available to her child(ren).

B. Example—Unmarried Medicaid Minor PG Woman

EXAMPLE #18: A Medicaid minor pregnant woman lives with her 2-year old child, her parents, and her 16 year old brother. The pregnant woman's family unit consists of the Medicaid minor pregnant woman, her unborn child, her 2 year old child, her parents and her brother. She has income from part-time work. The family unit is broken into budget units because the Medicaid minor PG woman has her own income and she is a minor parent living with her parents. Three budget units exist:

- budget unit #1 = the Medicaid minor PG woman (2);
- budget unit #2 = her 2 year old child (1);
- budget unit #3 = the parents, her 16 year-old brother (3).

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M0520.700 INDIVIDUAL UNDER AGE 21 FAMILY UNIT

A. Policy

The family unit of an individual who meets the covered group of MN Individuals Under Age 21 (who are in foster care, adoption assistance or in ICF/ICF-MR care) is determined using the family unit rules in M0520.100 above when the individual lives with a parent or spouse. If the individual does not live with a parent or spouse, the individual is in a family unit by himself.

If the individual under age 21 is living away from home, see M0520.001 B.3. to determine if the individual is considered living with his parents.

B. Procedure

The following sections contain the policy and procedures to use when determining the family/budget unit of an individual under age 21:

- M0520.701 Foster Care Child Family Unit;
- M0520.702 Non IV-E Adoption Assistance Family Unit;
- M0520.703 Special Medical Needs Adoption Assistance Child Family Unit;
- M0520.704 Child In ICF or ICF-MR.

M0520.701 FOSTER CARE CHILD FAMILY UNIT

A. Policy

A foster care child who is not living with his/her parents is a family unit of one person. A child in foster care who is not living with his or her parent(s) is evaluated as a separate family unit, even if the child is living with his or her own siblings in foster care. When a child is removed from his home and placed in foster care, the child becomes a family unit of 1 person effective the date of the commitment or entrustment to, or non-custodial agreement with the agency.

1. Child Living With Parents

If the foster child is living with his or her parents and/or siblings NOT on a trial visit basis, the foster care child is included in the family unit with his/her parents and siblings.

If the child's family unit has resources or income which exceeds the limit for the child's covered group, determine if the family unit can be broken into BUs. The foster care child is included in a BU with his/her parents UNLESS:

- the child has his/her own resources;
- the child has his/her own income;
- the child's stepparent is in the family unit;
- the child's parent with whom he/she lives is a minor (under age 21) and they live with the minor parent's parent(s);

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- the child(ren)'s acknowledged father lives in the household and is not married to the child(ren)'s mother.

2. Child Placed In Own Home For Trial Visit

A foster care child who is placed in the home with his/her parents and siblings **for a trial visit** is a family unit of 1 person. The parent(s)' resources and income are NOT deemed available to the foster care child. Verify the trial visit with the agency's *Family* Services staff.

The trial visit is no longer than 6 months for this section's purposes. A child will continue to be a single person BU during a trial visit and only the child's income and resources will be counted in determining the child's Medicaid eligibility.

3. Foster Care Payment Is Excluded

The foster care payment is excluded when determining the family unit's financial eligibility.

B. Examples

1. Trial Visit

EXAMPLE #19: The agency services staff places the foster care child, age 10, with his family for a trial visit. The child does not receive a foster care payment from the agency. The household consists of the foster care child, his mother and father, his 13-year old sister, and his 22-year old brother. The household consists of 2 family units:

- family unit #1 = foster care child (1);
- family unit #2 = foster care child's parents, 13-year old sister (3).

2. Home Placement, Not Trial Visit

EXAMPLE #20: The agency services staff places the foster care child, age 10, with his family. This is NOT a trial visit, but the agency retains custody of the child. The child does not receive a foster care payment from the agency. The household consists of the foster care child, his mother and father, his 13-year old sister, and his 22-year old brother. The household consists of one family unit: the foster care child, his parents and his 13-year old sister (4).

M0520.702 NON IV-E ADOPTION ASSISTANCE CHILD FAMILY UNIT

A. Policy

A non IV-E adoption assistance child who is not living with his/her parents is a family unit of one person.

1. Child Living With Parent(s)

A non IV-E adoption assistance child who is living with his or her parent(s) is evaluated as a separate family unit from placement until the interlocutory or final order of adoption, whichever comes first. The adoptive parents' resources and income are NOT deemed available to the adoption

assistance child until the interlocutory or final order of adoption, whichever comes first, is entered.

After the interlocutory or final order of adoption, whichever comes first, a non IV-E adoption assistance child who is living with his or her parent(s) is included in a the family unit with his/her parent(s). If the family unit has resources (F&C MN only) or income which exceeds the limit for the child's covered group, determine if the family unit can be broken into BUs. The non IV-E adoption assistance child is included in a BU with his/her parents UNLESS:

- the child has his/her own resources;
- the child has his/her own income;
- the child's stepparent is in the family unit.

2. Exclude Adoption Subsidy Payment

The adoption subsidy payment is excluded when determining the unit's financial eligibility.

B. Example –Child Placed With Adoptive Parents

EXAMPLE #21: Mary B. is a 19-year old non IV-E foster care child who is in the custody of the local social services agency. On August 5, 1997, she is placed with Mr. and Mrs. G who plan to adopt her. The adoption assistance agreement was signed on August 5, 1997. There is no interlocutory order and the final order will not be signed until February 1998. Mr. and Mrs. G have two children, Tom who is age 17 and Jane who is age 15. Mary receives $575 per month SSA benefits from her deceased father's work record. Mr. G earns $3,000 per month gross earnings. Mrs. G has no income of her own. Mary's continued Medicaid eligibility is determined:

Mary's family unit consists of Mary by herself because she does not live with any responsible relative. The final order of adoption will not be signed until February 1998. Beginning with the month following the month in which the final adoption order is signed. Mary will be in a family unit with her adoptive parents and siblings.

C. Example—Child Living With Adoptive Parents

EXAMPLE #22: John is a 20-year old non IV-E adoption assistance child who is in the custody of the local social services agency until August 5, 1997, when the final order of adoption was signed by the judge. His adoptive parents are Mr. and Mrs. T. The adoption assistance agreement was signed on September 15, 1996. Mr. and Mrs. T have two other children, George who is age 17 and Julie who is age 15. John receives $250 per month adoption subsidy. Mr. T earns $3,000 per month gross earnings. Mrs. T has no income of her own. John's continued Medicaid eligibility for September 1997 and subsequent months is determined:

John's family unit consists of himself, his adoptive parents and his two siblings, a family unit of 5 persons.

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M0520.703 SPECIAL MEDICAL NEEDS ADOPTION ASSISTANCE CHILD FAMILY UNIT

A. Policy

A non IV-E special medical needs adoption assistance child who is living with his or her parent(s) is evaluated as a separate family unit. **The adoptive parents' income is NOT deemed available to the special medical needs adoption assistance child at any time.**

B. Exclude Adoption Subsidy Payment

The adoption subsidy payment is excluded when determining the child's financial eligibility.

M0520.704 CHILD IN ICF OR ICF-MR FAMILY UNIT

A. Policy

When an individual under age 21 is in an intermediate care facility (ICF) (nursing facility) or ICF-MR (intermediate care facility for the mentally retarded) for 30 consecutive days or more, the child is institutionalized and is considered separated from his/her parents.

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

The child is a family unit of one person, regardless of the child's covered group. The parents' resources and income are **not** deemed available to the child. If the parents give the child any money, that money is counted as income according to the F&C income rules in chapter M07.

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COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
MEDICAID PROGRAM
MEDICAID F&C RESOURCE/INCOME DEEMING WORKSHEET

CASE NAME: _____ CASE NUMBER: _____
DEEMOR'S NAME: _____ DATE: _____

RESOURCE DEEMING

Reminders:

Deem resources when evaluating LIFC or MN eligibility. Count only the pro-rata share when appropriate.

Deemor's Countable Resources:

Cash $_____
Checking Account(s) _____
Savings Account(s) _____
Other Liquid Resources _____
Vehicles - excess value (1 is totally excluded in MN) _____
Real Property _____
Other Non-Liquid Resources _____

TOTAL COUNTABLE RESOURCES = $_____

Minus Resource Deeming Standard -

___ $1,000 or

___ $500 (Use when parents are in the same BU and have a child in common, and at least one parent is deeming to a child who is not the spouse's child.)

DEEMABLE RESOURCES $_____

INCOME DEEMING

Step 1

Deemor's Gross Earned Income (Parent 1 or Applicant's Spouse) $ _____ (1)
Minus Standard Work Exclusion 90.00 (2)
Sub-total _____ (3)
Minus Other Exclusions _____ 4)
Sub-total _____ 5)
Add Unearned Income _____ 6)
Countable Income $ _____ (7)
(Parent 1 or Applicant's Spouse)

Deemor's Gross Earned Income (Parent 2) $ _____ (8)
Minus Standard Work Exclusion 90.00 (9)
Sub-total _____ (10)
Minus Other Exclusions _____ (11)
Sub-total $ _____ (12)
Add Unearned Income _____ (13)
Parent 2 Countable Income _____ (14)
TOTAL COUNTABLE INCOME _____ (15)
(Line 7 + Line 14)

Step 2
Determine the Income Deeming Standard. The deeming standard is the F&C 100% Monthly Income Limit for the number of persons in the deemor's BU plus the number of deemor's excluded children in the home who are or could be claimed as tax dependents on the deemor's federal tax income return. Total # of people .

_____Whole income deeming standard, or

_____One-half income deeming standard
(Use when parents are in the same BU and have a child in common, and at least one parent is deeming to a child who is not the spouse's child.)

Income Deeming Standard _____(16)

Step 3
Total Countable Income (line 15) $ _____(17)
Minus Income Deeming Standard (line 16) _____(18)
Minus alimony/support paid by the deemor(s) to individuals not in the home _____(19)
DEEMABLE INCOME $ _____(20)

DETERMINING AMOUNT OF RESOURCES AND INCOME DEEMED TO EACH PERSON

Divide the DEEMABLE RESOURCES and DEEMABLE INCOME amounts by the **number of persons** for whom the parent is legally responsible who are **in BU's outside** the parent(s) BU.

DEEMABLE RESOURCES $_____divided by _____ = $_____Resources deemed to each person
DEEMABLE INCOME $_____divided by _____ = $_____Income deemed to each person

032-03-813

CHAPTER M05
MEDICAID ASSISTANCE UNIT
SUBCHAPTER 30

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M0530 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Appendix 1, page 1
TN #DMAS-34	1/1/25	Appendix 1, page 1
TN #DMAS-31	4/1/24	Appendix 1, page 1
TN #DMAS-26	1/1/23	Appendix 1, page 1
TN #DMAS-22	1/1/22	Appendix 1, page 1
TN #DMAS-18	1/1/21	Appendix 1, page 1
TN #DMAS-15	1/1/20	Appendix 1, page 1
TN #DMAS-11	1/1/19	Appendix 1, page 1
TN #DMAS-8	4/1/18	Appendix 1, page 1
TN #DMAS-6	10/1/17	Pages 2, 24, 30
TN #DMAS-3	1/1/17	Appendix 1, page 1
TN #DMAS-2	10/1/16	Pages 23, 24
TN #DMAS-1	6/1/16	Appendix 1, page 1
TN #100	5/1/15	Pages 14, 16, 29, 30 Appendix 1, page 1
TN #99	1/1/14	Appendix 1, page 1
UP #9	4/1/13	Appendix 1, page 1
UP #6	4/1/12	Appendix 1, page 1
Update (UP) #5	7/1/11	Page 14
TN #95	3/1/11	Page 1 Appendix 1, page 1
TN #93	1/1/10	Pages 11, 19 Appendix 1, page 1

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M0530.000 ABD ASSISTANCE UNIT

M0530.001 OVERVIEW

A. Introduction

This subchapter contains the policy and procedures for determining the assistance unit for a non institutionalized individual who meets an aged, blind or disabled (ABD) covered group. Do not use this subchapter for an institutionalized individual; use subchapter M1460 to determine an institutionalized individual's financial eligibility.

The number of persons in the assistance unit and the individual's covered group determine which resource and income limits apply. The deeming policy and procedures in this subchapter explain how to determine how much of a legally responsible relative's resources and income is deemed to the ABD individual.

Appendix 1 to this chapter lists the deeming allocations used when deeming income of a legally responsible relative.

B. Assistance Unit Composition

When determining composition of the ABD assistance unit, identify the individual who applies for Medicaid, who meets the aged, blind or disabled definition in M0510 and who meets an ABD covered group's requirements.

1. Responsible Relatives

a. Spouse

The unit must include the individual's spouse with whom the individual lives when the spouse applies for Medicaid and meets the aged, blind or disabled definition in M0510, regardless of whether the spouse receives an SSI or IV-E foster care/adoption subsidy payment.

b. Parent of Blind/Disabled Child Under Age 21

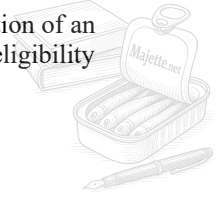
The parent(s) with whom the blind or disabled child under age 21 lives is legally responsible to support the child. However, the parent is not included in the child's assistance unit. The parent's resources and income are deemed available to the child.

2. SSI Recipients

The policy in this subchapter applies when determining the **resource** eligibility of individual SSI recipients or of couples when both spouses receive SSI and one or both owns an interest in real property contiguous to the home or undivided interest in heir property, or a former residence.

If the SSI recipient is ineligible for Medicaid in the SSI Medicaid covered group due to excess resources, first determine the individual's eligibility in an F&C covered group, if possible, using the F&C assistance unit and financial eligibility rules. If the individual is not eligible in one of the F&C covered groups, then determine his eligibility as an ABD individual.

This subchapter does **not** apply to the **income eligibility** determination of an SSI recipient because an SSI recipient meets the Medicaid income eligibility requirements just by the fact that he/she receives an SSI payment.



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3. Living With Family and Children

If the ABD individual lives with his/her spouse and/or dependent child(ren) who request Medicaid in a families and children covered group, the policy in this subchapter applies only to the ABD individual. Use the assistance unit policy in M0520 and the financial requirements in chapters M06 and M07 for the family members who meet an F&C covered group.

4. Living Arrangement

An ABD individual's, couple's or child's living arrangement on the first day of the month is used to determine the individual's status for the entire month. If they are living together (or child is living with parent) on the first of the month, they are living together for the entire month except when separation due to institutionalization occurs within the month. If they are living apart on the first of the month, they are considered separated for the entire month.

When an individual is admitted to an *assisted living facility (ALF)* or other residential facility, he is considered separated and living apart from his spouse (or parent if the individual is under age 21) as of the first of the month following the admission month.

5. Institutional-ization

When an individual is institutionalized in a medical facility, he is considered separated and living apart from his spouse (or parent if the individual is under age 21) as of the first day of the month in which he is admitted to a nursing facility or to Medicaid-approved community-based care waiver services. He is considered separated as of the first of the month during which he has been hospitalized in an acute care or rehabilitation hospital for 30 consecutive days.

Do **not** use this subchapter *for* an institutionalized individual; use the policy and procedures in chapter M14 to determine eligibility. *See M0530.204 F to determine the eligibility of a non-institutionalized spouse who has an institutionalized spouse.*

6. Deeming From Married Parent

When determining how much of the child's parent's income is deemed available to the child's unit, any income of the parent's spouse who is not the child's parent is not counted.

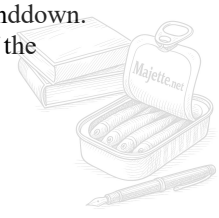
C. Pregnant Blind or Disabled Woman

If the blind or disabled individual also meets the pregnant woman definition, first determine the woman's eligibility in the MI Pregnant Woman covered group using the F&C assistance unit and financial eligibility rules. If she is not eligible as an MI pregnant woman, then determine her eligibility as an ABD individual.

D. Spenddown Expenses

If an ABD assistance unit is ineligible because of excess income, the assistance unit's member(s)'s medical expenses will count toward the spenddown. If an individual in the unit is legally liable for another person in the household who is not in the assistance unit, the other person's medical bills can count toward the unit's spenddown. If the ABD individual's spouse's or parent's income is deemed to the individual, the spouse's or parent's medical expenses are also deducted from the ABD individual's spenddown.

A medical expense can only be used once to meet only one unit's spenddown. A child's medical expenses are first deducted from the child's unit. If the child's unit spenddown is not met, the child's medical expenses



can be deducted from the parent's spenddown. If the child's unit's spenddown is met, then the child's medical expenses that were not used to meet the child's spenddown can be deducted from the parent's spenddown, if the medical expenses are not covered by Medicaid or other health insurance.

M0530.002 DEFINITIONS

A. Introduction

This section contains the definitions of terms used in this subchapter that are applicable to ABD individuals' assistance units and financial eligibility determinations.

B. Child

For ABD assistance unit composition purposes, a child is someone who is not married, is not the head of a household, and is either under age 18 or is under age 22 and a student. For ABD **deeming** purposes, a child is an individual under age 21.

1. Blind/Disabled (BD) Child For Deeming Purposes

A blind/disabled (BD) child who is subject to deeming is a natural or adopted child under age 21, who lives in a household with one or both parents and who meets the blind or disabled definition in M0510. Deeming to the BD child no longer applies beginning the month following the month the child attains age 21. An individual attains a particular age on the day preceding the anniversary of his/her birth. Deeming applies in the month of attainment of age 21 regardless of whether an application is filed before or after the day of attainment.

For purposes of ABD deeming, a blind or disabled (BD) child who does NOT apply for Medicaid is still a BD child for deeming purposes and NO allocation is deducted for a BD child when calculating the NABD spouse's or parent's deemable income.

2. Non Blind/Disabled (NBD) Child For Deeming Purposes

A non blind/disabled (NBD) child, for deeming purposes, means the natural or adopted child of an Medicaid-eligible individual or the individual's spouse, or the natural or adopted child of a parent or the parent's spouse, who

- lives in the same household with the ABD individual or BD child,
- is **not** blind or disabled, and
- is under age 18, or under age **21** and a **student** regularly attending a school, college, or university, or a course of vocational training to prepare him for gainful employment.

3. NBD Child Documentation Requirements

If the parent does not provide the following documentation for an NBD child in the household, do NOT deduct an NBD child allocation for that NBD child from the parent=s income when calculating deemable income:

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a. Age

Accept the allegation of an NBD child's age, absent evidence to the contrary.

b. Relationship

Accept an individual's statement that a parent-child relationship exists in both initial application and redeterminations. If there is reason to question the allegation, verify relationship.

c. School Attendance

If an NBD child is alleged to have no earnings, accept the allegation of student status. If an NBD child under age 21 alleges student status and earnings, verify school attendance and document the file according to the instructions in M0530.002, item I, below. Do not redetermine student status unless a change in school attendance is alleged.

C. Parent

For ABD deeming procedures, "parent" means the BD child's natural or adoptive parent who lives with the BD child. Deeming applies from a parent to a child when they live together in the same household.

A stepparent is not considered a parent for ABD deeming purposes. Even if a natural or adoptive parent is deceased or is divorced from the stepparent, and the child is living with the stepparent, the stepparent is **not** a parent of the BD child for deeming purposes.

D. Aged, Blind or Disabled (ABD) Spouse

For ABD deeming procedures, "ABD spouse" means the ABD individual's spouse who meets the aged, blind or disabled definition in M0510, and who applies for Medicaid.

E. Non Aged, Blind or Disabled (NABD) Spouse

For ABD deeming procedures, "NABD spouse" means the ABD individual=s spouse who

- does not meet the aged, blind or disabled definition in M0510, or
- who does not apply for Medicaid.

Deeming applies from a spouse to a spouse when they live together in the same household.

F. Allocation

An allocation is an amount deducted from income subject to deeming which is considered to be set aside for the support of certain individuals other than the ABD individual or BD child. The types and amounts of these allocations are described in this subchapter. Changes in allocations (e.g., due to birth or death, entering or leaving a household, no longer meeting the definition of a child) are effective with the month following the month of change.

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1. NBD Child Allocation

An allocation from an Parent's or spouse's income is given for each NBD child living in the same household. The amount of the allocation is equal to the difference between the SSI payment limit for two persons and the SSI payment limit for one person.

The allocation amount increases automatically whenever the SSI payment limit increases. *See Appendix 1 to this subchapter for current amount.*

The allocation for an NBD newborn child is effective the month following the month of birth. An NBD child allocation is given for a child who is away at school if the child is under age 21 and considered to be temporarily absent from the household. Allocations from a spouse's or a parent's income for an NBD child in the household end the month after the month the child attains age 18 or, if a student, age 21.

Each NBD child's allocation is reduced by the amount of his or her own income, including child support payments from an absent parent. (Note, however, that NBD children **do not** receive the one-third child support exclusion).

2. Parent Living Allowance

A living allowance is deducted from a parent's own income when deeming parental income to a BD child. The amount of the living allowance depends upon whether one or both parents are living in the household. The living allowance for one parent living with the child in the household *is* the SSI payment limit for one person. The living allowance for both parents living with the child in the household *is* the SSI payment limit for a couple.

The living allowance increases automatically whenever the SSI payment limit increases. *See Appendix 1 to this subchapter for current amounts.*

G. Household

A household is common living quarters and facilities under such domestic arrangements and circumstances as to create a single economic unit or establishment. For the purposes of deeming, the household comprises

- the ABD individual, the spouse and any children of the couple or either member of the couple; or
- the BD child, the parent(s), and other children of the parent(s).

Deeming only applies in household situations. Unless temporarily absent, only those individuals residing in the household are a part of the household for deeming purposes. An individual is not a member of the household for deeming purposes if he/she is absent from home for a

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period which is not a temporary absence as defined below in item I. (for example, military service or confinement in a public institution).

If a child is born in an institution (e.g., a hospital) the child is not a member of a household until the **month after the month** the child goes home. A child born at home is a member of the household the month of birth.

NOTE: Deeming does not apply when an ABD individual and NABD spouse are living in an institution even when they are sharing a room. Deeming **does** apply in noninstitutional care situations (e.g., adult foster care) if the ABD individual is placed with a deemor spouse or parent.

H. Student Child

A student child is an individual who

- is neither married nor head of a household,
- is under age 21 years, and
- regularly attends school or college or training designed to prepare him/her for a paying job.

1. Regular Attendance

Regular attendance means that the individual takes one or more courses of study and attends classes

- in a college or university for at least 8 hours a week under a semester or quarter system;
- in grades 7-12 for at least 12 hours a week;
- in a course of training designed to prepare him/her for a paying job for at least 15 hours a week if the course involves shop practice or 12 hours a week if the course does not involve shop practice. This type of training includes anti-poverty programs such as the Job Corps and government-supported courses in self-improvement; or
- for less than the amount of time indicated above for reasons beyond the student's control, such as illness, if the circumstances justify the reduced credit load or attendance.

NOTE: Attendance at an elementary school does not satisfy the student child requirement.

2. Homebound Students

An individual may be a student when he/she has to stay home because of a disability, and

- studies a course or courses given by a school (grades 7-12), college, university or government agency, or
- a home visitor or tutor from school directs the study or training.

3. Periods of Nonattend-ance

a. Vacation

An individual remains a student when classes are out if he/she actually attends classes regularly just before the time classes are out and:

- tells the agency that he/she intends to resume attending regularly when school reopens; or
- actually does resume attending regularly when school reopens.

b. Recommendation of Teacher or Counselor

A student=s counselor or teacher may believe the student needs to stay out of class for a short time during the course or between courses to enable him/her to continue study or training. Consider the individual to be a student regularly attending school, college, or training to prepare him/her for a paying job if he/she is in a course:

- designed to prepare disabled people for work; or
- to prepare the individual for a job that is specially set up for people who cannot work at ordinary jobs.

c. Last Month of School

An individual is a student regularly attending school for the month in which he/she completes or stops the course of study or training.

4. Development

Develop school attendance for a child between the ages of 18-21 who is not blind or disabled and could be included in the parent-to-child and spouse-to-spouse deeming calculations.

a. Basic Information

Obtain the following information:

- Name and address of the school or institution furnishing the training:
- Name and telephone number of the person to contact for verification, if necessary; and
- Information on the course or courses of study, dates of enrollment, number of hours of attendance, other activities of the child.

b. School Enrollment

Verify enrollment by:

- examining a school record such as an ID card, tuition receipt, or other comparable evidence; or



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- contacting the school or agency, but only if the individual does not have the evidence.

Document the file with enrollment information. If you contact the school or agency, accept either a written statement from the contact or an oral statement recorded in the file.

c. Student's Allegation of Number of Hours of Attendance

Accept the student's allegation without requesting school certification of attendance, if the allegation of attendance meets the regular attendance requirements above. If the student alleges a reduced credit load or attendance due to circumstances beyond his or her control, obtain an explanation from the student and place it in the file.

d. Special Education

If a student indicates he/she is enrolled in special education for the disabled which does not satisfy the standard academic or vocational training requirements, develop to determine whether the course contains training to prepare him/her for a paying job.

e. Vocational or Technical Training

Absent evidence to the contrary, accept the school or agency's allegation that the course includes some formalized instruction.

I. Temporary Absence

For the purposes of deeming, a temporary absence exists when an individual (ABD individual or BD child, NABD spouse or parent, or NBD child) leaves the household but intends to, and does, return in the same month or the following month. If the absence is temporary, deeming continues to apply.

1. Child Subject To Parental Control

A child who is away at school but returns home on some weekends, holidays, or vacations and **is** subject to parental control is considered temporarily absent from the parents' household, regardless of the duration of the absence. If a child is away at school and is **not** subject to parental control, he/she is **not** living in the parents' household.

2. Operating Procedures

A child who is away at school is one who is participating in an educational or vocational training program. The rule above only applies to a child who is away at an educational or vocational training facility.

When a child resides at a facility and the facility is not an educational or vocational training facility, the rule above does not apply. When a child resides in a facility and leaves the facility for brief visits to the parents' home, do not deem the parents' income and resources for any month if the absence from the facility is temporary. An individual is considered

temporarily absent from a facility for deeming purposes if the absence is not intended to and does not exceed a full calendar month.

Certain evidence may indicate that a child away at school is not subject to parental control. Such evidence includes an existing agreement, a court order, or the signed statements of the parents and the school authorities. In the absence of such evidence, assume that a child is subject to parental control. Parental control is the authority of the parent(s) to make decisions on the child's behalf, whether or not the control is actually exercised.

M0530.010 EXCLUDED RESOURCES

A. Policy

Assets which are not resources to an ABD individual are not resources to an NABD spouse or NBD child (See S1120).

In addition to assets which are not resources, there are certain resources which are excluded from the resources of an individual whose resources are deemed to an applicant/recipient. These exclusions from resources used in the resource deeming calculation correspond to exclusions of an ABD individual's own resources.

B. Related Policies

1. Resource Determination

To determine the NABD spouse's or parent's resources, see chapter S11. See S1120 for assets that are not, or may not be, resources. See S1130 for the list of resource exclusions. See S1140 for countable resources. See S0830.605 concerning Home Energy Assistance funds and Support and Maintenance Assistance funds that are retained beyond the month of receipt.

2. Pension Funds

a. Excluded Pension Funds

Pension funds owned by the NABD spouse or parent are excluded from deeming. Pension funds are defined as funds held in an individual retirement account (IRA) as described by the Internal Revenue Service (IRS) code, or funds held in work-related pension plans (including such plans for self-employed individuals, sometimes referred to as Keough plans). However, amounts distributed from a pension fund to the NABD spouse or parent will count as income that can be deemed to the ABD spouse or BD child.

b. Countable Pension Funds

IRA's, Keough plans, 401-K plans, and similar pension funds owned by the applicant/recipient and/or his/her ABD spouse or parent are **countable resources**, and amounts distributed from the funds are countable income, since these types of pension funds may be withdrawn by the owner.

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c. Development Procedures

1) If an NABD spouse or parent alleges having money in a pension fund, accept the allegation.

2) Develop interest income from excluded pension funds per M0830.500.

3) If an NABD spouse or parent withdraws monies he or she had contributed to a pension fund, treat the withdrawal as a conversion of a resource.

3. Other Resource Exclusions All resource exclusions that apply to an ABD individual's resources apply to the combined resources of an ABD individual and an NABD spouse or parent who lives with him or her.

4. Burial Fund Exclusion For treatment of the burial fund exclusion, see M1130.410.

5. Burial Space Exclusion For treatment of the burial space exclusion, see M1130.400.

M0530.020 EXCLUDED INCOME

A. Policy Receipts which are not income to an ABD individual are not income to an NABD spouse or NBD child (See S0815).

In addition to items which are not income, there are certain items which are excluded from the income of an individual whose income is deemed to an applicant/recipient. Furthermore, an NBD child's allocation is not reduced by any of these excluded items. These exclusions from income used in the deeming calculation correspond to exclusions of an ABD individual's own income AND include some additional exclusions. For example, one-third of child support payments from an absent parent is excluded for a BD child, but is NOT excluded from an NBD child's income in the deeming calculation.

B. Excluded Income The following types of income are excluded when determining countable income of an NABD spouse or parent subject to deeming. These types of income are also excluded from the income of an NBD child in a household for purposes of reducing the NBD child allocations:

1. Income Excluded In S08 Income excluded by policy in chapter S08 is also excluded from the income of an NABD spouse or parent.

2. Grant, Scholarship or Fellowship Exclude any portion of any grant, scholarship, or fellowship which is used to pay the cost of tuition and fees at an educational institution or costs of vocational technical training designed to prepare the individual for gainful employment.



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3. *SNAP*

Exclude the bonus value of *Supplemental Nutrition Assistance Program (SNAP) benefits* (*formerly* Food Stamps) and the value of USDA donated foods.

4. Support Paid

Exclude any portion of the NABD individual's income paid to the Division of Child Support Enforcement (DCSE), court, ex-spouse, or child(ren) as court-ordered or DCSE-ordered support.

a. Ask whether any of the income received by the NABD spouse or parent is used to make any support payments. If such payments are alleged:

- Document the allegation that such support payments are made;
- Request a copy of the court order or State agreement which shows the amount of the payments and the beginning and ending dates of the payments. Exclude the amount specified in the court order or State agreement, or the actual payment, **whichever is less**. A deemor's own records may be used to document the amount of support payments made.

b. Deduct the amount of the support payment from the income of the NABD spouse or parent **before** determining the amount of income to be deemed. Deduct the amount of such payments from the income of an NBD child (if the child **pays** support payments) before reducing the NBD child's allocation.

- Deduct the support amount first from the NABD spouse=s, parent=s or NBD child=s unearned income.
- Use any remaining balance of the support obligation to reduce the NABD spouse's, parent's or NBD child's earned income.

5. Student Earnings

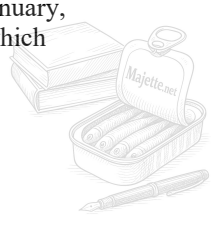
Exclude income earned by an NBD child in the home who is a student (unless the child actually makes the income available to the family).

If an NBD child is a student (M0530.002 I.), the child's earned income up to $400 a month but not more than $1,620 per year does **not** reduce the allocation for the NBD child.

a. If an NBD child has earnings, verify that the NBD child is a student (see M0530.002 I.). If a child's student status ends, stop applying the student earned income exclusion beginning with the month after the month in which the student status ended.

b. Verify the NBD child's wages. Verify the wages even if alleged to be $65 or less per month.

c. Allocate the student earned income exclusion beginning with January, or the first month the NBD child has earnings or the month in which



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the ABD individual becomes eligible for Medicaid, whichever is later in a calendar year. See S0820.510 for additional information on this exclusion.

d. The exclusion may be applied during a period of nonattendance at school if the requirements in M0530.002 I. are met.

6. Blind Work Expenses

Expenses of an NABD spouse, parent or NBD child who is blind and working are used to reduce earned income before it is deemed or before using the earnings to reduce the NBD child allocation. See S0820.535 for instructions on applying this exclusion.

7. Impairment Related Work Expenses

The impairment-related work expenses (IRWE) incurred and paid by a deemor who meets the Medicaid disability definition will be deducted from the deemor's earned income prior to considering the income available for deeming. See S0820.540 for instructions on determining the amount of IRWE.

8. In-Home Supportive Services Payments

Payments made by programs funded under title XX of the Social Security Act or other State funding sources for in-home supportive services necessary to enable an individual who needs these services to live in his or her home are "in-home supportive services payments." The payments are made either to the individual to pay for the services or to the person performing the services. The Veterans Administration also pays an allowance for medically qualified veterans, widows, or widowers in need of the aid and attendance of another person. This aid and attendance payment is included in the pension or compensation payment to the veteran or widow(er).

In-home supportive services (chore, attendant, homemaker) payments are medical or social services and are not income when paid directly to an ABD individual to pay for the services (S0815.050). However, the payment **is income** to the individual who is providing the care or services.

Payments provided under title XX or other Federal, State, or local governmental programs to an ABD individual and **paid** by the individual to his/her NABD spouse or NBD child living in the same household in return for in-home supportive (chore, attendant, homemaker) services, are excluded from the NABD spouse's, parent's or NBD child's income for deeming purposes. Such payments, made directly to the NABD spouse or parent or NBD child to provide the services to the ABD individual, are also excluded from income for deeming purposes.

NOTE: If an NABD spouse or parent receives in-home supportive services payments for services provided to anyone other than his/her ABD spouse or BD child, the payments are included as income subject to deeming.

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M0530.100 UNMARRIED INDIVIDUAL (AGE 21 OR OLDER)

A. Policy

An unmarried ABD individual's assistance unit consists of one person--the individual. The individual's child(ren) living with him or her are NOT included in the ABD individual's assistance unit, nor is any of the individual's resources or income allocated for the child(ren) when determining countable resources and countable income.

B. Assistance Unit

Resources Determination - unit of one.

Income Determination - unit of one.

M0530.200 MARRIED INDIVIDUAL LIVING WITH SPOUSE

A. Introduction

A married individual living with his/her spouse is always an ABD couple assistance unit (2 persons) for the **resource** eligibility determination. For the **income** eligibility determination, a married individual living with his/her spouse is an ABD couple assistance unit (2 persons) when the NABD spouse has deemable income, or an assistance unit of 1 person when the NABD spouse has no deemable income.

An aged, blind, or disabled individual or couple found guilty of Medicaid fraud by a court is ineligible for Medicaid benefits for a period of twelve months from conviction. If only one member of an aged, blind, or disabled couple is found guilty, the innocent spouse's eligibility is not affected. The assistance unit remains the same. The guilty spouse is ineligible for twelve months *(see M1700.200)*.

B. Procedure

For an ABD couple, see M0530.201.

For an ABD individual with an NABD spouse, see M0530.202 and 203 below.

M0530.201 ABD COUPLE ASSISTANCE UNIT

A. Policy

This section contains the policy and procedures for determining an ABD couple's assistance unit.

When a married couple is living together and each individual in the couple meets the Aged, Blind or Disabled definition in M0510, AND each

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individual applies for Medicaid, their financial eligibility is determined as an ABD couple--an assistance unit of two persons (see M0530.201 below). If one spouse receives SSI, this spouse must be included in the unit with the spouse who does not receive SSI. The resources and income (other than the SSI payment) of the SSI recipient spouse must be considered available along with those of the spouse who does not receive SSI.

EXCEPTION: When

- a member of the ABD couple is a Medicaid minor spouse (under age 21),
- the ABD couple lives with the minor spouse's parent(s), and
- the parent's(s') deemed resources or income makes the ABD couple ineligible,

recalculate each spouse's resource and income eligibility as a separate assistance unit (1 person in each). Deem the parent's(s') resources and income to the Medicaid minor spouse. Do NOT deem the spouses' resources and income to each other.

B. Resource Determination

Determine the couple's countable resources according to chapter S11. NOTE: Some resources' values are calculated differently *depending on the* ABD covered *group*. If a spouse also has Medicare Part A, determine a resource's value using both the MN and *Categorically Needy (CN)* methods.

1. Compare To Couple's Resource Limit

Total the couple's countable resources and compare to the resource limit appropriate to each individual's covered group. The ABD resource limits are contained in M1110.003.

2. Resources Meet Limit

If the couple's resources are less than or equal to the resource limit, the couple meets the resource requirements for the covered group whose resource limit was met.

3. Resources Exceed Limit

If the couple's resources exceed the resource limit, the couple is not eligible for Medicaid in that covered group. If the couple's resources exceed both resource limits, the couple is not eligible for Medicaid in any ABD covered group. Deny Medicaid because of excess resources. If the wife is pregnant, determine her eligibility as a pregnant woman.

EXCEPTION: When

- a member of the ABD couple is a Medicaid minor spouse (under age 21),
- the ABD couple lives with the minor spouse's parent(s), and

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- the parent's(s') deemed resources makes the ABD couple ineligible,

recalculate each spouse's resource eligibility as a separate assistance unit (1 person in each). Deem the parent's(s') resources to the Medicaid minor spouse. Do NOT deem the spouses= resources to each other. If a spouse is resource-eligible after this recalculation, determine the spouse's income eligibility as an ABD individual (assistance unit of 1 person); see M0530.100.

C. Income Determination

Determine the couple's countable income according to chapter S08. Total the couple's countable income.

NOTE: In calculating an ABD couple's countable income, **do not** allocate or deduct any amount for a child.

1. Compare To Income Limit

Compare the couple's total countable income to the income limit for two persons appropriate to each individual's covered group. See M0810.002 for the income limits.

2. Income Meets Limit

If the couple's income is less than or equal to the income limit, the couple meets the income requirements for the covered group whose income limit was met. See chapter M15 for Medicaid entitlement policy.

3. Income Exceeds Limit

If the couple's income exceeds the income limit, the couple is not eligible for Medicaid in that covered group. If the couple's resources meet the MN requirements and the MN resource limit, the couple may become eligible for a limited period of MN coverage if they meet a spenddown. See *chapter M13* for spenddown policy. If the wife is pregnant, determine her eligibility as a pregnant woman.

D. Examples

1. ABD Couple-- One Spouse Receives SSI

EXAMPLE #2: (*Using 1999 figures)*
A husband and wife, each 67 years old, live together in a Group II locality. The wife receives SSA of *$391* and SSI of $109 per month. The husband receives *$455* SSA and $100 VA pension per month. Both have Medicare Part A and both apply for Medicaid. The husband and wife are an ABD assistance unit of two for Medicaid resource eligibility purposes. Their countable resources are within the Medicaid resource limit for 2 persons. The wife is income-eligible because she receives SSI. The husband's income eligibility is based on an assistance unit of two. All of the husband's income is counted; only the wife's SSA benefit is counted because SSI payments are excluded. The husband=s income eligibility is calculated:

$*455* husband's SSA
+100 husband's VA pension
+391 wife's SSA
946 couple's unearned income
- 20 general income exclusion
$926 couple's countable income

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$ 920 couple's countable income
- 922 QMB income limit for 2
0 excess

$ 920 couple's countable income
x 6 months
$5,520 6 month's income
- 1,850 Group II income limit for 2
$3,670 excess

The couple's income is compared to the *CN limits* for two persons, since the husband has Medicare Part A, and to the MN income limit for two persons in Group II. Because the couple's income does not exceed the QMB limit for 2 persons, the husband is eligible for QMB Medicaid. The couple's countable income exceeds the MN limit for two; only the husband is placed on spenddown. The wife is eligible as a CN SSI recipient.

2. ABD Couple With NBD Child

EXAMPLE #3: (Using 1999 figures)
Mr. and Mrs D live in a Group I locality with their 18 year-old daughter. Mr. D is 67 years old. Mrs. D is 58 years old and disabled, but she works part-time. Her impairment-related work expenses (IRWE) are $50 per month. Mr. D receives SSA of $475 per month and $100 gross earnings per month. Mrs. D receives $150 SSA and $300 gross earnings per month. Their daughter has no income. Mr. and Mrs. D both have Medicare Part A and both apply for Medicaid. They are an assistance unit of two for Medicaid resource eligibility purposes. Their countable resources are within the Medicaid resource limit for 2 persons. Their income eligibility is calculated (NOTE: no allocation is subtracted for their NBD child because they are an ABD couple):

$475 Mr. D's SSA
+150 Mrs. D's SSA
625 couple's unearned income
- 20 general income exclusion
$605 couple's countable unearned income

$300 Mrs. D's gross earned income
- 50 Mrs. D's IRWE exclusion
250 Mrs. D's net earnings
+100 Mr. D's gross earned income
350 couple's gross earnings
- 65 exclusion
285
2 2 remainder earnings exclusion
142.50 couple's countable earned income
+605.00 couple's countable unearned income
$747.50 couple's countable monthly income
- *922*.00 QMB income limit for 2
0 excess

$747.50 couple's countable monthly income
x 6 months
4485 6-month income
-1700 Group I limit for 2
$2785 excess

Because the couple's income is less than the QMB limit for 2 persons, they are eligible for QMB Medicaid. Their income exceeds the medically needy limit for two and they are placed on a spenddown.

M0530.202 DEEMING RESOURCES FROM NABD SPOUSE

A. Policy

When a married couple is living together BUT

- only one spouse applies for Medicaid, or
- only one spouse meets the Aged, Blind or Disabled definition in M0510,

the individual spouse's resource eligibility is determined as a couple--an ABD assistance unit of 2 persons, and the NABD spouse's resources are counted available to the ABD individual.

The resources of one spouse are considered available to the other whether or not they are actually made available. Resource eligibility exists if the value of the couple's combined resources does not exceed the resource limit for two persons. **The resources of an SSI recipient spouse must be counted available even if SSI recipient spouse does not apply for Medicaid.**

Verify and document the NABD spouse's resources as required for an ABD individual.

***B.* Excluded Resources**

When determining the NABD spouse's resources, do not include the resources listed in section M0530.010 above.

***C.* Countable Resources**

Total countable resources are the combination of the resources of the ABD individual and the NABD spouse after all applicable resource exclusions are applied.

Total countable resources are compared to the resource limit for a couple. If the amount of the resources does not exceed the limit, the applicant/recipient meets the resource eligibility requirement. If countable resources exceed the limit, the applicant/recipient is ineligible because of excess resources.

***D.* Example--No Resources Excluded**

EXAMPLE #4: Mr. and Mrs. Daley live together. Mr. Daley, who is age 65, applies for Medicaid on February 4, 1997. His wife is under age 65 and neither blind nor disabled, nor does she meet any Medicaid

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covered group. Mr. Daley has no resources of his own. However, Mrs. Daley has $1,900 in a savings account and owns a vacant lot valued at $500 which does not produce income.

The couple's countable resources are as follows:

$1,900 - Mrs. Daley's savings account
+ 500 - Mrs. Daley's lot
$2,400 - couple's combined resources
- 0 - applicable exclusions
$2,400 - couple's countable resources
- 3,000 - couple's resource limit
0 excess

Mr. Daley meets the resource eligibility requirements.

***E.* Example--Some Resources Excluded**

EXAMPLE #5: Mr. and Mrs. Sands live together. Mr. Sands, who is disabled, applies for Medicaid on October 2, 1997. Mrs. Sands does not meet a Medicaid covered group. She works for a company with a pension plan and states she has accumulated $5,000 in her pension fund which she can withdraw at any time. Mr. and Mrs. Sands jointly own two grave sites worth $500 each and have a joint bank account with a balance of $ 1,000.

The couple's resources are as follows:

Excluded Resources:
$5,000 - pension fund
+ 1,000 - grave sites
$6,000 - excluded resources

Countable Resources:
$1,000 - joint bank account

$1,000 - couple's countable resources
- 3,000 - couple's resource limit
0 excess

Mr. Sands meets the resource eligibility requirements.

***F.* Example--Some Resources Excluded--Individual is Ineligible**

EXAMPLE #6: Mr. Smith, who is 69 years old, applies for Medicaid on October 15, 1997. He lives with his wife who is age 62, neither blind nor disabled, nor does she meet a Medicaid covered group. They have the following resources: a joint checking account of $250; United States savings bonds (in both their names) worth $400, and two automobiles--one with a current market and equity value of $6,000, and the other with a current market value and equity value of $3,000. In addition, Mrs. Smith owns a plot of land which produces no income and has an equity value of $2,000. Mr. Smith owns a life insurance policy on his own life with a face value of $5,000 and a cash surrender value (CSV) of $897.

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Mrs. Smith owns a life insurance policy on her life with a face value of $1,000 and a CSV of $900.

Excluded Resources:
$6,000 - one automobile
+ 900 - CSV of life insurance of Mrs. Smith with face value not over $1,500
$ 6,900 - excluded resources.

Countable Resources:

$ 250 - joint checking account
400 - savings bonds
3,000 - second automobile
2,000 - Mrs. Smith's real estate
+ 897 - CSV of Mr. Smith's life insurance (face value > $1,500)
$6,547 - couple's countable resources
-3,000 - couple's resource limit
$3,547 - excess resources

Mr. Smith is ineligible because of excess resources.

M0530.203 DEEMING INCOME FROM NABD SPOUSE

A. Policy

When a married couple is living together BUT

- only one spouse applies for Medicaid, or
- only one spouse meets the Aged, Blind or Disabled definition in M0510,

the individual's income eligibility is determined as an individual--an ABD assistance unit of one person--if the NABD spouse has no deemable income. If the NABD spouse has deemable income, the individual=s income eligibility is determined as an ABD couple. The NABD spouse=s income is deemed available to the ABD individual applicant UNLESS the NABD spouse receives SSI or other income based on need.

The income of the NABD spouse, after applying the applicable deeming procedures in this section, is considered to be the ABD individual's own unearned income, and is called deemed income. This deemed income is added to the individual's own earned and unearned income in order to determine the individual's income eligibility.

B. Do Not Deem If Spouse Receives Benefits Based On Individual Need

If the NABD spouse receives assistance or a benefit paid by a government agency which is based on economic need, none of the NABD spouse's income is deemed available to the applicant/recipient. Government benefits based on need include SSI, TANF, Veterans Administration pensions, General Relief payments, etc., but do not include *SNAP*,

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fuel assistance, or any benefit based on the entire household's needs. If the NABD spouse does not receive a government benefit which is based on need, the spouse's income is deemed available.

The government benefits based on need are those payments made under:

1. **TANF** — Title IV-A of the Social Security Act, Temporary Assistance to Needy Families with Children (TANF);
2. **SSI and AG** — Title XVI of the Social Security Act (Supplemental Security Income (SSI), including Virginia's Auxiliary Grants program payments (state-administered mandatory supplements);
3. **Refugee Assistance** — The Refugee Act of 1980 (those payments based on need);
4. **Disaster Relief** — The Disaster Relief Act of 1974;
5. **BIA Assistance** — General assistance programs of the Bureau of Indian Affairs;
6. **State or Local Assistance** — State or local government assistance programs based on need; and
7. **VA Assistance Based On Need** — U.S. Veterans Administration programs (those payments based on need).

C. Excluded Income — When determining the NABD spouse's income, do not include the income listed in section M0530.020 above.

D. Deeming Process — When an NABD spouse lives in the same household as the ABD individual, these deeming rules are applied in the following order:

- Determine the NABD spouse's earned and unearned income in the month;
- Deduct an allocation for each NBD child in the household (item E below);
- Compare the remainder to the deeming standard (item F below).

First, determine the NABD spouse's countable earned and unearned income in the month.

E. Subtract NBD Child Allocation — Deduct an allocation for each NBD child who lives in the household is deducted. **Exception:** no allocation is given for any children who are receiving public assistance maintenance payments, such as TANF.

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1. NBD Child Allocation

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

The allocation amount automatically increases whenever the SSI limits increase. *See Appendix 1 to this subchapter for current amount.*

2. Reduce NBD Child Allocation

Each NBD child's allocation is reduced by the amount of his or her own income. The items listed in section M0530.020 above are not included as income to the NBD child for purposes of reducing the allocation.

If any NBD children in the household have income, verify the NBD child's income. However, when the alleged income exceeds the amount of the NBD child allocation amount (i.e., no NBD child allocation will apply for that NBD child), document the allegation in the file but do not verify the income. Document an allegation in the file when any NBD child living in the household has no income. Do not redevelop the NBD child's income unless a change is alleged or there is a reason to believe a change has occurred.

3. Subtract NBD Child Allocation Amount

Subtract the allocations for NBD children first from the NABD spouse's **unearned** income. If the NABD spouse does not have enough unearned income to cover the allocations, the allocation balance is subtracted from the NABD spouse's **earned** income.

F. Compare Remainder To Deeming Standard

Compare the NABD spouse's remaining income to the deeming standard (the difference between the SSI payment limit for two persons and the SSI payment limit for one person). *See Appendix 1 to this subchapter for current amount.*

G. Result (To Deem or Not To Deem...)

1. Less Than or Equal To Deeming Standard

If the NABD spouse's remaining income is equal to or less than the deeming standard, there is no income to deem to the ABD individual. In this situation, the ABD individual's own countable income is determined and subtracted from the appropriate income limit for one person to determine eligibility. See S0810.002 for the income limits.

2. More Than Deeming Standard

If the remaining income of the NABD spouse is more than the deeming standard, the ABD individual and the NABD spouse are treated as a couple, using the procedures in H "Couple Calculation" below.

NOTE: The $20 general exclusion has not been deducted from the ABD individual's income at this point.

H. Couple Calculation

The ABD individual and the NABD spouse are treated as a couple using the following procedures:

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1. Combine Income

Combine the amount of the NABD spouse's unearned income remaining after NBD child allocation(s) with the ABD individual's own unearned income. Combine the amount of the NABD spouse's earned income remaining after NBD child allocation(s) with the ABD individual's earned income.

2. Subtract Exclusions

Subtract the appropriate income exclusions *from the remaining income*:

- the first $20 of the couple's unearned income (if less than $20 of unearned income in a month, any remaining portion of the $20 exclusion is applied to the couple's earned income in the month),
- $65 of the couple's earned income in a month, and one-half of remaining earned income in a month.

The result is the couple's monthly countable income. When determining MN eligibility, multiply the couple's monthly countable income by 6.

3. Compare To Income Limit

Compare the couple's countable income to the income limit for two persons appropriate to the ABD individual's covered group. See M0810.002 for the income limits.

4. Income Meets Limit

If the couple's countable income is less than or equal to the income limit, the ABD individual meets the income requirements for the covered group whose income limit was met. See chapter M15 for Medicaid entitlement policy.

5. Income Exceeds Limit

If the couple's countable income exceeds the income limit, the ABD individual is not eligible for Medicaid in that covered group. If the couple's resources meet the MN requirements and the MN resource limit, the ABD individual may become eligible for a limited period of MN coverage if he/she meets a spenddown. See *chapter M13* for spenddown policy.

I. Examples

The examples below illustrate application of the spouse-to-spouse deeming rules in the ABD income eligibility calculation.

1. No Deemed Income After NBD Child Allocation

EXAMPLE #7: ***(Using January 2000 figures)***
Ms. Wilson, an aged individual, applied for Medicaid. She lives with her NABD spouse Mr. Wilson and their 20 year old NBD child, Mike, in Group II. Their resources are within the resource limit. Mr. Wilson receives a $80 monthly benefit (unearned income) per month. He has no earned income. Mike receives $20 monthly unearned income. Ms. Wilson's income is *$800* monthly SSA. She has Medicare Part A. Her assistance unit is one person with income deemed from her NABD spouse. The deeming calculation is:

$257 NBD child allocation amount
<u>- 20</u> Mike′ income
237 NBD child allocation

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$ 80 Mr. Wilson's unearned income
- *237* NBD child allocation
- *157* remainder NBD child allocation
+ 0 Mr. Wilson's earned income
$ 0 NBD spouse's total income after allocation

Since Mr. Wilson has no remaining income, and $0 is less than the *$257* deeming standard, no income is deemed to Mrs. Wilson. Instead, only her own countable income is compared to the MN, QMB, SLMB *and QI* income limits for one person to determine whether she is eligible. Mrs. Wilson's own countable income is *$780*, which exceeds the MN and the QMB income limit for one person. However, it is within the SLMB income limit. She is eligible for SLMB coverage beginning *January 1, 2000.* She is also placed on a spenddown of *$3,180* (*$780* x 6 months = *4,680 -1500 = $3180*) for the period *January 1* through *June 30*.

2. Spouse Has Earned and Unearned Income After Allocation

EXAMPLE #8: ***(Using January 2000 figures)***
Mr. Jack Ingalls, a disabled individual, applies for Medicaid. He lives with his NABD spouse and NBD 19 year old child, Cathy, in a Group I locality. Mr. And Mrs. Ingalls' resources are within the resource limit. Mr. Ingalls receives $100 unearned income monthly; he does not have Medicare Part A. Cathy has no income. Mrs. Ingalls has earned income of $450 a month and unearned income of $285 a month. Mr. Ingalls' assistance unit is one person with income deemed from his NABD spouse. The deeming calculation is:

$285 Mrs. Ingalls' unearned income
-257 NBD child allocation
28 remainder unearned income
+450 Mrs. Ingalls' earned income
$478 NBD spouse's total income after allocation

Mrs. Ingalls' total income is more than the *$257* deeming standard. Therefore, Mrs. Ingalls' income is deemed to Mr. Ingalls by combining Mrs. Ingalls' income after allocation with Mr. Ingalls' income to determine his MN eligibility:

$285 Mrs. Ingalls' unearned income
-257 NBD child allocation
28 remainder unearned income
+100 Mr. Ingalls' unearned income
128 combined unearned income
- 20 general income exclusion
108 couple's countable unearned income

$450 Mrs. Ingalls' earned income
+ 0 Mr. Ingalls' earned income
450 couple's earned income
- 65 earned income exclusion
385

385
÷ 2 1/2 remainder earned income exclusion
192.50 couple's countable earned income
+108.00 couple's countable unearned income
300.50 couple's total countable monthly income
x 6 months
1,803.00 countable monthly income
-1,700.00 income limit 2 in Group I
$ 103.00 excess

The couple's countable monthly income exceeds the medically needy income limit for a couple. Mr. Ingalls is placed on a spenddown of $103 for the 6-month period January 1 through June 30.

3. Both ABD Individual and NABD Spouse Have Income--Individual Is Eligible

EXAMPLE #9: (Using January 2000 figures)
Harold Bergman, a disabled individual, applies for Medicaid. He lives in Group III with his NABD spouse, who earns $259 per month. They have no children. Mr. Bergman receives a pension (unearned income) of $165 a month and earns $100 gross per month. He does not have Medicare Part A. The couple's resources are within the Medicaid limit. Because Mrs. Bergman's income exceeds the deeming standard of $257, Mrs. Bergman's income is deemed to Mr. Bergman by combining Mrs. Bergman's income with Mr. Bergman's income to calculate his MN eligibility:

$165.00 Mr. Bergman's unearned income
+ 0 Mrs. Bergman's unearned income
$165.00 couple's unearned income
- 20.00 general income exclusion
$145.00 couple's countable unearned income

$259.00 Mrs. Bergman's earned income
+100.00 Mr. Bergman's earned income
359.00 couple's earned income
- 65.00 earned income exclusion
294.00
)÷ 2 ½ remainder earned income exclusion
147.00 couple's countable earned income
+145.00 couple's countable unearned income
$292.00 couple's total countable monthly income
x 6 months
$1752.00 countable income
- 2400.00 income limit for 2 in Group III
0 excess

The couple's countable income is within the MN income limit for 2 persons, so Mr. Bergman is eligible for Medicaid as medically needy beginning January 1.

M0530.204 CHANGES IN STATUS--MARRIED COUPLES

A. Introduction

Several events can change deeming status *for applicants and enrollees*. All such changes affect deeming the month after the month in which the change

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occurs, except as described below. This section contains the rules that apply when there is a change of status.

NOTE: These status changes are effective, for deeming purposes, the month after the month the change occurs. For example, if an NBD child moves out of the household in May, no allocation is given for that child beginning with June for purposes of determining eligibility.

B. NABD Spouse Becomes ABD

If an NABD spouse becomes an ABD spouse, the individual and spouse are treated as an ABD couple effective with the month the spouse becomes an ABD spouse. Eligibility is based on the couple's income for that month.

C. Individual Begins Living With an NABD Spouse

If an ABD individual begins living with an NABD spouse, deeming of the NABD spouse's income begins effective with the month after the month they begin living together.

D. NABD Spouse Dies

If an NABD spouse dies, deeming stops for purposes of determining eligibility effective with the month following the month of death.

E. Spouses Separate or Divorce--Not Due To Institutionaliza-tion

If an NABD spouse and ABD spouse separate, or their marriage ends in divorce, the NABD spouse's income is no longer deemed to determine eligibility effective with the month after the month of separation or divorce. In the month following the month in which separation occurred, the ABD individual is an assistance unit of one person with nothing deemed from the separated spouse.

NOTE: If an application is filed in the month of separation or divorce, deeming applies that month even if the application is filed on or after the date of separation or divorce.

1. Both Meet ABD Group and Both Apply

Financial eligibility is determined as an ABD couple assistance unit (two persons) through the month in which the couple separated. Each is a unit of one starting the month **after** the month in which they separated.

2. Only One Spouse Meets ABD Group or Applies

The ABD applicant spouse is an assistance unit of one person if the NABD spouse has no deemable income. Count the NABD spouse=s resources and deem income to the ABD applicant only in the month in which the couple separated. Starting the month after the month of separation, do NOT count any resources or deem any income from the separated spouse.

F. One Spouse Becomes Institutionalized

If an ABD individual becomes institutionalized, either in a medical facility or in Medicaid CBC waiver services, deeming stops for purposes of determining eligibility for the institutionalized spouse effective with the first month in which the individual is institutionalized. Deeming stops for purposes of determining eligibility for the community spouse effective the month **following** the month of separation due to institutionalization.

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1. Both Meet ABD Group and Apply

a. The Non Institutionalized Spouse

When determining the non institutionalized spouse's financial eligibility, the non institutionalized spouse is an assistance unit of one person beginning the first day of the month **following** the month in which the spouse was institutionalized. Do not deem the institutionalized spouse's resources or income to the non institutionalized spouse beginning the month following the month of separation.

b. The Institutionalized Spouse

For the institutionalized spouse who began institutionalization **before** September 30, 1989, the institutionalized spouse is an assistance unit of one person beginning the first day of the month in which the spouse was institutionalized.

For the institutionalized spouse who began institutionalization **on or after September 30, 1989**, *who has no community spouse*, see *subchapter M1460* to determine the institutionalized spouse's financial eligibility. *For the institutionalized spouse who began institutionalization **on or after September 30, 1989**, who has a community spouse, see subchapter M1480 to determine the institutionalized spouse's financial eligibility.*

2. Only One Spouse Meets Covered Group or Only One Applies

a. The Non Institutionalized Spouse

When determining the non institutionalized spouse's financial eligibility, the non institutionalized spouse is an ABD couple assistance unit of one person beginning the first day of the month **following** the month in which the spouse was institutionalized. Do not deem the institutionalized spouse=s resources or income to the non institutionalized spouse begining the month following the month of separation.

b. The Institutionalized Spouse

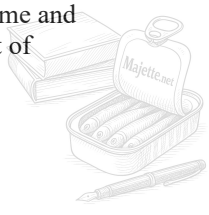
For the institutionalized spouse who began institutionalization **before** September 30, 1989, the institutionalized spouse is an assistance unit of one person beginning the first day of the month in which the spouse was institutionalized.

For the institutionalized spouse who began institutionalization **on or after September 30, 1989**, *who has no community spouse*, see *subchapter M1460* to determine the institutionalized spouse's financial eligibility. *For the institutionalized spouse who began institutionalization **on or after September 30, 1989**, who has a community spouse, see subchapter M1480 to determine the institutionalized spouse's financial eligibility.*

G. Non Institutionalized Examples

1. NABD Spouse Becomes ABD

EXAMPLE #10: In November 1997, Mrs. Manners, a disabled individual, lives with her NABD spouse. Mrs. Manners has no income and Mr. Manners receives a monthly private company retirement benefit of



$310 (he is not disabled according to the Medicaid definition). Mrs. Manners is eligible for Medicaid in November; her eligibility is determined using deemed income from Mr. Manners. On December 1, 1997, Mr. Manners becomes age 65 and applies for Medicaid. Effective with December, the deeming rules no longer apply. The Mannerses are an ABD couple. Eligibility is determined using their combined income in December.

2. NABD Spouse and ABD Individual Separate

EXAMPLE #11: On September 15, 1997, Mrs. Ellen Bowers, a disabled individual, and her NABD spouse separate. They live in Group II. Mrs. Bowers' only income is a title II benefit of $150 per month. Mr. Bowers works and is paid a salary of $405 per month. To determine Mrs. Bowers' eligibility for September, the couple's unearned income is reduced by the general exclusion ($150 - $20 = $130). The couple's earned income is reduced by the earned income exclusion ($405 - $65 = $340)÷ 2 = $170). The couple's total countable income ($130 countable unearned + $170 countable earned = $300 monthly x 6 months = $1800) is compared to the income limit for an ABD couple ($1850 semi-annual). Mrs. Bowers is eligible in September. Effective with October, the deeming rules no longer apply when redetermining her eligibility. Her countable income is recalculated: $150 SSA - $20 general exclusion = $130 monthly countable x 6 months = $780. Because $780 is less than the income limit for 1 person in Group II, Mrs. Bowers remains eligible.

3. ABD Individual Begins Living With NABD Spouse

EXAMPLE #12: On August 2, 1997, Mrs. Barbara Rogers, an NABD spouse, returns to live with her ABD husband in Group III. She is working and earns $700 per month. In August, Mr. Rogers is eligible for Medicaid based on his own unearned income of $68. Effective September 1997, the deeming rules are applied to determine his eligibility. Mr. Rogers' $68 unearned income is reduced by the $20 general income exclusion, leaving $48. Mrs. Rogers' earned income is reduced by the earned income exclusion ($65 plus one-half the remainder), leaving $317.50. The total countable income ($365.50 x 6 = $2193) is within the income limit for a couple in Group III, so Mr. Rogers remains eligible.

4. NABD Spouse Dies

EXAMPLE #13: Mrs. Pauline Pinot is a disabled recipient who receives $150 a month in worker's compensation. She lived with her NABD husband until he died on August 15, 1997. He had been working part-time and received gross wages of $400 in July and $200 in August. Effective September 1997, Mrs. Pinot is eligible as an individual without a spouse and the income limit for an individual applies.

D. Institutionalized Examples

1. ABD Individual Becomes Institutional-ized

EXAMPLE #14: Mr. Malaga was admitted to a nursing facility on September 5, 1997. His NABD spouse is working and receives gross wages of $900 a month. Mr. Malaga is institutionalized beginning September 1997 and August is the last month in which income from his NABD spouse is deemed to him.

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2. Individual Institutional-ized Before 9-30-89

EXAMPLE #15: An institutionalized aged individual applies for Medicaid in August 1997. He has a 58-year-old spouse at home who is neither blind nor disabled. He was admitted to the institution from their home in February 1989. He is an assistance unit of one for both resource and income determinations because he is not living with his spouse and he was institutionalized before September 30, 1989. There may be an expected contribution from the spouse as a legally responsible relative.

3. ABD Couple--One Becomes Institutional-ized

EXAMPLE #16: In October 1997, Mrs. B, a disabled individual, applies for Medicaid for herself and her husband. She lives in Group III. She separated from her ABD spouse, Mr. B, in October 1997 when he was admitted to a nursing facility. Mrs. B earns $459 per month. Mr. B receives a pension (unearned income) of $165 a month and earned $200 gross in October; he does not have Medicare Part A. Mr. B's financial eligibility is determined using the policy and procedures for married institutionalized individuals in *subchapter M1480.*

To determine Mrs. B's eligibility: the couple's combined resources are within the Medicaid limit in October 1997. Her income eligibility is calculated for October:

$165.00 Mr. B's unearned income
+ 0 Mrs. B's unearned income
$165.00 couple's unearned income
- 20.00 general income exclusion
$145.00 couple's countable unearned income in October

$459.00 Mrs. B's earned income
+200.00 Mr. B's earned income
659.00 couple's earned income
- 65.00 earned income exclusion
594.00
)÷ 2 ½ remainder earned income exclusion
297.00 couple's countable earned income
+145.00 couple's countable unearned income
$442.00 couple's total countable monthly income for October
400.00 income limit for 2 for 1 month Group III

November 1997 through March 1998:

$459.00 Mrs. B's earned income
- 20.00 general income exclusion
$439.00
- 65.00 earned income exclusion
374.00
) ÷ 2 ½ remainder earned income exclusion
187.00 countable earned income
+ 0 countable unearned income
$187.00 total countable monthly income
x 5 months (November - March)

$ 935.00	countable income November - March
+442.00	countable income for October
1377.00	total countable income for 6 months
- 2025.00	income limit for October - March ($325 x 5=$1625 +$400 = $2025)
0	no excess for 6 months

Mrs. B's countable income for the 6-month period October 1997 through March 1998 is within the MN income limit for the period and she is eligible as a disabled medically needy individual beginning 10-1-97.

M0530.300 BLIND/DISABLED CHILD UNDER AGE 21

A. Introduction

When determining the Medicaid eligibility of a blind/disabled (BD) child who is under age 19 years, first determine the child's *CN* eligibility because the *CN* covered group has no resource limit and a higher income limit. If the child's income exceeds the *CN limits*, then determine the child's MN eligibility using the resource and income deeming policy and procedures in this section.

B. Policy

An unmarried blind or disabled child is always an assistance unit of one person, even when he/she lives with siblings who are blind or disabled and also apply for Medicaid. The parent's(s') resources and income are deemed available to a blind or disabled child under age 21 years when the child lives with the parent(s) and when the parent(s) is not eligible for Medicaid. Do NOT deem a stepparent's resources or income to a BD child.

A married blind or disabled (BD) child under age 21 who does not live with his/her spouse is an assistance unit of one person. If the married BD child lives with his/her spouse, resources and income are deemed from the spouse according to section M0530.200 above. If the married BD child lives with his/her spouse **and** his/her parent(s), the parent(s) resources and income are deemed to the BD child **before** calculating the spouse's resources and income.

C. Child Under 21 Living Away From Home

A blind or disabled child under age 21 who is living away from home is considered living with his/her parent(s) for deeming purposes if:

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

Children living in foster homes or non medical (residential) institutions are NOT temporarily absent from home. They are indefinitely absent from home and are NOT living with their parents or siblings for Medicaid purposes.

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

D. Deeming

A parent's income and resources are deemed to an BD child beginning:

- the month following the month the child comes home;
- the month following the month a child born in a hospital comes home from the hospital;
- the month of birth when a child is born in the parent's home;
- the month after the month of adoption; the month of adoption in Virginia is the month the interlocutory order or final adoption order, whichever comes first, is entered.

E. BD Child Assistance Unit Examples

EXAMPLE #17: A blind 16-year-old child lives with his 65-year-old father and 52-year-old mother. His mother is neither blind, disabled, nor pregnant. His father does not apply for Medicaid for himself. The child is an assistance unit of one for both resource and income determinations. A portion of his parents' resources and income is deemed available to him.

EXAMPLE #18: A 19-year-old disabled child lives with his mother and his two brothers who are under age 18. The children's father died. The mother applies for Medicaid for herself and all children. She is not eligible in the LIFC group and she meets no other covered group. When determining the disabled child's eligibility, the disabled child is not included in an assistance unit with his mother and brothers; the disabled child is an assistance unit of one, with deemed income and resources from the mother.

M0530.301 DEEMING RESOURCES FROM PARENTS

A. Policy

In determining eligibility of a BD child under 21 who lives with his parent(s), the resources of the child include the value of the countable resources of the parent(s), to the extent that the resources of the parent(s) exceed the resource limit of:

- an individual, if one parent lives in the household; or
- a couple, if two parents live in the household.

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The value of parental resources is subject to deeming whether or not those resources are actually made available to the child.

B. More Than One BD Child In Household

If there is more than one blind or disabled BD child under age 21 in the household, equally divide the value of the deemed resources among those children.

If an BD child is later determined ineligible for Medicaid for any reason or is no longer subject to deeming (e.g., after attainment of age 21), divide the value of the deemed resources among the remaining BD children, effective with the first month the child is ineligible or no longer subject to deeming.

C. Excluded Resources

When determining the parent's resources, do not include the resources listed in section M0530.010 above.

D. Countable Resources

Total countable resources are the combination of the resources of the parents after all applicable resource exclusions are applied.

1. Subtract Resource Limit

From the parent's(s') total countable resources, subtract the resource limit of

- **$2,000** (one person) when one parent lives in the home, or
- **$3,000** (a couple) when both parents live in the home.

2. Deem Excess To BD Child

Deem the amount of the resources over the limit to the BD child. If more than one BD child lives in the household, divide the amount of resources over the limit equally among the number of BD children in the household.

E. Child's Total Countable Resources

A child's total countable resources are the combination of the value of the deemed resources from the parent(s) and the nonexcluded resources of the child.

F. Resource Limit

Compare the BD child's countable resources to the resource limit for one person. If the resources do not exceed the limit, the child meets the Medicaid resource eligibility requirement. If countable resources exceed the limit, the child is ineligible for Medicaid because of excess resources.

G. Example--BD Child Living With Parents- Child Meets Resource Requirement

EXAMPLE #19: Mr. and Mrs. Blake live together with their son, Thomas, who is age 16 and blind. Thomas has no resources of his own. Mr. and Mrs. Blake applied for Medicaid on behalf of Thomas on January 23, 1997.

The parents' resources are as follows:

$4,150 - savings belonging to both Mr. and Mrs. Blake

The resource calculation follows:

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$4,150 parent's countable resources subject to deeming
- 3,000 couple resource limit
$1,150 deemed resources to Thomas
+ 0 child's resources
$1,150 child's countable resources

Since Thomas's countable resources do not exceed the resource limit for an individual, Thomas meets the resource eligibility requirement.

H. Example--Two BD Children Living With Parent and Stepparent - Children Meet Resource Requirements

EXAMPLE #20: John and Joan Goode, ages 15 and 16, are both disabled and live with their mother and stepfather. John's only resources are three U.S. savings bonds worth $25 each. Joan's resources are a $100 savings account and a stamp collection valued at $400. The parents own:

one automobile valued at $3,000
joint savings account with balance of $5,000
Mrs. Smith's cash on hand = $200

Mrs. Smith, John and Joan's mother, applies for Medicaid on their behalf on September 17, 1997. The parent's (mother's) resource calculation follows:

Parent's Excluded Resources: one automobile

Parent's Countable Resources:
$2,500 ½ savings account (mother's share of joint account)
+ 200 cash on hand
$2,700 parent's total countable resources
-2,000 individual resource limit
$ 700 value of deemed resources ($350 resources deemed to each child)

John's Resources (no excluded resources)
$ 75 savings bonds
+ 350 deemed from parent
$ 425 countable resources

Joan's Resources (stamp collection excluded)
$ 100 savings account
+ 350 resource value deemed
$ 450 countable resources

Since neither John's nor Joan's countable resources exceed the resource limit, they both meet the Medicaid resource eligibility requirement.

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I. Example--Two Children Living with Parent and Stepparent - One Child Found NBD First and Other Child Becomes NBD as a Result

EXAMPLE #21: The same situation exists as described in Example #20 above except that Joan also owns four savings bonds worth $450 each, and John also owns a savings account worth $1,500.

Joan's resources (stamp collection excluded):

$ 100 savings account
1,800 savings bonds
+ 350 deemed from parent
$2,250 countable resources

John's resources:

$1,500 savings account
75 savings bonds
+ 350 deemed from parent
$1,925 countable resources

John initially meets the resource eligibility requirement because his countable resources do not exceed the resource limit. But Joan does not meet the resource eligibility requirement because her countable resources exceed the resource limit. Since Joan is ineligible, the parent's resources must all be deemed to John.

John's Resources (no excluded resources):

$ 75 savings bonds 1,500 savings account
+ 700 parent=s deemed resources
$ 2,275 countable resources

Because John's countable resources now exceed the limit for 1 person, he is not eligible for Medicaid because of excess resources. Both John and Joan are ineligible because of excess resources.

M0530.302 DEEMING INCOME FROM ONE PARENT

A. Policy

A BD child (blind or disabled child) under age 21 who resides in the same household with a parent is considered to share in the parent's income. A BD child living in the same household with a parent is subject to the deeming provisions as long as he/she is under age 21, if the individual meets the definition of a child in M0530.002 above. A child who is away at school may be considered to be temporarily absent from the parents' household and would also be subject to deeming.

The following subsections explain the rules to follow when deeming income from one parent when

- only one parent lives in the household, or
- the parent is married and living with his/her spouse who is not the BD child's parent (is the BD child's stepparent). Do NOT deem any of the stepparent's resources or income to the BD child(ren).

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B. Excluded Income

When determining the parent's income, do not include the income listed in section M0530.020 above.

C. Deeming Rules

When a BD child lives in the same household with his/her parent, these deeming rules are applied in the following order:

1. Determine Parent=s Income

Determine the monthly amount of the Parent's earned and unearned income, applying the appropriate exclusions in M0530.020.

2. Determine NBD Child Allocation

a. Parent Is Not Living With Spouse

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

The allocation amount automatically increases whenever the SSI limits increase. *See Appendix 1 to this subchapter for current amount.*

b. Parent Is Living With Spouse (BD Child's Stepparent)

1) Parent's own NBD child(ren): the allocation for each NBD child is the difference between the SSI payment limit for two persons and the SSI payment limit for one person. *See Appendix 1 to this subchapter for current amount.*

2) Parent's child(ren)-in-common with stepparent: calculate the stepparent's ability to meet the needs of the child(ren)-in-common. If the stepparent refuses to verify his/her income, **do not allocate any amount of the parent's income for the child(ren)-in-common**:

   a) **Step 1:** Determine the stepparent's earned and unearned income, applying the appropriate exclusions in M0530.020.

   b) **Step 2:** Deduct an allocation for each of the stepparent's own children living in the household who are **not** the children of the Parent. Reduce the allocation by the amount of the child's own countable income.

   c) **Step 3:** Subtract the unearned and earned income exclusions from the stepparent's income remaining after deducting allocations.

   d) **Step 4:** Deduct a **living allowance** for the stepparent. *See Appendix 1 to this subchapter for current amount.*

   e) **Step 5:** Subtract the NBD child allocation from the remaining income after deducting the living allowance. (If only one

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child-in-common lives in the household, the allocation is *the amount of the NBD child allocation.* If there *is* more than 1 child-in-common, multiply the allocation by the number of children-in-common). The result is the stepparent's contribution to the child(ren)-in-common.

(1) If the stepparent's contribution is **less than or equal to** the allocation amount, the stepparent is not able to fully meet the child(ren)-in-common's needs. **Use the allocation amount when calculating the parent's allocation for the child(ren)-in-common, and count the stepparent's contribution as income to the child(ren)-in-common**. If more than one child-in-common lives in the household, divide the stepparent's contribution by the number of children-in-common living in the household.

(2) If the remainder is **more than** the allocation amount, the stepparent is able to meet the child(ren)-in-common's needs. **DO NOT allocate any** of the parent's income for the child(ren)-in-common. .

3. Reduce NBD Child Allocation

Each NBD child's allocation is reduced by the amount of his or her own income. The items listed in section M0530.020 above are not included as income to the NBD child for purposes of reducing the allocation.

If any NBD children in the household have income, verify the NBD child's income. However, when the alleged income exceeds the amount of the NBD child allocation amount (i.e., no NBD child allocation will apply for that NBD child), document the allegation in the file but do not verify the income. Document an allegation in the file when any NBD child living in the household has no income. Do not redevelop the NBD child=s income unless a change is alleged or there is a reason to believe a change has occurred.

4. Subtract NBD Child Allocation Amount

Subtract the allocations for NBD children first from the parent's **unearned** income. If the parent does not have enough unearned income to cover the allocations, the allocation balance is subtracted from the parent's **earned** income.

5. Subtract Unearned and Earned Income Exclusions

a. All Remaining Parental Income Is Earned

If all of the income of the parent that remains after applying the NBD child allocations is earned:

- Subtract $85 (the sum of the $20 general income exclusion and the $65 earned income exclusion);
- Subtract ½ of the remaining earned income.

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b. All Remaining Parental Income is Unearned

If all of the income of the parent that remains after applying the NBD child allocations is unearned:

- subtract the $20 general income exclusion.

c. Parental Income is Both Earned and Unearned

If all of the income of the parent that remains after applying the NBD child allocations is both earned and unearned:

1) subtract $20 from the parent's unearned income. If the total unearned income is less than $20, subtract the balance of the $20 from the parent's earned income;

2) subtract $65 plus one-half the remainder from the earned income (after subtracting any of the remaining $20 exclusion).

6. Subtract Living Allowance for Parent

Subtract a living allowance for the parent from any remaining parental income, unless the parent receives a public assistance payment such as TANF. No living allowance is given to a parent who is receiving public assistance payments. The parental living allowance, even if the parent is married and living with his/her spouse who is not the BD child's parent, is the SSI monthly payment limit for an individual.

7. Result = Deemable Income

Any positive remainder, after subtracting the living allowance for the parent, is the parent's deemable income.

8. One BD Child in Household

If only one BD child lives in the household, the parent's deemable income is deemed to the child as unearned income.

Add the deemed income to the BD child's own unearned income. Subtract the appropriate unearned income exclusions, including the $20 general exclusion, to determine the child's countable unearned income in the month. Add the countable unearned income to any countable earned income the child has. Subtract the total countable income from the appropriate income limit for 1 person to determine whether or not the child is eligible for Medicaid, or to determine the amount of the child's medically needy spenddown.

9. Two or More BD Children in Household

If two or more BD children live in the household, divide the parent's deemable income equally among them.

To determine each BD child's income eligibility, add the deemed income to each BD child's own unearned income. Apply the appropriate unearned income exclusions, including the $20 general exclusion, to determine the child's countable unearned income in the month. Add the countable

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unearned income to any countable earned income the child has. Subtract the total countable income from the appropriate income limit for 1 person to determine whether or not each child is eligible for Medicaid, or to determine the amount of the child's medically needy spenddown.

D. Examples

1. Two BD Children

EXAMPLE #22: ***(Using January 2000 figures)***
James and Janet Jackson are disabled children age 19 and 20 who live with their mother in a Group I locality. Their mother applied for Medicaid for them in *January*. The children have no income but their mother receives $640 in unemployment compensation each month. Since all of Mrs. Jackson's income is unearned and she has no NBD child allocation, her deemed income is calculated:

$640 parent's unearned income
- 20 general income exclusion
620 countable unearned
- *512* parent's living allowance
108 remainder deemed to BD children
)÷ 2 BD children
$54 deemed to each child

When the $20 general income exclusion is applied to each child's income, each child has *$34* monthly countable income.

$34 countable monthly income for each child
x 6 months
204 6 months' income
- 1300 income limit for 1 person Group I
0 excess

Because each child's countable income is within the income limit for 1 person, each child is eligible for Medicaid as an MN disabled individual.

2. Two BD Children; One Has Excess Income

EXAMPLE #23: ***(Using January 2000 figures)***
In *January*, Mrs. Jones applied for Medicaid for her 2 disabled children, John age 19 and James age 20. Also living in the household is her husband who is not the father of the BD children. They live in a Group III locality. Mrs. Jones receives $960 in unemployment compensation per month and James receives $200 from his grandparents each month. John has no income. Mrs. Jones has no resources to deem. Since all of Mrs. Jones's income is unearned and she has no NBD child allocation, her deemed income is calculated:

$960 parent's unearned income
- 20 general income exclusion
940 countable unearned
- *512* parent's living allowance
428 remainder deemed to BD children
)÷ 2 BD children
214 deemed to each child

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James's income is calculated:

$200 unearned income from grandparents
+*214* deemed from parent
414 James's total unearned income
- 20 general income exclusion
394 monthly countable income
x 6 months
2364 6 months' income
-1950 income limit for 1 Group III
$414 excess for James (spenddown)

James is ineligible for Medicaid because of excess income. He is placed on spenddown. John's income is calculated:

$214 deemed from parent
- 20 general income exclusion
194 monthly countable income
x 6 months
1164 6 months' income
- 1950 income limit for 1 Group III
0 excess for John

John is eligible for Medicaid as an MN disabled individual.

3. One BD Child; Stepparent In Home

EXAMPLE #24: ***(Using January 2000 figures)***
Jerry Smith is a 19 year-old disabled child who lives with his mother, stepfather, his 15 year-old sister, his 3 year-old half brother and his 2 step-siblings in a Group II locality. His mother, Mrs. Green, applied for Medicaid for him in *January*. Jerry has no income. His mother receives $540 in unemployment compensation each month. Mr. Green, his stepfather, earns $2,300 per month. Jerry's 15 year old sister and his 3 year old half brother have no income of their own. Jerry's step-siblings receive $50 a month each from their grandparents.

a. Mrs. Green's deemed income is calculated:

Stepparent's contribution to children-in-common:
Each step-sibling's allocation:

$*257* allocation standard
- 50 each child's income
207 each child's allocation from stepparent=s income
x 2 children
414 total allocation for step-children

$2,300 Mr. Green's earnings
- *414* allocation for his 2 children
1,886 remainder
- *512* living allowance for Mr. Green
1,374 remainder

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$1,374 remainder
- 257 allocation standard for 1 child-in-common
$1,117 stepparent's contribution to child-in-common

Because *$1,117* is greater than the allocation standard for 1 child-in-common, NONE of Mrs. Green's income is allocated for the 3-year old child-in-common.

NBD Child allocation calculation:

$ *257* allocation standard for 15 year old sister
- 0 income of child
257 allocation for NBD 15 year old child

$ 540 Mrs. Green's unearned income
- 257 allocation for her NBD child
283 remainder
- 20 general income exclusion
263 countable unearned
- 512 parent's living allowance
0 remainder to deem to BD child

Mrs. Green has no income deemed to Jerry. Because he has no income of his own, he is eligible for Medicaid as an MN disabled individual.

M0530.303 DEEMING INCOME FROM TWO PARENTS

A. Introduction

This section explains the rules to follow when deeming income from both of the BD child(ren)'s parents who live in the household with the BD child(ren).

B. Excluded Income

When determining the parents' income, exclude the income listed in section M0530.020 above.

C. Deeming Rules

These deeming rules are applied in the following order:

1. Determine Parent's Income

The monthly amount of the parents' earned and unearned income is determined, applying the appropriate exclusions in M0530.020.

2. NBD Child Allocation

a. NBD Child Allocation Amount

An allocation for each NBD child who lives in the household is deducted from the **NBD child's parent's** income. Exception: no allocation is given for any children who are receiving public assistance payments such as TANF payments.

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

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The allocation amount automatically increases whenever the SSI limits increase. *See Appendix 1 to this subchapter for current amount.*

b. Reduce NBD Child Allocation

Each NBD child's allocation is reduced by the amount of his or her own income. The items listed in section M0530.020 above are not included as income to the NBD child for purposes of reducing the allocation.

If any NBD children in the household have income, verify the NBD child's income. However, when the alleged income exceeds the amount of the NBD child allocation amount (i.e., no NBD child allocation will apply for that NBD child), document the allegation in the file but do not verify the income. Document an allegation in the file when any NBD child living in the household has no income. Do not redevelop the NBD child's income unless a change is alleged or there is a reason to believe a change has occurred.

c. Subtract NBD Child Allocation

1) **Step 1, Parent #1:** determine the NBD child allocation(s) for the NBD child(ren) of only one of the parents (Parent #1) when Parent #1 has an NBD child(ren) who is not the child(ren) of the other parent (Parent #2).

   a) Determine the NBD child's own income,

   b) Subtract the NBD child's income from the NBD child allocation amount,

   c) any positive remainder is the NBD child allocation for that child;

   d) repeat a), b) and c) for each of Parent #1's NBD children.

   e) total all of the Parent #1's NBD child(ren) allocations; the result is Parent #1's NBD child allocation for his/her own child(ren);

   f) subtract the Parent #1's NBD child(ren) allocation first from the Parent #1's **unearned** income. If Parent #1 does not have enough unearned income to cover the allocation, subtract the allocation balance from Parent #1's **earned** income.

2) **Step 2, Parent #2:** determine the NBD child allocation(s) for the NBD child(ren) of Parent #2 when Parent #2 has an NBD child(ren) who is not the child(ren) of the Parent #1.

   a) Determine the NBD child's own income,

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b) Subtract the NBD child's income from the NBD child's allocation amount,

c) any positive remainder is the NBD child allocation for that child;

d) repeat a), b) and c) for each of Parent #2's NBD children.

e) total all of the Parent #2's NBD child(ren) allocations; the result is Parent #2's NBD child allocation for his/her own child(ren);

f) subtract the Parent #2's NBD child(ren) allocation first from the Parent #2's **unearned** income. If Parent #2 does not have enough unearned income to cover the allocation, subtract the allocation balance from Parent #2's **earned** income.

3) **Step 3, Parents' child(ren)-in-common:** when the parents have an NBD child(ren)-in-common (both parents are NBD child's parents):

a) Determine the NBD child-in-common's own income,

b) Subtract the NBD child's income from the NBD child-in-common's allocation amount,

c) any positive remainder is the NBD child allocation for the child-in-common;

d) repeat a), b) and c) for each of the parents' NBD children-in-common;

e) total all of the NBD child(ren)-in-common allocations; the result is the parents' NBD child-in-common allocation for their child(ren)-in-common;

f) combine the Parents' unearned income that remains after deducting each parent's NBD child allocations;

g) combine the parents' earned income that remains after deducting each parent's NBD child allocations;

h) subtract the Parents' NBD child(ren)-in-common allocation first from the Parents' **combined unearned** income.

If the Parents do not have enough unearned income left to cover the NBD child(ren)-in-common allocation, subtract the NBD child(ren) in-common allocation balance from the Parents' **combined earned** income.

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3. Subtract Unearned and Earned Income Exclusions

a. All Remaining Parental Income Is Earned

If all of the income of the parents that remains after applying the NBD child-in-common allocation is earned:

- Subtract $85 (the sum of the $20 general income exclusion and the $65 earned income exclusion);
- Subtract ½ of the remaining earned income.

b. All Parental Income is Unearned

If all of the income of the parents that remains after applying the NBD child-in-common allocation is unearned:

- subtract the $20 general income exclusion.

c. Parental Income is Both Earned and Unearned

If all of the income of the parents that remains after applying the NBD child-in-common allocation is both earned and unearned:

1) subtract $20 from the parents' remaining unearned income. If the remaining unearned income is less than $20, the balance of the $20 is subtracted from the parents' remaining earned income;

2) subtract $65 plus one-half the remainder from the remaining earned income (after subtracting any of the remaining $20 exclusion).

4. Subtract Living Allowance for Parents

Deduct a living allowance for the parents from any remaining parental income, unless the parents receive a public assistance payment such as TANF. No living allowance is given to parents who receive public assistance payments. The parental living allowance is the SSI monthly payment limit for a couple (2 persons).

5. Result = Deemable Income

Any positive remainder, after subtracting the living allowance for the parents, is the parents' deemable income.

6. One BD Child in Household

If only one BD child lives in the household, the parents' deemable income is deemed to the child as unearned income.

Add the deemed income to the BD child's own unearned income. Subtract the appropriate unearned income exclusions, including the $20 general exclusion, to determine the child's countable unearned income in the month. Add the countable unearned income to any countable earned income the child has. Subtract the total countable income from the

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appropriate income limit for 1 person to determine whether or not the child is eligible for Medicaid, or to determine the amount of the child's medically needy spenddown.

7. Two or More BD Children in Household

If two or more BD children live in the household, **divide** the parents' deemable income equally among the BD children.

To determine the income eligibility of the BD child(ren) who apply for Medicaid, add the deemed income to the BD child's own unearned income. Subtract the appropriate unearned income exclusions, including the $20 general exclusion, to determine the child's countable unearned income in the month. Add the countable unearned income to any countable earned income the child has. Subtract the total countable income from the appropriate income limit for 1 person to determine whether or not the child is eligible for Medicaid, or to determine the amount of the child's medically needy spenddown.

D. Examples

1. One NBD Child in Common; Parents Have Both Earned and Unearned Income

EXAMPLE #25: ***(Using January 2000 figures)***
Bobby Miller, a disabled child age 19, lives with his mother and father and a 10-year-old NBD brother in a Group II locality. On *January 3,* his mother applies for Medicaid for him. She receives an annuity payment of $285 and his father earns $1,025. Bobby receives $250 per month from a trust fund set up for him by his deceased grandmother. His brother has no income.

Parents' deeming calculation:

$285	mother's unearned income
-257	NBD child allocation
28	unearned income to deem from mother
- 20	general income exclusion
8	parents' countable unearned income
$1025	father's earned income
- 65	earned income exclusion
960	
)÷ 2	½ remainder earned income exclusion
480	countable earned income
+ 8	countable unearned income
488	
-769	living allowance for the parents
0	excess to deem

None of his parents' income is deemed to Bobby. Bobby's MN income eligibility is calculated:

$250	monthly unearned income
- 20	general exclusion
230	countable income
x 6	months
$1380	countable 6 months' income

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1380 countable 6 months= income
-1500 income limit for 1 Group II
0 excess

Bobby is eligible for Medicaid as an MN disabled individual.

2. One NBD Child in Common; Parents Have NBD Children Of Their Own

EXAMPLE #26: ***(Using January 2000 figures)***
Billie Barty, a disabled child age 19, lives with her mother, father, her twin brother age 19, her mother's 20-year-old NBD son and her father's 20 year-old daughter in a Group III locality. On *January 4*, her mother applies for Medicaid for Billie. Her mother receives an annuity payment of $585 per month and her father earns $3,000 per month. Billie receives $150 per month from a trust fund set up for her by her deceased grandmother. Her half-siblings have no income.

a. Parent #1's (mother's) deeming calculation:

$585 mother's unearned income
-257 NBD child allocation (20 year old)
328 remainder unearned income

b. Parent #2's (father's) deeming calculation:

$3000 father's earned income
- 257 NBD child allocation (20 year old)
2743 remainder earned income

c. Parents= child-in-common allocation and deeming calculations:

$ *328* mother's remainder unearned income
+ 0 father's remainder unearned income
328 parents' total remainder unearned income
- 257 NBD child-in-common allocation
71 parents' countable unearned income
- 20 general income exclusion
51 parents' countable unearned income

$2,743 father's remainder earned income
- 65 earned income exclusion
2,678
)÷ 2 ½ remainder earned income exclusion
1,339 countable earned income
+ *51* countable unearned income
1,390 total countable income
- *769* living allowance for parents
621 deemed to Billie

d. Billie's income calculation:

$150 monthly unearned income
+ *621* deemed from parents
771 total unearned income

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771	total unearned income
- 20	general exclusion
751	countable income
x 6	months
$ *4,506*	countable 6 months' income
- 1,950	income limit for 1 Group III
2,556	excess (spenddown)

Billie is not eligible for Medicaid because of excess income and is placed on a spenddown.

M0530.304 CHANGES IN STATUSc PARENTS OF CHILDREN

A. Introduction

Deeming of a parent's income to an BD child can begin or end when there has been a change in the family's situation. Except where noted below, all changes in status are effective with the month following the month the change occurs. The rules that apply when such a change of status occurs are listed below.

NOTE: There are other status changes in addition to the ones described in B. These other changes are effective, for deeming purposes, the month after the month the change occurs. For example, if an NBD child moves out of the household in May, no allocation is given for that child beginning with June (for purposes of determining eligibility of a blind or disabled child).

B. Policy

1. Parent Dies

If a parent dies, deeming stops from that parent beginning with the month following the month of death. If the child lives with two parents and one dies, deeming continues from the surviving parent to determine eligibility. Only the surviving parent's income is used, and one parental living allowance is subtracted.

2. Parent and BD Child No Longer Lives in Same Household

If a parent and BD child no longer live in the same household, deeming of that parent's income stops effective the month after the month the parent (or child) leaves the household for purposes of determining eligibility.

NOTE: If a parent (or child) was temporarily absent from the household, this rule applies effective with the month after the month the parent's (or child's) absence is no longer considered temporary.

3. Parent and BD Child Begin Living in Same Household

If an BD child begins living with a parent in the same household (e.g., a newborn child comes home from a hospital), the parent's income is deemed to the child for purposes of determining eligibility beginning the month after the month they begin living together.

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NOTE: An BD child born at home is subject to deeming effective with the month of birth.

4. BD Child Becomes Institution-alized

If an BD child becomes institutionalized, either in a medical facility or under a Medicaid CBC waiver, deeming stops for purposes of determining eligibility effective the month in which institutionalization began.

5. Child Attains Age 21

Deeming stops effective the month following the month in which a child attains age 21. An individual attains age 21 on the day preceding the anniversary of his/her birth. Eligibility is determined using only the individual's own income. The individual's income for the current month and subsequent months must include any income in the form of cash provided by the parents.

C. Examples

1. Parent Dies

EXAMPLE #27: ***(Using January 2000 figures)***
Henry Walden is a disabled child who lives with his parents in Group III. On *January 4,* Mrs. Walden died. She had been working and received gross wages of $981 in January. Mr. Walden's only income is a pension check of $450. Henry has no income. There are no NBD children living in the household. In *January*, Henry's eligibility is determined by calculating deemed income from both his parents. His father's unearned income of $450 is reduced by $20, leaving $430. His mother's earned income of $981 is reduced by the earned income exclusion ($65 plus one-half the remainder) leaving $458. The total income remaining ($888) is then reduced by the parents' living allowance ($*769*), which leaves deemed income of *$119*. The $20 general income exclusion is subtracted from Henry's income, which leaves him with *$99* countable income. Beginning with *February*, Henry's eligibility is determined using only his father's income, since Henry has no income of his own and his mother died in *January*.

2. BD Child Begins Living With Parent

EXAMPLE #28: Gene Prescott, a disabled child age 19, is a Medicaid recipient who lives in a private residential facility. In October, he is discharged from the facility and goes home to live with his mother and his NBD sister. Beginning with November, his mother's resources and income are deemed to Gene to determine his eligibility.

M0530.400 MULTIPLE DEEMING

A. Introduction

When more than one ABD individual lives in the same household and there is a parent-child relationship, a multiple deeming situation may exist. The following sections provide the rules to follow in parent-child multiple deeming situations. When this type of deeming is involved, it may or may not be necessary to recalculate eligibility, depending on the situation.

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M0530.401 DEEMING INCOME FROM AN NABD SPOUSE TO AN ABD INDIVIDUAL AND A BD CHILD

A. Policy

If a BD child (or children) under age 21 lives in the same household with his/her parents who are an ABD individual (spouse) and an NABD spouse, income is always deemed first to the ABD individual (i.e., the parent who is aged, blind or disabled). Then, any remaining income is deemed to the BD child(ren).

B. Determining the Spouse's and Child's Eligibility

The steps below are followed to determine eligibility for Medicaid when both an ABD individual (spouse) and a BD child under age 21 live in the same household with an NABD spouse/parent.

1. Determine the amount of the NABD spouse's earned and unearned income using the appropriate exclusions in M0530.020.

2. Deduct an allocation for each NBD child in the household from the NABD spouse's income as described in M0530.203.

3. Follow the rules in M0530.203 to determine if any of the NABD spouse's income is deemed to the individual, and if so, to determine countable income for a couple. Follow the rules in M0530.301 and 302 to determine the BD child's eligibility.

   NOTE: Excess income, if any, is determined from the "couple" calculation.

4. If the ABD spouse/parent **is eligible** for Medicaid after the NABD spouse's income has been deemed, **no** income is deemed to the BD child from his/her parents. To determine the child's eligibility, compare the child's own countable income (without income deemed from his/her parents) to the income limit for 1 person.

5. If the ABD individual (parent) is **not** eligible for Medicaid after the NABD spouse's income has been deemed, deem any excess monthly income to the BD child.

   When the couple's countable income exceeds the income limit, the ABD spouse/parent is **not** eligible for Medicaid and is placed on a spenddown. The spenddown amount is based on the amount of the monthly excess income which was deemed to the BD child. Deeming income does not reduce the ABD spouse/parent's countable income.

C. Examples

1. Parents' Income Less Than Couple Limit

EXAMPLE #29: Mrs. Crowley, a blind individual, lives with her husband and their disabled child, John in Group III. Mrs. Crowley has been receiving Medicaid for 4 months. She and John have no income. Mr. Crowley is employed and earns $825 in August 1997. First

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determine Mrs. Crowley's eligibility. Since Mr. Crowley's income exceeds the deeming standard, the $825 is treated as the earned income available to Mr. and Mrs. Crowley as a couple. Because they have no unearned income, reduce the $825 by the $20 general income exclusion, and then by the earned income exclusion ($65 plus one-half the remainder). This leaves $370 in countable income, which is less than the $400 income limit in Group III for a couple, so Mrs. Crowley is eligible for Medicaid. Therefore, no income is deemed to John. Since John's total countable income (zero) is less than the income limit for an individual, John is also eligible for Medicaid.

2. Parents' Income Exceeds the Couple Limit

EXAMPLE #30: Mr. Potter, a disabled individual, resides with his NABD spouse and their disabled son, Dwayne who is age 19, in Group II. Mr. Potter and Dwayne have no income. Mrs. Potter works and earned $1,195 in September 1997. Since Mrs. Potter's income is more than the deeming standard, the $1,195 earned income is treated as income available to Mr. and Mrs. Potter as a couple. Next, the income is reduced by the $20 general income exclusion and then by the $65 plus one-half the remainder (earned income exclusion), leaving $555 in countable income. This exceeds the monthly income limit in Group II by $246.67. Mr. Potter is ineligible because the couple's $555 countable income exceeds the Group II income limit for a couple. His spenddown amount is $1480 ($555 x 6 = 3330 - 1850 = 1480).

Since Mr. Potter is ineligible, $246.67 is deemed to Dwayne. Treat the $246.67 deemed to Dwayne as unearned income, and apply the $20 general income exclusion, reducing Dwayne's countable income to $226.67. Multiply his monthly countable income by 6 months. Compare Dwayne's 6 months' countable income to the semi-annual income limit for 1 person in Group II. Because his countable income does not exceed the income limit. Dwayne is eligible for Medicaid as an MN disabled individual.

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Deeming Allocations

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

NBD (Non-blind/disabled) Child Allocation

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

SSI payment for couple - SSI payment for one person = NBD child allocation

2026: $1,491- $994 = $497
2025: $1,450 - $967 = $483
2024: $1,415 - $943 = $472
2023: $1,371 - $914 = $457
2022: $1,261 - $841 = $420

Parental Living Allowance

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

SSI payment for one person = *$994 for 2026;* $967 for 2025; $943 for 2024; $914 for 2023; $841 for 2022.

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

SSI payment for both parents = *$1,491 for 2026;* $1,450 for 2025; $1,415 for 2024; $1,371 for 2023; $1,261 for 2022.

Deeming Standard

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

SSI payment for couple - SSI payment for one person = deeming standard

2026: $1,491 - $994 = $497
2025: $1,450 - $967 = $483
2024: $1,415 - $943 = $472
2023: $1,371 - $914 = $457
2022: $1,261 - $841 = $420
2021: $1,191 - $794 = $397

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CHAPTER M06

FAMILIES AND CHILDREN RESOURCES

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CHAPTER M06
FAMILIES AND CHILDREN RESOURCES

SUBCHAPTER 10

GENERAL RULES FOR FAMILIES AND CHILDREN RESOURCES

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M0610 Changes

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TN #DMAS-33	10/1/24	Page 5
TN #DMAS-32	7/1/24	Page 1, Page 7a is added
TN #DMAS-14	10/1/19	Table of Contents Pages 1, 2 Page 2a was added as a runover page.
TN #DMAS-12	4/1/19	Page 1
TN #100	5/1/15	Pages 1, 2

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M0610.000 GENERAL RULES FOR FAMILIES AND CHILDREN RESOURCES

M0610.001 OVERVIEW

A. Introduction

Medicaid is a needs based program. Two financial criteria, income and resources, are used to determine if a person is in need and is financially eligible for Medicaid. Most F&C categorically needy (CN) covered groups (see subchapter M0330) do not have a resource requirement. Resource policy does not apply to the following categorically needy covered groups:

- CN Pregnant Women & Newborn Children;
- Plan First,
- CN Child Under Age 19 (FAMIS Plus);
- IV-E Foster Care or IV-E Adoption Assistance Recipients;
- Low Income Families With Children (LIFC);
- Individuals Under Age 21;
- Special Medical Needs Adoption Assistance;
- BCCPTA,
- MAGI Adults (see M1460 for resource requirements)
- Former Foster Care Children Under Age 26

This section addresses how to determine resource eligibility for the following covered groups and individuals:

- F&C in Medical Institution, Income ≤ 300% SSI age 18 years and older*;
- F&C Receiving Waiver(CBC) Services age 18 years and older*;
- F&C Hospice age 18 years and older*; and
- all F&C medically needy covered groups.

***Children under age 18 in the F&C 300% SSI covered group are not subject to a resource test.**

All real and personal property legally owned by each member of the family unit/budget unit (FU/BU) is evaluated and the countable value is considered in determining Medicaid eligibility for the FU/BU.

Resources of each member of a FU/BU are evaluated using the rules in this chapter. Resource eligibility is determined by comparing the countable resources to the appropriate limit based on the composition of FU/BU. The policy governing the formation of the FU/BU is contained in M05.

B. Policy Principles

1. Monthly Determinations

Eligibility with respect to resources is a determination made for each calendar month, beginning with the third month prior to the month in which the application is received. *Resource eligibility exists for the full month if countable resources were at or below the applicable resource limit for any part of the month. If resource amounts reported are reasonably compatible with values received from electronic verification sources, the evaluation can continue. If reported resource amounts and verified resource amounts are both below the established limit, resource eligibility is assumed to exist. If both amounts are over the resource limit, additional verification may be needed – must check for exclusions. In all situations, the sources of the resources do not need to match.*



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2. Countable Resources

Any assets that are resources but are not specifically excluded by policy are countable resources. Only countable resources are used to determine resource eligibility. See:

- M0610.002 for the resource limits;
- M0610.100 for the distinction between assets and resources;
- M0630.100 for a listing of exclusions.

3. Whose Resources Must Count

For MN eligibility, Medicaid law requires that resources are only considered available between spouses and from parents to their children under age 21 who live at home.

4. Whose Resources *Do Not* Count

Medicaid law does not allow certain resources to be considered in determining eligibility. Do not count resources:

- from a step-parent to a step-child;
- from siblings to siblings;
- from child to parent;
- from parent *when the child is between 18 and 21 and meets the 300% SSI covered group;*
- from spouse *when the spouses are living apart and neither spouse meets the definition of an institutionalized individual with a community spouse in M1480;*
- from an alien sponsor.

For an individual between the ages of 18 and 21 who meets the F&C 300% SSI covered group, the resources of a parent are not counted. Children under age 18 in the F&C 300% SSI covered group are not subject to a resource test.

For married individuals who meet the F&C 300% SSI covered group, see subchapter M1480.

5. Total Countable Resources

The total value of the countable resources owned or deemed available to all FU members are counted in determining the resource eligibility of each FU member.

The total value of the countable resources owned or deemed available to all BU members is counted in determining the resource eligibility of each BU member.

6. Resource Eligibility

If the total countable value of the FU/BU's countable resources are at or below the resource limit at any point during the application month, retroactive month, or a month in which the case is pending, resource eligibility exists for that month.

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7. Excess Resources

After determining countable resources in accordance with B.2 through *B*.5 above, if the family unit has resources other than the excluded items listed in M0630 totaling more than the allowable resource limit, determine if budget units can be formed. See Budget Unit rules in M0520. If BUs cannot be formed, or the BU's countable resources exceed the resource limit, resource eligibility does not exist.

If the FU/BU has a real property resource, see M0630.105 and M0630.110 for reasonable effort to sell real property.

8. Income Not Resources

When determining the value of resources available to the family/budget unit, do not consider any income as a resource in the month in which it is received.

M0610.002 RESOURCE LIMITS

A. Introduction

A separate resource limit is set for each Medicaid classification. A resource limit is the maximum dollar amount of countable resources a FU or BU may own and the individuals within that unit be eligible for Medicaid.

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B. Policy Principles

1. Resource Eligibility

A FU or BU with countable resources equal to or less than the resource limit applicable to the individual's covered group classification is resource eligible. A FU or BU with countable resources in excess of the limit applicable to the individual's covered group classification is not eligible for Medicaid.

2. Resource Limits

F&C Classification	Limit
Categorically Needy	$1000 for the FU or BU
Medically Needy	$2000 for one person $3000 for two persons and $100 for each additional person in the FU or BU

M0610.100 DISTINCTION BETWEEN ASSETS AND RESOURCES

A. Introduction

Everything an individual owns is an asset. A resource is an asset the individual owns, has the right, authority, or power to convert to cash, and is not legally restricted from using for his/her support and maintenance. Changes in situations may result in an asset becoming a resource or a resource becoming an asset. The distinction is important as resources may affect Medicaid eligibility and assets that are not income or resources do not affect eligibility.

B. Definitions

1. Assets

Assets are all monies received and everything owned. An asset that is not income or a resource does not impact Medicaid eligibility.

EXAMPLE: An individual has an ownership interest in property but is not legally able to transfer that interest to anyone else. This ownership interest in the property is the individual's asset but because he is legally restricted from selling it (converting it to cash), it is not a resource and it does not meet the definition of income. It remains an asset, but it is not counted in determining his financial eligibility.

2. Resources

Resources are cash and any other real and personal property that a member of the family or budget unit:

- owns;
- has the right, authority, or power to convert to cash (if not already cash); and
- is not legally restricted from using for his/her support and
- maintenance.

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NOTE: A trust may be a countable resource even though the individual does not have the authority to convert it to cash or is legally restricted from using it. See subchapters M1120.200-202 and M1140.400-404 for policy and procedures specific to determine if a trust (other than one established by a will) is a resource.

3. **Countable Resources** — Resources that are not specifically excluded by policy are countable resources.

4. **Real Property** — Real property is land, including buildings or immovable objects attached permanently to the land. (See M620.150 for a mobile home that is taxed as real property.)

5. **Personal Property** — Personal property is any property that is not real property. The term encompasses such things as cash, tools, farm and business equipment, life insurance policies, automobiles, and mobile homes taxed as personal property.

6. **Ownership** — Ownership of property by an individual means that the individual has a clear legal entitlement to the property, real or personal, or a specific portion thereof.

C. Policy

1. **Sale or Trade of an Asset** — Proceeds from the sale or trade of an asset must be evaluated as income in the month of receipt.

2. **Sale or Trade of a Resource** — Proceeds from the sale or trade of a resource are also resources. The sale or trade of a resource is converting a resource from one form to another.

3. **Increased Value** — Increases in the assessed or market value of a resource are not income.

4. **Resources with Zero Value** — Property does not cease to be a resource simply because it has no current market value. Even though there is no value to count, the property remains a resource for so long as it meets the definition of a resource in B.2. above. If the property develops a market value at a later time, this is an increase in the value of a resource, not a receipt of income.

M0610.200 UNKNOWN ASSETS

A. Policy — Real or personal property the FU/BU is unaware of and had no reason to be aware of is not considered an available resource for the period of time the unit can demonstrate it did not know or had no reason to know about the property. Once the unit becomes aware or has reason to become aware of the existence of the resource, it is considered available to the unit.

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B. Development and Documentation

The family/budget unit has the burden of proving that the members of the unit were unaware of and had no reason to be aware of the resource.

- Obtain a signed statement from the applicant/recipient or authorized representative.
- Obtain supporting documentation including (but not limited to) signed statements from other individuals who are familiar with the individual's situation.

M0610.400 WHAT VALUES TO APPLY TO RESOURCES

A. Introduction

The countable value of a resource is the owner's pro rata share of the equity value. The equity value is the fair market value minus encumbrances (legal debts) against the property. This section contains the procedures for determining the fair market values, equity values, and the countable values of resources.

B. Policy

The value of an asset as a resource to the individual or family is the client's equity in the real or personal property.

C. Establishing Fair Market Value

The fair market value of a resource is determined as follows:

1. Real Property

For real property other than the home, apply the local assessment rate to the tax assessed value

2. Personal Property

For personal property (other than motor vehicles) if it is taxed, use the tax assessed value. If not taxed, obtain one statement from a knowledgeable source such as a supplier or distributor.

3. Motor Vehicles

For countable motor vehicles:

a. *Online at Get New Car Prices & Used Car Values | Find Real-world Car Costs (jdpower.com) (J. D. Powers bought NADA and now provides this information).*

d. If the vehicle is not listed *on the J.D. Powers website*, the value which is assessed for tax purposes, or

e. If the methods listed above are not available:

- *a* statement from a licensed dealer, or
- the statement of the applicant/recipient.

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D. Equity Value

Equity value (EV) is the fair market value minus encumbrances (legal debts) against the property.

E. Disputed Fair Market Value

If the applicant/recipient disagrees with the fair market value as established above, the value may be changed using the following procedures:

1. Vehicles

Advise the applicant/recipient that the fair market value can be changed if the individual provides:

- one statement from a licensed dealer, or
  if the statement is not obtainable, the statement of the applicant/recipient

2. Real or Personal Property

Advise the individual in writing that the fair market value can be changed if the individual provides:

- two written estimates from appropriate qualified parties of the resource's current fair market value, or
- the reassessed tax value of real or personal property.

3. Qualified Parties

Appropriate qualified parties for this purpose are:

- personal property - Persons deemed qualified by the agency to value the property in question.
- real property - Lending institutions, appraisers, or licensed real estate firms.

4. Revised Fair Market Value of Real or Personal Property

The revised fair market value of real or personal property is the lesser of the following:

- the average of the two estimates;
- the current agency established value; or
- the reassessed value of real or personal property.

5. Redetermination

If found eligible based on the revised fair market value, the recipient is not required to reestablish the fair market value at each redetermination.

The revised fair market value will serve as the fair market value until:

- the worker has reason to believe the fair market value has increased, or
- the value of other resources available to the recipient increases; or

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- the recipient acquires additional resources which, when combined with the established fair market value of the disputed resource, cause the total value of the FU/BU's resources to exceed the applicable resource limit.

The recipient must reestablish the fair market value of the disputed resource according to item E. 1.- 4. above.

M0610.500 OWNERSHIP

A. Introduction

The case record must contain verified information regarding ownership of property and its value, where applicable.

B. Definition

Ownership of property by an individual means the individual has a clear legal entitlement to the property, real or personal, or a specific portion thereof.

C. Shared Ownership

Assume, absent evidence to the contrary, that each owner of shared property owns only his or her fractional interest in the property. Divide the total value of the property among all of the owners in direct proportion to the ownership share held by each.

D. Property Owned by SSI Recipient

The value of any property owned by an SSI recipient living in the home is not a countable resource to individuals who meet a F&C covered group even though the SSI recipient is a child or is the parent of the child(ren) who meets a F&C covered group.

When property is owned jointly by an SSI recipient and a Medicaid applicant/recipient in the Families and Children categories, refer to:

- M0640.100 for policy on jointly owned real property,
- M0640.210 for policy on joint bank accounts, and

M0640.300 for policy on jointly owned vehicles.

M0610.600 DETERMINING ELIGIBILITY BASED ON RESOURCES

A. Policy

The value of any asset that meets the definition of a resource counts against the applicable resource limit to the extent that the instructions in M0630 do not provide for its exclusion.

The total of the countable equity value of each countable resource belonging to or deemed to a member of the family/budget unit is compared to the resource limit. The resource limit is based on the number of individuals in the FU/BU and the classification of the individuals. If the total of countable resources is less than or equal to the resource limit, the individual is eligible for Medicaid. If the total of countable resources exceeds the resource limit, the individual is not eligible for Medicaid.



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Make all resource determinations per calendar month. Resource eligibility exists for the full month if countable resources were at or below the resource standard for any part of the month. If resource amounts reported are reasonably compatible with values received from electronic verification sources, the evaluation can continue. If reported resource amounts and verified resource amounts are both below the established limit, resource eligibility is assumed to exist. If both amounts are over the resource limit, additional verification may be needed – must check for exclusions. In all situations, the sources of the resources do not need to match. If the member attests to having resources below the limit and values received from electronic sources are above the limit, additional verification should be requested.

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SUBCHAPTER 20

IDENTIFYING RESOURCES

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M0620 IDENTIFYING RESOURCES

M0620.140 TRUSTS

A. Trusts Established By a Will

For all classifications, any trust established by a will must be evaluated by the Assistant Attorney General (AAG) to determine if it is a countable resource.

B. Operating Procedure for Trusts Established by a Will

1. The applicant/recipient or authorized representative must submit the trust documents to the agency.

2. The agency must obtain such documents within the time standards established for determining initial/continuing eligibility and forward the documents to the Medicaid Regional Specialist who will consult with the Assistant Attorney General.

3. If the AAG advises that it is available without further court action, the amount of the trust must be counted as an available resource and compared to the appropriate resource limit.

4. If the AAG determines that the trust is not available, it is not a countable resource.

5. If the AAG cannot determine the availability of the trust or determines that court action is necessary to make the trust funds available, the applicant/recipient must initiate action, within 30 days of notification by the agency, to have the court release the trust funds.

Pending a determination by the court, the trust is not considered available provided the applicant/recipient demonstrates continued efforts to have the trust released.

C. All Other Trusts

For all classifications, follow policy in M1120.201.

M0620.150 MOBILE HOMES

A. Policy

A mobile home in which the applicant/recipient lives and its contents are excluded resources.

If a mobile home is not used as the applicant/recipient's home, it is a countable resource.

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B. Procedure

1. Determine if Real or Personal Property

If a mobile home is not used as the applicant/recipient's home, determine if the property is taxed as real property or taxed as personal property.

2. Establish Fair Market Value

Use policy in M0610.400 to establish the fair market value of the mobile home as real or personal property.

3. Rental Income

If the mobile home is not used as the applicant/recipient's home, but is rented, it is a countable resource and the rental income is countable.

C. References

- Income From Self-Employment, M0720.200.
- Rental Income, M0730.505.
- Reasonable Effort to Sell Real Property, M0630.105 and M0630.110.

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CHAPTER M06
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F&C EXCLUDED RESOURCES

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M0630.000 Families and Children (F&C) EXCLUDED RESOURCES

M0630.001 OVERVIEW

A. Introduction

After determining that an asset meets the definition of a resource, determine that resource's effect on eligibility. Certain resources do not count against the resource limit; i.e., they are excluded.

B. Procedure

Section M0630.100 below contains the policy and procedures for determining if an individual's resource is excluded from determining eligibility for Medicaid in an F&C covered group.

M0630.100 EXCLUDED RESOURCES

A. Identifying Excluded Resources

As long as they are identifiable, exclude the resources described in the sections below.

If any funds derived from an excluded resource are combined with other resources, the individual must provide documentation to verify the excluded amount. Otherwise, the funds must be counted in determining eligibility.

B. Types of Excluded Resources

1. Resources Owned By SSI Recipient

Resources (real and personal property) owned solely by any individual in the household who is receiving SSI are excluded from the F&C individual's eligibility determination.

When property is owned jointly by an SSI recipient and an F&C applicant/recipient, only the share of the property owned by the F&C individual is considered available.

2. Trusts

See M0620.140 to determine if a trust is excluded.

3. Sold or Transferred

When any of the excluded resources are sold or transferred into cash or other liquidable assets, these items are countable resources and will be considered in relation to the applicable resource limit.

EXAMPLE #1: Ms. C sells her excluded vehicle and receives $500 from the sale. This sum of money is a countable resource.

EXAMPLE #2: Ms. H. sells her excluded home. She receives net proceeds of $20,000. This money is a countable resource and will be considered in relation to the applicable resource limit.

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4. Life Estates

A life estate gives an individual certain property rights for the duration of his or her life, or someone else's life. A life estate in real property is not a countable resource.

C. Procedure

Sections M0630.110 through M0630.160 below contain the policy and procedures for determining whether a resource is partially or totally excluded in the resource eligibility determination.

- M0630.115 Home Property
- M0630.120 Personal Property
- M0630.125 Savings *or Other Investment* Account for *Purpose of Self-Sufficiency*
- M0630.130 Casualty Property Loss
- M0630.140 Government Program Benefits & Payments
- M0630.150 Education Assistance
- M0630.160 Indian Tribe Funds and Land.

M0630.105 REASONABLE EFFORT TO SELL FOR THE CATEGORICALLY NEEDY COVERED GROUPS

A. Policy

When ownership of real property alone, or in combination with other countable assets, causes the family/budget unit's resources to exceed the $1000 resource limit, the applicant/recipient must be given the opportunity to receive Medicaid for the otherwise eligible family/budget unit for a maximum period of nine consecutive months while efforts are being made to dispose of the real property.

B. Determining Nine Month Period

The nine-month period runs for nine consecutive months regardless of whether Medicaid is received during all of that period. For an applicant, the period begins with the first month of entitlement. For a recipient, the nine-month period begins the month in which the recipient receives the property. When it is learned that the recipient owns property which has not been reported, the nine-month period begins in the month the unit became aware or had reason to become aware of the existence of the resource.

C. Procedures

1. Written Notice

Advise the applicant/recipient, in writing:

- of the amount by which the real property exceeds the resource limit;
- that if he/she is willing to make reasonable effort to sell the property he/she is eligible for Medicaid during the nine-month period, if otherwise eligible.

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- that the disposition of the property will be evaluated as an asset transfer.

2. Good Faith Effort

The eligibility worker must:

- Explain to the applicant/recipient that agreeing to sell the property includes making good faith efforts to sell the property within a range of 10% of fair market value.
- Explore with the applicant/recipient ways to satisfy a good faith effort, which includes but is not limited to, listing the property with a real estate company, advertising in various ways, etc. Document discussion.
- Advise that failure to make good faith efforts to sell will result in ineligibility.
- Verify the good faith efforts to dispose of the property during the third and sixth months of the disposal period. Document the case record.

3. Notification of Contract

Advise the applicant/recipient to report to the agency no later than the next working day after a contract to sell the property is made.

4. Failure to Sell

If the property has not been sold in the nine-month period, the individual and family is no longer eligible in an F&C CN covered group. The family remains ineligible until the property has been disposed of or until such time as the property does not preclude eligibility.

D. One-Time Exclusion

This exclusion of property is a one-time per resource, limited exclusion. If the individual reapplies in an F&C or CN covered group and still owns the property, the property cannot be excluded under the reasonable effort to sell provision.

M0630.110 REASONABLE EFFORT TO SELL FOR THE MEDICALLY NEEDY

See policy and procedures in M1130.140

M0630.115 HOME PROPERTY

A. Policy

For all F&C classifications, the home in which the applicant/recipient lives and its contents are excluded.

If income is received from the use of the property or buildings on it, evaluate the income as earned or unearned income according to M07.

B. Definitions

1. Home

The home means the house, lot, and all contiguous property. It also means any buildings, in addition to the house, which are situated on the property.



2. Contiguous Property

Contiguous property means the land, and improvements which are not separated from the house lot by land owned by others. Streams and public rights of way which run through the property and separate it from the home will not affect the property's contiguity.

3. Other Shelter as Home Property

If the family/budget unit is using a vehicle, a boat, a camper, or another type of shelter as a home, this shelter is an excluded resource. Ownership of this resource does not affect eligibility for the period of time the family/budget unit lives in it. The month the family/budget unit moves to a house or apartment, the vehicle, boat, camper, or other shelter that the family/budget unit owns becomes an available resource and must be evaluated per M0640.

M0630.120 PERSONAL PROPERTY

A. Motor Vehicle

1. *All Groups Other Than Medically Needy (MN)*

For F&C covered groups other than MN, one motor vehicle with an equity value of $1,500 or less is excluded.

2. MN

For the MN covered groups, one vehicle of any value is excluded.

B. Income-producing Farm or Business Equipment

For all classifications, income producing farming and business equipment is excluded. If farm or business equipment is not producing income, it is countable personal property.

C. Tools and Equipment

For all classifications, the following are excluded:

- tools and equipment belonging to a temporarily disabled member of the family/budget unit during the period of disability;
- tools and equipment belonging to an unemployed parent when such tools and equipment have been and will continue to be used for employment.

D. Life Insurance

1. *All Groups Other Than MN*

For F&C covered groups other than MN, the cash value of any life insurance policy owned by the individual or his/her spouse is counted.

2. MN

For MN covered groups, all life insurance policies on a person under age 21 years are excluded.

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Any life, retirement, or other related types of insurance policies with face values totaling $1500 or less on any one person 21 years old and over are excluded. When the face values of such policies of any one person exceed $1500, the cash surrender value of the policies is counted as a resource.

E. Burial Plots

1. All Groups Other Than MN For F&C covered groups other than MN, one burial plot per member of the family/budget unit is excluded.

2. MN All burial plots are excluded for MN.

F. EITC Refunds or Advance Payments For all classifications, Earned Income Tax Credit refunds and advance payments are excluded as resources in the month following the month of receipt. Any portion of the refund or advance payment retained after the month following the month of receipt is a countable resource.

G. Bona Fide Loans For all classifications, all bona fide loans are excluded, regardless of the intended use. See M0640.800.

***H. COVID-19 Relief* Payments** *COVID-19 relief payments provided under federal law* are not counted as income and are **not** counted as resources for **12 months following the month** of receipt. Interest earned on the payments is countable as income for individuals subject to a resource test per M0610.001.

M0630.121 BURIAL ARRANGEMENTS

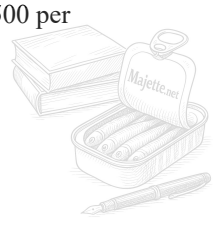
A. All Groups Other Than MN

1. Bona Fide Funeral Agreement A bona fide funeral agreement covering a family/budget unit member with a maximum equity value of $1500 per individual is excluded. A bona fide funeral agreement is a formal agreement for funeral and burial expenses, such as a revocable burial contract, burial trust, or another funeral arrangement (generally with a licensed funeral director). Passbook bank accounts, or simple "set asides" of savings for funeral expenses, and cash surrender values of life insurance policies are not bona fide funeral agreements and **are not** excluded resources.

NOTE: Funds in excess of the $1500 burial limit per individual are counted against the resource limit. See section M0640.500.

2. Irrevocable Burial Contracts Irrevocable burial contracts, regardless of value, are not counted as resources since they cannot be converted to cash by the individual.

B. MN Burial funds are excluded from resources up to a maximum of $3,500 per individual. From August 1, 1994 on, in order for resources to be disregarded under the burial funds exclusion, they must be in the



following forms:

- irrevocable burial trusts established on or after August 11, 1993;
- revocable burial trusts;
- revocable burial contracts; other revocable burial arrangements (including the value of certain installment sales contracts for burial spaces);
- cash;
- financial accounts (e.g., savings or checking accounts);
- other financial instruments with a definite cash value (e.g., stocks, bonds, certificate of deposit, life insurance policies, etc.).

Use the ABD policy and procedures in M1130.410 and M1130.420 for MN F&C groups.

M0630.125 SAVINGS OR OTHER INVESTMENT ACCOUNT FOR THE PURPOSE OF SELF-SUFFICIENCY

A. Policy

For all covered groups that have resource requirements, up to $5,000 of principal and interest in one savings or other investment account for the purpose of self-sufficiency, is excluded. Investment accounts may include but are not limited to, mutual funds, money market accounts and stock ownership.

Any excess principal and/or interest over the $5,000 limit is a countable resource.

B. Requirements

1. Must Be Kept Separate

The funds on deposit in such an account cannot be commingled with funds intended for another use.

2. More Than One Account

If the family unit has more than one savings account established for self-sufficiency, the family unit must specify which account is the excluded resource.

3. Withdrawals

Self-sufficiency expenditures may include expenses related to securing and maintaining employment, education, home purchase, vehicle purchase, starting a business or other purposes reasonably determined to promote self-sufficiency. If any amount is withdrawn from the account for any purpose other than self-sufficiency, any portion of the amount determined to be misused will be treated as a countable resource in the month following the month withdrawn, if it is retained.

C. Notification

The eligibility worker must explain the policy in this section to the applicant/recipient who has one of these accounts.

D. Documentation

When a savings or investment account established for the purpose of self-sufficiency is first reported or discovered, the agency must verify the amount in the account and obtain a written statement from the applicant/recipient which includes the purpose of the account. The balance must be verified at application and redetermination.



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M0630.126 WALKER V. BAYER SETTLEMENT PAYMENTS

A. Policy

Section 4735 of the Balanced Budget Act of 1997 (P.L. 105-33) states that payments described in this subsection from the settlement of the Susan Walker v. Bayer Corp., et.al., class action lawsuit are NOT counted as resources in determining eligibility for Medicaid. Payments described in this subsection are:

1. payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corp., et.al., 96-C-5024 (N.D.III.); and

2. payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement of Walker v. Bayer Corp., et.al., and that is signed by all affected parties on or before the later of

   X December 31, 1997, or

   X the date that is 270 days after the date on which such release is first sent to the persons to whom the payment is to be made.

To be excluded as a resource, the Walker v. Bayer funds cannot be commingled with other funds.

The interest earned on these funds is NOT excluded.

B. Development & Documentation

Information received by claimants in this lawsuit shows that claimants can choose to receive the payment in one of three ways - in a lump sum, a structured settlement, or a special needs trust. Regardless of which form the individual chooses, the payment(s) are excluded if the requirements in subsection A above are met AND the payments are held in a separate account or financial instrument. To be excluded as a resource, the Walker v. Bayer funds cannot be commingled with other funds.

1. Verification

Verify the source of the funds from a letter from the individual=s attorney or a copy of the check which identifies the payor as a Walker v. Bayer settlement account. Verify by deposit records that all the funds deposited in the account or financial instrument were from the Walker v. Bayer settlement.

2. Count the Interest Earned

Exclude only the Walker v. Bayer payment amounts that were deposited. Any interest earned on these funds must be evaluated as unearned income in the month of receipt and as a resource thereafter.

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M0630.130 CASUALTY PROPERTY LOSS PAYMENTS

A. Policy

For all classifications, cash and in-kind items received for the repair or replacement of lost, damaged, or stolen resources may be excluded for up to 12 months.

In situations involving casualty property loss payments for the repair or replacement of damaged/lost resources, such payments will not be considered resources if the recipient:

- initiates action to repair or replace the resource prior to or within 30 calendar days after the receipt of the payment; AND
- expends the payment for such repair or replacement within 12 months after receipt; AND
- keeps the payment separate from other resources.

NOTE: If the payment is not kept separately from other resources, the lump sum policy in M0730.800 applies.

B. Development and Documentation

Verification of initiation of action to repair or replace the resource, expending the payment within 12 months, and the use of the payment must be documented in the record.

M0630.140 GOVERNMENT PROGRAM BENEFITS & PAYMENTS

A. Policy

For all classifications, certain government benefits and payments are excluded resources.

B. Excluded Benefits and Payments

1. *SNAP*

The value of the food coupons under the *Supplemental Nutrition Assistance Program (SNAP) (formerly* Food Stamps) is excluded.

2. USDA Commodities

The value of foods donated under the U.S.D.A. Commodity Distribution Program is excluded.

3. Child Nutrition Act

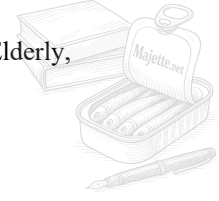
The value of supplemental food assistance received under the Child Nutrition Act of 1966 is excluded. This includes all school meal programs, the Women, Infants and Children (WIC) Program and the Child Care Food Program.

4. Relocation Assistance

Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 is excluded.

5. Older Americans Act

Any benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965, as amended, is excluded.



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6. Domestic Volunteer Service Act

Payments to VISTA volunteers under Title I, when the monetary value of such payments is less than minimum wage as determined by the director of the Action Office, and payments for services or reimbursement for out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and other programs pursuant to Titles II and III, of Public Law 93-113, the Domestic Volunteer Service Act of 1973 are excluded.

The worker must contact the Action Office at the following address or telephone number when VISTA payments are reported: Action Office, 400 N. 8th Street, Richmond, Virginia 23219, (804) 771-2197.

7. Support Disregards

Disregarded support payments, if retained following the month of receipt, are excluded resources. See M0730.

8. Disaster Relief

Federal major disaster and emergency assistance provided under the Disaster Relief and Emergency Assistance Amendments of 1988 and disaster assistance provided by state and local governments, and disaster assistance organizations (Public Law 100-707) are excluded.

9. Payments to Japanese Ancestry & Aleuts

Payments received by individuals of Japanese ancestry under the Civil Liberties Act of 1988, and by Aleuts under the Aleutian and Pribilof Islands Restitution Act (Public Law 100-383) are excluded.

10. Agent Orange

Any payment received from the Agent Orange Settlement Fund or any other fund established in response to the Agent Orange product liability litigation is excluded. To verify whether a payment is an Agent Orange payment, use documents in the individual's possession. If the individual cannot provide verification or the situation is unclear, write to the Agent Orange Veteran Payment Program, P. O. Box 110, Hartford, CT 06304, Attention: Agent Orange Verification. Include in the request the veteran's name and social security number. If a survivor of the qualifying veteran was paid, also provide the survivor's name and social security number.

11. Radiation Exposure Compensation

Payments received by individuals under the Radiation Exposure Compensation Act (Public Law 101-426) are excluded.

12. Certain HUD Funds

Funds in an escrow account established under the Family Self-Sufficiency Program of the Department of Housing and Urban Development are excluded.

13. Victims of Nazi Persecution

Payments received by victims of Nazi persecution under Public Law 103-286 are excluded.

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M0630.150 EDUCATION ASSISTANCE

A. Policy

For all classifications, certain types of education assistance payments are excluded resources.

B. Excluded Education Assistance

1. Programs Administered By U.S. Secretary of Education

Any grant or loan to any undergraduate student for educational purposes made or insured under any program administered by the U.S. Secretary of Education is excluded. Programs that are administered by the U.S. Secretary of Education are:

- Pell Grants,
- Supplemental Educational Opportunity Grant,
- Perkins Loan,
- Guaranteed Student Loans (including the Virginia Education Loans),
- PLUS Loans,
- Congressional Teachers Scholarship Program,
- College Scholarship Assistance Program,
- Virginia Transfer Grant Program.

2. Programs Under Title IV of Higher Education Act

Student financial assistance received under Title IV of the Higher Education Act is excluded. Assistance excluded under this provision, whether awarded to an undergraduate or graduate student, includes but is not limited to:

- Pell Grants,
- Supplemental Educational Opportunity Grants,
- State Student Incentive Grants,
- Federal College Work-Study Programs,
- Perkins Loans (formerly National Direct Student Loans), and
- Guaranteed Student Loans (including PLUS loans and Supplemental Loans for Students).

3. Student Assistance Under Public Law 101-392

Student financial assistance received under the Carl D. Perkins Vocational and Applied Technology Education Act made available for attendance costs (Public Law 101-392) is excluded. Attendance costs are defined below:

a. tuition and fees normally assessed a student carrying the same academic workload as determined by the institution, including costs for rental or purchase of any equipment, materials, or supplies required of all students in the same course of study; and

b. an allowance for books, supplies, transportation, dependent care, and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution.

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4. BIA Student Assistance Student financial assistance received under Bureau of Indian Affairs (BIA) Student Programs is excluded.

C. Documentation Obtain verification of the source of the education assistance through the school.

M0630.160 INDIAN TRIBE FUNDS & LAND

A. Policy For all classifications, certain types of Indian funds and land are excluded resources.

B. Excluded Funds and Land

1. Funds and Distributions Any funds distributed to, or held in trust for, members of any Indian tribe under the following Public Laws are excluded:

- Public Law 92-254,
- Public Law 93-134,
- Public Law 94-540,
- Public Law 98-64,
- Public Law 98-123,
- Public Law 98-124,
- Public Law 97-458.

Additionally, interest and investment income accrued on such funds while held in trust, and purchases made with such interest and investment income, are excluded.

2. Native Corporations Under P.L. 100-241 The following types of distributions received from a Native Corporation under the Alaska Native Claims Settlement Act (Public Law 100-241) are excluded:

a. Cash (including cash dividends on stock received from a Native Corporation) to the extent that the total received does not exceed $2,000 per individual per calendar year;

b. Stock (including stock issued or distributed by a Native Corporation as a dividend or distribution on stock);

c. A partnership interest;

d. Land or an interest in land (including land or an interest in land received from a Native Corporation as a dividend or distribution on stock); and

e. An interest in a settlement trust.

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3. Maine Indians & Micmacs Settlement Acts

Funds received pursuant to the

- Maine Indians Claims Settlement Act of 1980 (Public Law 96-420), and
- Aroostook Band of Micmacs Settlement Act (Public Law 102-171)

are excluded.

4. Income From Submarginal Land

Income derived from certain submarginal land of the United States which is held in trust for certain Indian tribes (Public Law 94-114) is excluded.

C. Documentation

Obtain verification of the type of Indian funds or land through the tribal council.

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CHAPTER M06
FAMILIES AND CHILDREN RESOURCES
SUBCHAPTER 40

TYPES OF COUNTABLE RESOURCES

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M0640 Changes

Changed With	Effective Date	Pages Changed
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	8/1/2000	Page 3
	12/1/2003	TOC, Pages 1, 4, 5, 6,
	1/1/98	Page 2

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M0640.000 TYPES OF COUNTABLE RESOURCES

M0640.001 OVERVIEW

A. Introduction

This subchapter contains instructions for the development of resources whose value ordinarily will count toward the resource limit. Use these instructions only after you have made certain that the asset:

- is a resource, based on instructions in the M0610 subchapter; and
- is not an excluded resource, based on instructions in the M0630 subchapter.
- *The reported values of the resources are not reasonably compatible with electronic sources AND below the resource limit. In all situations the sources of the resources do not have to match. See M0610.001.*

NOTE: A trust may or may not be a countable resource. See M0620.140 to determine if a trust established by a will is a countable resource. For all other trusts, see M1120.201.

NOTE: If the individual is a married institutionalized individual, go to subchapter M1480.

REAL PROPERTY

M0640.100 NON-HOME REAL PROPERTY

A. Definition

Non-home real property consists of land and buildings or immovable objects that are attached permanently to the land and that do not meet the definition of a home (house, lot and all contiguous property).

B. Development and Documentation of Fair Market Value

Ascertain fair market value from the Commissioner of Revenue or Assessor's Office.

C. Ownership/Value

1. Sole Owner

If the applicant/recipient is the sole owner, the property is a resource.

If the applicant/recipient is the sole owner with a living spouse, the property is a resource to the applicant/recipient regardless of the spouse's willingness to join in a deed to sell the property.

2. Tenants by Entirety

If the property is held by the applicant/recipient and spouse as tenants by the entirety with survivorship at common law:

a. When the applicant/recipient and spouse are living together, the property is a resource regardless of the spouse's consent to sell.

When the spouses live apart, if the separated spouse gives consent to dispose of property, one-half of the total value of the property is



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considered a resource to the applicant/recipient. If the separated spouse does NOT give consent to dispose of property, **none** of the property is counted as a resource to the applicant/recipient.

b. If a decree of divorce has been entered, one-half of the total value of the property is considered a resource.

c. If the spouse is deceased, *the* total value of the property is a resource.

d. If the non-applicant spouse cannot be located by the agency or if that spouse refuses to cooperate with the agency, he/she is considered unwilling to give his/her consent to sell the property or to join in a deed and the property is not a resource. Document the case record regarding the separated spouse's refusal to cooperate or the agency's inability to locate the applicant's spouse.

3. Tenants in Common

If the applicant/recipient jointly owns property with other than a spouse as tenants in common or joint tenants, the applicant/recipient's prorata share is considered a resource. If the joint owner refuses to join in a deed to sell the property, the estimated cost of a partition suit is deducted to determine the value of the applicant/recipient's share of the property.

a. If documentation does not clearly establish the applicant/recipient's interest in jointly owned property, the eligibility worker must contact the Medicaid Regional Specialist to obtain an interpretation from the Assistant Attorney General.

b. Deduct the estimated cost of partitioning and attorney fees in establishing equity value when the joint owner refuses to join in a deed to sell:

- Estimated costs associated with a partition suit must be based on prevailing community charges as determined by a local person having knowledge of the cost of such an action.

- Shared partition costs (commissioner's fees, survey costs, etc.) are deducted from the whole property's value.

- The individual's attorney's fees is deducted from the individual's prorata share of the property value that remains after deducting shared partition costs (and liens, if any).

- After calculation, add the remainder to other countable resources and compare the total to the resource limit for the FU/BU classification.

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M0640.110 OTHER PROPERTY RIGHTS

A. Life Estates

A life estate gives an individual certain property rights for the duration of his or her life, or someone else's life. A life estate in real property is not a countable resource.

B. Remainder Interest

When property is owned by one party and a second party has a life estate or "life rights" to the property, then the first party has a remainder interest in the property. A remainder interest is a countable resource.

To determine the fair market value of a remainder interest in property, multiply the tax assessed value of the property by the fraction corresponding to the age of the individual who has life rights. M0640, Appendix 1 contains the table used to perform this calculation.

M0640.200 CASH AND LIQUID ASSETS

A. Policy

Cash held by the individual is a resource. Money in a financial institution is a liquid asset and is a resource. Absent evidence to the contrary, assume that the person designated as the owner on the account owns all the funds in the account and has the right to withdraw funds from the account.

Interest received is treated as income in the month received and as a resource thereafter.

B. Development and Documentation

1. Document, in addition to the balances themselves:

   - the name and address of the financial institution;
   - the account number(s); and
   - the exact account designation.

2. Cash and liquid assets can be verified by documentation in the individual's possession such as: savings account book, bank statement, trust agreements, or affidavits.

3. Other acceptable verification includes bank clearances, credit union records, savings and loan records, and joint bank account statements.

4. When it is necessary to request account information from a financial institution, have the individual sign an authorization for the release of the information.

M0640.210 JOINT BANK ACCOUNTS

A. Policy

If it is established that an applicant/recipient, owns a joint bank account with another party and that all funds in the joint account belong to the other party, and the account was established for the convenience of the other party, it is not considered a resource to the applicant/recipient.

If it cannot be established that all the funds in the account belong to the other party, the applicant/recipient's pro rata share will be considered the



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resource.

B. Development and Documentation

Verify ownership of the account by a statement from both parties. If a statement of ownership cannot be obtained from both parties, assume the applicant/recipient owns a pro rata share of the account. For example, if the account is owned by the applicant/recipient and one other individual, the applicant/recipient's pro rata share is one-half.

M0640.300 MOTOR VEHICLES

A. Policy

1. *All Groups Other Than MN*

One motor vehicle owned by the FU/BU with an equity value up to $1500 is excluded. Any equity value above $1500, is a countable resource.

2. MN

One vehicle of any value is an excluded resource.

3. Used as a Home

For all classifications, if the FU/BU is using a vehicle, a boat, or a camper as a home, the vehicle is excluded for the period of time the FU/BU lives in it. The month that the FU/BU moves to a house or an apartment the vehicle, boat, camper, or other shelter that the FU/BU owns becomes an available resource and must be evaluated.

B. Value of Vehicle

1. Listed in NADA

The average trade-in value listed in the current NADA Official Used Car Guide or the average trade-in value listed in the NADA Official Older Used Car Guide is considered the fair market value from which encumbrances must be deducted in order to establish equity value. Do not adjust the average trade-in value amount specified in the NADA guides for optional features, special equipment for the handicapped, mileage, condition, operability, etc.

2. Not Listed in NADA

If a motor vehicle is not listed in the current NADA Guide, or the Older Used Car Guide, the applicant/recipient may provide a statement of assessment for tax purposes which contains the value of the vehicle in order to establish the equity value.

3. Licensed Dealer's Statement

If a tax assessment statement is not available, the applicant/recipient can provide a licensed dealer's statement in order to establish the value. It is the responsibility of the applicant/recipient to obtain this licensed dealer's statement, but if assistance is requested, the EW must contact a licensed dealer to ascertain the fair market value.

4. Re-verification of Equity Value

Re-verify the motor vehicle's equity value only at redetermination unless the recipient reports a change in equity value before redetermination.

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5. ***Disputed Value*** *If the applicant/recipient disagrees with the fair market value established by the agency, the individual must be given an opportunity to dispute the finding and provide the agency with a written statement of the value from a disinterested knowledgeable source, such as a used car dealer.*

If eligibility is established using the revised vehicle value, the value of the vehicle is not re-verified at subsequent redeterminations.

C. Ownership of Two or More Vehicles

1. ***All Groups Other Than MN*** If two or more motor vehicles are owned by the family/budget unit, the motor vehicle with the highest equity value will be excluded up to $1,500.
The equity value in all other vehicles plus the equity *value* above $1500 in the excluded vehicle is combined and is counted as a resource.

2. **MN** *If more than one vehicle is owned, the individual's vehicle with the highest equity value is excluded. The equity value in all other vehicles must be counted*. The value used for countable vehicles is the average trade-in value listed in NADA Guide. In the event the vehicle is not listed, the value assessed by the locality for tax purposes may be used.

D. Motor Vehicles Jointly Owned If a motor vehicle is owned jointly by a member of the family/budget unit with any individual not in the family/budget unit, the agency must establish whether or not the non-member is willing to sell the vehicle(s). If the non-member is willing to sell, the family/budget unit member's prorata share of the equity is considered an available resource.

If it is established that the non-member is not willing to sell, then the vehicle(s) is not counted as a resource. The non-member's refusal to cooperate with the agency or the agency's inability to locate the non-member is considered his/her unwillingness to sell the property.

M0640.400 LIFE INSURANCE

A. Policy

1. ***All Groups Other Than MN*** A life insurance policy is a resource if it generates a cash surrender value (CSV). Its value as a resource is the amount of the CSV.

All life insurance policies on a person under age 21 years are excluded.

2. **MN** Any life, retirement, or other related types of insurance policies with face values totaling $1,500 or less on any one person 21 years old and over are excluded. When the face values of such policies of any one person exceed $1,500, the cash surrender value of the policies is counted as a resource.

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B. Development and Documentation

Verify the availability and the cash value of the policy by contacting the insurance companies or examining the policies of all family/budget unit members.

M0640.500 BURIAL ARRANGEMENTS FOR COVERED GROUPS *OTHER THAN MN*

A. Policy

A bona fide funeral agreement covering a family/budget unit member, with a maximum equity value of $1,500 per individual is excluded. A bona fide funeral arrangement is a formal agreement for funeral and burial expenses, such as a revocable burial contract, burial trust, or another funeral arrangement (generally with a licensed funeral director). Passbook bank accounts, or simple "set asides" of savings for funeral expenses, and cash surrender values of life insurance policies are not bona fide funeral agreements and **are not** excluded resources. See M0630.121.

B. Excess Funds

Funds in excess of the $1,500 per individual limit are counted against the resource limit.

C. Irrevocable Contracts

Irrevocable burial contracts, regardless of value, are not counted as resources since they cannot be converted to cash by the individual.

M0640.510 BURIAL ARRANGEMENTS FOR THE MEDICALLY NEEDY

A. Policy

Burial funds are excluded from resources up to a maximum of $3,500 per individual. From August 1, 1994 on, in order for resources to be disregarded under the burial funds exclusion, they must be in the following forms:

- irrevocable burial trusts established on or after August 11, 1993;
- revocable burial trusts;
- revocable burial contracts;
- other revocable burial arrangements (including the value of certain installment sales contracts for burial spaces);
- cash;
- financial accounts (e.g., savings or checking accounts);
- other financial instruments with a definite cash value (e.g., stocks, bonds, certificate of deposit, life insurance policies, etc.).

B. Reduction of Burial Exclusion

The maximum exclusion amount is reduced by:

1. the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources; and

2. the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting



the individual's or his spouse's burial expenses when that trust, contract, or other arrangement is not a countable resource.

C. Development and Documentation Use the ABD policy and procedures in M1130.410 and M1130.420 for medically needy F&C groups.

M0640.800 LOANS

A. Policy All bona fide loans are excluded, regardless of intended use. Loans may be from a private individual as well as from a commercial institution.

If the applicant/recipient indicates that money received was a loan, but does not provide required verification, the money is unearned income in the month received and a resource thereafter.

B. Bona Fide A simple statement signed by both parties indicating that the payment is a loan and must be repaid is sufficient to verify that a loan is bona fide.

C. Used to Purchase Resource Any resource purchased with the proceeds of a loan must be evaluated to determine if the resource is totally or partially excluded according to resource policy in M06.

D. Encumbrance Against Property When a bona fide loan is used to purchase real or personal property, the amount owed on the loan is considered an encumbrance against the property if the loan is a recorded deed of trust or lien against the property.

E. Interest on Proceeds of a Loan Interest earned on the proceeds of a loan while held in a savings account, checking account, or other financial instrument are counted as unearned income in the month received and a resource thereafter.

M0640.900 CHILD SUPPORT REFUNDS

A. Policy Refunds of child support from the Division of Child Support Enforcement (DCSE) identified as closed case refunds are countable resources.

B. Reference M0730.400

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AGE	REMAINDER	AGE	REMAINDER	AGE	REMAINDER
0	.02812	40	.08429	80	.56341
1	.01012	41	.08970	81	.58033
2	.00983	42	.09543	82	.59705
3	.00992	43	.10145	83	.61358
4	.01019	44	.10779	84	.63002
5	.01062	45	.11442	85	.64641
6	.01116	46	.12137	86	.66236
7	.01178	47	.12863	87	.67738
8	.01252	48	.13626	88	.69141
9	.01337	49	.14422	89	.70474
10	.01435	50	.15257	90	.71779
11	.01547	51	.16126	91	.73045
12	.01671	52	.17031	92	.74229
13	.01802	53	.17972	93	.75308
14	.01934	54	.18946	94	.76272
15	.02063	55	.19954	95	.77113
16	.02185	56	.20994	96	.77819
17	.02300	57	.22069	97	.78450
18	.02410	58	.23178	98	.79000
19	.02520	59	.24325	99	.79514
20	.02635	60	.25509	100	.80025
21	.02755	61	.26733	101	.80468
22	.02880	62	.27998	102	.80946
23	.03014	63	.29304	103	.81563
24	.03159	64	.30648	104	.82144
25	.03322	65	.32030	105	.83038
26	.03505	66	.33449	106	.84512
27	.03710	67	.34902	107	.86591
28	.03938	68	.36390	108	.89932
29	.04187	69	.37914	109	.95455
30	.04457	70	.39478		
31	.04746	71	.41086		
32	.05058	72	.42739		
33	.05392	73	.44429		
34	.05750	74	.46138		
35	.06132	75	.47851		
36	.06540	76	.49559		
37	.06974	77	.51258		
38	.07433	78	.52951		
39	.07917	79	.54643		

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CHAPTER M07

FAMILIES AND CHILDREN INCOME

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TN #DMAS-17	7/1/20	Table of Contents, page i
Transmittal (TN) #DMAS-1	6/1/16	Table of Contents, pages i and ii

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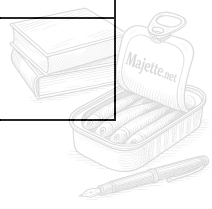
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GENERAL F & C INCOME RULES

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M0710 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-35	7/1/25	Page 2 ; Appendices 2 and 3
TN #DMAS-32	7/1/24	Appendices 2 and 3
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TN #DMAS-24	7/1/22	Appendices 2 and 3
TN #DMAS-20	7/1/21	Appendix 2 Appendix 3
TN #DMAS-17	7/1/20	Appendix 2 Appendix 3
TN #DMAS-14	10/1/19	Pages 1, 2, 7, 8 Page 2a was added as a runover page.
TN #DMAS-13	7/1/19	Appendix 2 Appendix 3
TN #DMAS-9	7/1/18	Appendix 2 Appendix 3
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TN #DMAS-2	10/1/16	Appendix 2 Appendix 3
UP #11	7/1/15	Appendix 5
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TN #98	10/1/13	pages 1-4, 8, 9 Page 1a was added. Appendix 1 Appendix 3 Appendix 5
UP #9	4/1/13	Appendix 6, pages 1, 2 Appendix 7
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TN #95	3/1/11	Appendix 6, pages 1, 2 Appendix 7
Update (UP) #1	7/1/09	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1



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M0710.000 GENERAL-- F&C INCOME RULES

M0710.001 OVERVIEW

A. Introduction

Medicaid is a needs based program. Two financial criteria, income and resources, are used to determine if a person is in need and is financially eligible for Medicaid. The income eligibility policies that are used for the eligibility determination depend on the individual's covered group, as well as the date of the determination.

1. Use Policies in Chapter M07

The policies in **chapter M07** apply for **all initial applications, reapplications and renewals** for the Families & Children (F&C) Medically Needy (MN) covered groups.

2. Use Policies in Chapter M04 and Chapter M07 as Directed

The income policies, procedures and income limits for Modified Adjusted Gross Income (MAGI) contained in **chapter M04** apply to the covered groups listed below.

- CN Pregnant Women & Newborn Children;
- Plan First;
- CN Child Under Age 19 (FAMIS Plus);
- Low Income Families With Children (LIFC);
- Individuals Under Age 21;
- Special Medical Needs Adoption Assistance;
- *MAGI Adults*.

The income types and verification procedures in chapter M07 are used with MAGI methodology as directed in chapter M04.

3. Use Other Policies

Income eligibility for Medicaid is not determined by the local DSS for the following F&C covered groups:

- IV-E Foster Care or IV-E Adoption Assistance Recipients;
- BCCPTA.

See subchapter M0330 for additional information about these covered groups.

B. Use of Family Units/Budget Units

Family Units (FUs) are formed to establish whose income and resources are counted in determining financial eligibility. If financial eligibility does not exist at the family unit level for one or more persons for whom Medicaid was requested and if budget unit (BU) rules permit, form BUs.

Financial eligibility is determined at the BU level for each person for whom Medicaid was requested and who was financially ineligible in the FU determination. Eligibility is not determined for an individual who was found eligible in the FU determination.

See M0520 for F&C Family Unit/Budget Unit (FU/BU) policy and procedures.

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C. Individual Income Eligibility

An individual's income eligibility is based on the total countable income available to his/her FU/BU.

Each source of income received by a member of the FU/BU is evaluated and the countable amount determined based on the policy in this chapter. The countable amount of each FU/BU member's income is added to the countable amount of the income of all other FU/BU members. That total is used to determine the income eligibility of each individual within that FU/BU. The FU/BU's total countable income is compared to the income limit that is applicable to the individual's classification and to the number of members in the FU/BU.

D. Policy Principles

1. Income

Everything an individual owns and all monies received are assets. Monies received are income in the month received when the monies are cash or its equivalent.

Income may be either earned or unearned. See M0720 for earned income and M0730 for unearned income.

2. Verification

The agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information, and information from SSA through SVES or SOLQ-I. Verification of income from available sources, including the VEC, may be used if it is dated within the previous *6* months. See M0130.001.B.3.

For all case actions effective August 26, 2022, if the income attested to by the applicant is within 20% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required. If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return.

All income other than Workforce Investment Act and the earned income of a student under age 19 must be verified. When attempts to verify income are unsuccessful because the person or organization who is to provide the information cannot be located or refuses to provide the information to both the applicant/recipient and the eligibility worker, a third party statement, a collateral contact, or as a last resort, the applicant's/recipient's written statement can be used as verification and to determine the amount of income to be counted.

Failure of the applicant/enrollee to verify his income results in the agency's inability to determine Medicaid eligibility and the applicant/enrollee's Medicaid coverage must be denied or canceled.

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3. Converted Income

For the ongoing evaluation period, all income received more frequently than monthly must be converted to a monthly amount.

- Weekly income is multiplied by 4.3
- Bi-weekly income is multiplied by 2.15
- Semi-monthly income is multiplied by 2.

4. Available Income

Retroactive period –available income is the gross income actually received in each month in the retroactive period.

Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months. The applicant's actual gross income received in the application month may be used to determine eligibility for that month if the application is processed after the month has passed and the person is eligible only when using the actual gross income for the month.

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5. **MN - Ongoing 6 Month Income Determination Period** — MN income eligibility for the ongoing period is based on income that is anticipated to be received within the six month period beginning with the month of application.

6. **MN - Retro 3 Month Income Determination Period** — MN income eligibility for the retroactive period is based on income that was actually received in the three-month period immediately prior to the month of application.

7. **Countable Income** — Assets that meet the definition of income minus the exclusions allowed by policy are countable income. Only countable income is used to determine income eligibility. See M0720 Earned Income, M0730 Unearned Income.

8. **Whose Income is Counted** — The total countable income of all FU members is used in determining the income eligibility of each FU member. The total countable income of all BU members is used in determining the income eligibility of each BU member.

9. **Income Eligibility** — If the total amount of the FU/BU's countable income is equal to or less than the income limit for the evaluation period, income eligibility exists.

10. **Excluded Income** — State and federal policy require that certain types of income or portions of income be excluded (not counted) when determining income eligibility. See:

    - Earned Income Exclusions, M0720.500
    - Unearned Exclusions, M0730.099

11. ***F&C MN Income Limits*** — *Refer to M0710, Appendix 2 for the grouping of localities and M0710, Appendix 2 for the MN income limits.*

M0710.*002* NET COUNTABLE INCOME

A. Policy Principle — Income is

- cash, or
- its equivalent unless specifically listed in M0715 as not being income.

B. Available Income — Retroactive period –available income is the gross income actually received in each month in the retroactive period.

Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months. The applicant's actual gross income received in the application month may be used to determine eligibility for that month if the application is processed after the month has passed and the person is eligible only when using the actual gross income for the month.

C. Net Countable Income — Net countable income is all money, both earned and unearned, which is available to the members of the FU/BU, after portions specifically excluded and all amounts that are not income are subtracted.



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M0710.*003* INCOME EXCLUSIONS

A. Introduction Medicaid eligibility is based on countable income. See M0710.003 for the definition of countable income. In determining countable income, apply any income exclusions. Some exclusions totally negate the amount of income received. Other exclusions reduce the amount counted.

B. Definition Excluded income is an amount which is income but does not count in determining eligibility.

C. Policy Principles Some Federal laws other than the Social Security Act prohibit counting some income for Medicaid purposes. Section 402(a) of the Social Security Act provides for several income exclusions in determining countable income for Medicaid purposes.

D. References

- Earned income exclusions, M0720.500
- Unearned income exclusions, M0730.099

M0710.010 RELATIONSHIP OF INCOME TO RESOURCES

A. Policy In general, anything received in a month from any source is income to an individual, subject to the definition of income in M0710.003.

Anything the individual owns in the month under consideration is subject to the resource counting rules.

An item received in the current month is income for the current month only. If held by the individual until the following month, that item is subject to resource counting rules.

B. References

- Definition of Resources, M0610.100
- Conversion or sale of a resource, M0715.200
- Casualty property loss payments, M0630.650
- Lump sums, M0730.800

M0710.015 TYPES OF INCOME

A. Policy Principle Income is either earned or unearned, and different rules apply to each.

B. Types of Income

1. Earned Income Earned income consists of the following types of payments:

- wages;
- salaries, and/or commissions;
- profits from self employment; or
- severance pay.

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2. Unearned Income

Unearned income is all income that is not earned income. Some types of unearned income are:

- annuities, pensions, and other periodic payments;
- alimony and support payments;
- dividends, interest, and royalties; or
- rental income.

C. References

- Definition of net countable income, M0710.003
- Earned income, M0720
- Unearned income, M0730

M0710.030 WHEN INCOME IS COUNTED

A. Policy Principles

For applications and reapplications, the income generally to be counted is the income verified for the calendar month prior to the month of application or the most current equivalent (last 4 weekly pays, last 2 bi-weekly pays, or last 2 semi-monthly pays). When evaluating eligibility for a retroactive period, income eligibility is based on income actually received each month in the retroactive period.

For redeterminations, the income generally to be counted is the income verified for the month prior to the month of review or the most current equivalent.

B. Exceptions to Policy Principles

1. Payment Not Received In Normal Month of Receipt

FU/BUs receiving monthly or semi-monthly income, such as state or federal payments or semi-monthly pay checks, must have the income assigned to the normal month of receipt even if mailing cycles, weekends or holidays cause the income to be received in a different month.

EXAMPLE #1: The applicant/enrollee is employed and is paid semi-monthly on the first and sixteenth. Because June 1 falls on a Saturday, the client receives her June 1 paycheck on May 31. The Eligibility Worker will count the paycheck received May 31 as income for June.

2. Self-Employment or Sale of Livestock or Cash Crops

Profit from the sale of livestock or cash crops, such as tobacco or peanuts, or from small businesses, such as but not limited to, vending stands, home beauty shops, or small grocery stores, is prorated on an annual basis or over the number of months in which the income is earned, whichever is appropriate. Federal farm subsidies are prorated over a 12-month period.

3. Contract Income

Guaranteed salaries paid under contract are prorated over the period of the contract even though the employee elects to receive such payments in fewer months than are covered by the contract. When the contract earnings will be received monthly over a period longer than that of the contract, the earnings must be prorated over the number of months the income is anticipated to be received.



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M0710.000 GENERAL - F & C INCOME RULES	**M0710.610**	**6**

C. References Contract Income, M0720.400
Income From Self-Employment, M0720.200

M0710.610 HOW TO ESTIMATE INCOME

A. Monthly Estimates Generally, estimate future income on a monthly basis.

1. Anticipated Income Anticipated income means any income the applicant/*enrollee* and local agency are reasonably certain will be received during the month. If the amount of income or when it will be received is uncertain, that portion of the FU/BU's income that is uncertain is not counted by the local agency. Reasonably certain means that the following information is known:

- who the income will come from,
- in what month it will be received, and
- how much it will be (i.e. rate, frequency and payment cycle).

2. Fluctuating Income When income fluctuates, use the previous months' actual receipts that will provide an accurate indication of the individual's future income situation. Average the income received in no more than 3 previous months.

See section M0720.155 C. for detailed information about how to estimate fluctuating income.

3. Income Expected Less Than Once a Month Determine the specific month(s) of receipt and use the amount(s) estimated for the appropriate month(s).

4. Converting to Monthly Totals To estimate income for an income evaluation, convert to a monthly amount:

- multiply average weekly amounts by 4.3
- multiply average bi-weekly amounts by 2.15
- multiply semi-monthly amounts by 2

5. Partial Month Income If the FU/BU will receive less than a full month's pay, use the exact monthly figure or an average per pay period times the actual number of pays. If actual income is used in any given calculation, adjust the figure for subsequent months if the actual income varies.

6. Examples

a. Example #2

The client's weekly pay for the prior month was:

$220.40
$175.80
$210.00
$195.70

To obtain a monthly amount, multiply the weekly average by 4.3.

$801.90 (total of the pay stubs) divided by 4 (number of paystubs) equals $200.48 (average weekly amount).

$200.48 x 4.3 = $862.06 monthly income.



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b. Example #3

The client's bi-weekly pay for the prior month was:

$185.40
$209.50
$394.90

To obtain a monthly amount, multiply the bi-weekly average by 2.15. $394.90 (total of the pay stubs) divided by 2 (number of pay stubs) equals $197.45 (average bi-weekly amount).

$197.45 x 2.15 = $424.52 monthly income.

c. Example #4

The client's salary is $100 weekly. The pay does not vary. The client is paid every Friday.

The client reports she quit her job and will receive a final weekly paycheck on September 3. Since the client was paid for a partial month, the exact amount of $100 will be used.

d. Example #5

The client reports she quit her job on June 21. She will receive a final bi-weekly paycheck on July 5.

For the month of May, she received $190 and $220 for a total of $410. This amount is divided by two (the number of pays) to determine the average bi-weekly pay of $205. $205 is used to calculate her July Medicaid eligibility.

B. Procedure

1. When a Change Occurs

An anticipated change in income occurs when you expect an individual's income to start, to stop, or to come in at a different rate in the future.

2. How to Develop a Change

When you anticipate an increase in income, use only that income which the individual is reasonably certain he will receive.

3. Handling Changes in Income

When a change in income occurs, redetermine Medicaid eligibility. Countable earned and unearned income is only verified if *reasonable compatibility does not exist or* the applicant's attested income *or information from electronic data sources* is over the income limit for his covered group.

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C. Documentation

1. What the File Must Contain

If income verification is requested and received, verify and document the case record regarding the rate and frequency of payment (i.e., weekly, biweekly, semi-monthly, monthly, etc.) and the payment cycle (i.e., on what day the client is paid).

The case record must be documented to reflect the method used to arrive at the anticipated income.

2. Who May Provide an Estimate

Estimates of income may come from the applicant/recipient, employer, or representative.

M0710.700 DETERMINING ELIGIBILITY BASED ON INCOME

A. Locality Grouping and Income Limits

The countable income, allowing income exclusions when appropriate, is compared to the MN income limits for the locality and the number of members in the FU/BU.

Refer to M0710, Appendix 2 for the grouping of localities and M0710, Appendix 5 for the MN income limits.

B. Gross Income

Total gross income includes all gross earned income, other than Workforce Investment Act income and/or other earned income of a child under age 19 who is a student. It also includes the unearned income of all FU/BU members and any income deemed available to the family/budget unit.

C. Excluded Income

The following income is excluded when income is compared to *MN* limits:

1. Unearned Income

All unearned income specifically excluded per M0730.099;

2. Earned Income

Earned income is excluded in the following order:

- standard work exclusion of the first $90 of gross earned income for each employed member of the assistance unit whose income;
- is not otherwise exempt per M0720.520;
- child care/incapacitated adult care exclusion per M0720.540.

D. Income Eligibility

If the *verified* countable income (gross income minus above exclusions) is equal to or less than the appropriate MN limit for the locality and the number of members in the FU/BU, the FU/BU is income eligible as MN. If the countable income is in excess of the MN limit, the FU/BU must be placed on an MN spenddown following policy in chapter M13.

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GROUPING OF LOCALITIES EFFECTIVE 7/01/17

GROUP I		GROUP II	GROUP III
Counties	Madison	Counties	Counties
Accomack	Mathews		
Alleghany	Mecklenburg	Albemarle	Arlington
Amelia	Middlesex	Augusta	Fairfax
Amherst	Nelson	Chesterfield	Montgomery
Appomattox	New Kent	Henrico	Prince William
Bath	Northampton	Loudoun	
Bedford	Northumberland	Roanoke	
Bland	Nottoway	Rockingham	Cities
Botetourt	Orange	Warren	
Brunswick	Page		Alexandria
Buchanan	Patrick		Charlottesville
Buckingham	Pittsylvania	Cities	Colonial Heights
Campbell	Powhatan		Falls Church
Caroline	Prince Edward	Chesapeake	Fredericksburg
Carroll	Prince George	Covington	Hampton
Charles City	Pulaski	Harrisonburg	Manassas
Charlotte	Rappahannock	Hopewell	Manassas Park
Clarke	Richmond County	Lexington	Waynesboro
Craig	Rockbridge	Lynchburg	
Culpeper	Russell	Martinsville	
Cumberland	Scott	Newport News	
Dickenson	Shenandoah	Norfolk	
Dinwiddie	Smyth	Petersburg	
Essex	Southampton	Portsmouth	
Fauquier	Spotsylvania	*Poquoson*	
Floyd	Stafford	Radford	
Fluvanna	Surry	Richmond	
Franklin	Sussex	Roanoke	
Frederick	Tazewell	*Salem*	
Giles	Washington	Staunton	
Gloucester	Westmoreland	Virginia Beach	
Goochland	Wise	Williamsburg	
Grayson	Wythe	Winchester	
Greene	York		
Greensville			
Halifax	Cities		
Hanover			
Henry	Bristol		
Highland	Buena Vista		
Isle of Wight	Danville		
James City	Emporia		
King George	Franklin		
King & Queen	Galax		
King William	Norton		
Lancaster	Suffolk		
Lee			
Louisa			
Lunenburg			

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F&C MEDICALLY NEEDY INCOME LIMITS

EFFECTIVE 7/1/25

GROUP 1			GROUP II		GROUP III	
# of Persons in Family/Budget Unit	**Semi-Annual Income**	**Monthly Income**	**Semi-Annual Income**	**Monthly Income**	**Semi-Annual Income**	**Monthly Income**
1	*$2,460.34*	*$410.05*	*$2,838.87*	*$473.14*	*$3,690.53*	*$615.08*
2	*$3,132.06*	*$522.01*	*$3,495.33*	*$582.55*	*4,449.18*	*741.53*
3	*$3,690.53*	*$615.08*	*$4,069.08*	*$678.18*	*5,015.39*	*835.89*
4	*$4,163.71*	*$693.95*	*$4,542.24*	*$757.04*	*5,488.55*	*914.75*
5	*$4,636.86*	*$772.81*	*$5,015.39*	*$835.89*	*5,961.70*	*993.61*
6	*$5,110.01*	*$851.66*	*$5,488.55*	*$914.75*	*6,434.85*	*1,072.47*
7	*$5,583.16*	*$930.52*	*$5,961.70*	*$ 993.61*	*6,908.00*	*1,151.33*
8	*$6,150.95*	*$1,025.15*	*$6,529.48*	*1,088.24*	*7,381.18*	*1,230.19*
Each add'l person	*$635.84*	*$105.97*	*$635.84*	*$105.97*	*$635.84*	*$105.97*

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F&C 100% STANDARD OF ASSISTANCE
EFFECTIVE 7/1/25
(Used as the F&C Deeming Standard)

Group I

Household Size	Income Limit
1	*$324*
2	*486*
3	*619*
4	*752*
5	*882*
6	*995*
7	*1,120*
8	*1,257*
Each additional person add	*137*

Group II

Household Size	Income Limit
1	*$422*
2	*599*
3	*755*
4	*897*
5	*1,055*
6	*1,191*
7	*1,334*
8	*1,485*
Each additional person add	*153*

Group III

Household Size	Income Limit
1	*$632*
2	*844*
3	*1,031*
4	*1,208*
5	*1,426*
6	*1,586*
7	*1,767*
8	*1,953*
Each additional person add	*185*

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CHAPTER M07
FAMILIES AND CHILDREN INCOME
SUBCHAPTER 15

WHAT IS NOT INCOME

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M0715 Changes

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TN #DMAS-20	7/1/21	Page 2
Transmittal (TN) #DMAS-17	7/1/20	Table of Contents Page 2

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M0715 F&C WHAT IS NOT INCOME	**M0715.100**		**1**

M0715.000 *F&C* WHAT IS NOT INCOME

M0715.001 WHAT IS NOT INCOME – GENERAL

A. Introduction

Some items that an individual receives are not income because they do not meet the definition of income and others are income but are excluded by federal statutes. In making income determinations, the eligibility worker must distinguish between an asset that is income and an asset which is not income by definition. This subchapter addresses assets that are not income based on federal regulation. Only those items specifically listed in the law and regulations can be excluded from income.

B. Policy

An asset received is not income if it is not cash or its equivalent (check, money order, etc.), or if it is listed in this subchapter.

C. Documentation

Document the receipt of the assets described in this subchapter and the determination that they are not income.

Verification is limited to establishing that the monies received is of a type listed in this chapter. Verify that the money received is one of the types listed in this subchapter.

M0715.050 REIMBURSEMENTS

A. Policy

Reimbursements for out-of-pocket expenses are not countable income.

B. Types of Reimbursements

Reimbursements may include, but are not limited to, reimbursement for travel expenses such as mileage, reimbursement to the caretaker of a child for child care expenses, reimbursement for expenses incurred as a volunteer, etc.

Payments from the Department of Medical Assistance Services to Medicaid registered drivers or Health Insurance Premium Payment (HIPP) participants are reimbursements and are not income.

M0715.100 MEDICAID RECIPIENT IS AN AGENT

A. Policy

Money which belongs to another person that is handled by an individual to pay expenses for that other person is not income to the individual. The individual is acting as an agent for the other person.

B. Examples

Example 1:

Mrs. C. has a son in the Army who is currently in Germany. He sends her $250 a month to pay his car payment of $250 a month. None of this money is considered as income to Mrs. C.



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Example 2:

Mrs. X and Mrs. Y live in the same house which is rented in Mrs. X's name. Mrs. Y gives Mrs. X an established portion of the rent each month. Mrs. X adds her portion to Mrs. Y's and pays the rent. Since this is a shared shelter arrangement, Mrs. Y's portion of the rent is not considered income to Mrs. X.

M0715.200 CONVERSION OR SALE OF A RESOURCE

A. Policy

Receipts from the sale, exchange, or replacement of a resource are not income, but are resources that have changed their form.-

This includes cash or in-kind items that are provided to replace or repair a resource that has been lost, damaged, or stolen.

B. Reference

Casualty Property Loss Payments, M0630.130

M0715.270 INCOME TAX REFUNDS AND CREDITS

A. Policy

Income tax refunds and Earned Income Tax Credit payments are not income.

COVID-19 relief payments provided under federal law are considered tax credits and are not countable as income.

B. Tax Withheld Prior to Application Date

Income tax refunds are not income even if the income from which the tax was withheld or paid was received in a period prior to application for Medicaid.

M0715.350 PROCEEDS OF A LOAN

A. Introduction

Proceeds of a loan are not income to the borrower because of the borrower's obligation to repay the loan.

B. Policy

1. Loan Not Income

All bona fide loans, regardless of the intended use, are not income. This includes loans obtained for any purpose and may be from a private individual as well as from a commercial institution.

2. Documentation of Bona Fide

A simple statement signed by both parties indicating that the payment is a loan and must be repaid is sufficient to verify that a loan is bona fide.

3. Loan Not Bona Fide

If an individual indicates that money received was a loan but does not provide required verification, the money is to be treated as unearned income in the month received and a resource thereafter.

4. Interest on a Loan

Interest earned on the proceeds of a loan while held in a savings account, checking account, or other financial instrument will be counted as unearned income in the month received and as a resource thereafter.

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M0715 F&C WHAT IS NOT INCOME	**M0715.400**	**3**

M0715.370 SHELTER CONTRIBUTED

A. Policy

Shelter that is contributed is not income.

This includes payments for shelter made to a third party (such as a rental agency) in lieu of or in addition to child support, whether *the payments made in lieu of support are* based on a court order, *establishment or pending establishment of a child support order, or* a mutual voluntary agreement between the Medicaid applicant/enrollee. *The payments made to a third party are* ***not*** *counted as income.*

B. Reference

Child/Spousal Support, M0730.400

M0715.400 BILLS PAID BY A THIRD PARTY

A. Policy

Bills paid by a third party directly to a supplier are not income.

EXAMPLE: A church pays the electric company for Mrs. Brown's electric bill. This is a bill paid by a third party and is not income to Mrs. Brown.

B. Exceptions

Pending establishment of a child support obligation by the District Child Support Enforcement Office, payments made to a third party such as a day care provider or telephone company in lieu of or in addition to child support, whether based on a court order or a mutual voluntary agreement between the Medicaid applicant/recipient and the responsible person, are NOT counted as unearned income to the family/budget unit.

Third party payments made by an absent spouse in lieu of spousal support are treated as contributions in kind and are not counted as income.

C. Reference

Child/Spousal Support, M0730.400

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CHAPTER M07
FAMILIES AND CHILDREN INCOME
SUBCHAPTER 20

F & C EARNED INCOME

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M0720
Changes

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TN #DMAS-33	10/1/24	Page 7
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TN #DMAS-16	4/1/20	Page 11
TN# DMAS -14	10/1/19	Page 2
TN# DMAS -11	01/01/19	Page 4
TN #DMAS-2	10/1/16	Table of Contents, page i Pages 11, 13, 14 Appendix 1 Pages 15-19 were deleted.
TN #DMAS-1	6/1/16	Page 2
TN #98	10/1/13	Pages 6, 10
TN #94	9/01/10	Pages 5, 6
TN #91	5/15/09	Page 11

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M0720.000 F & C EARNED INCOME

M0720.001 OVERVIEW

A. Introduction

This subchapter provides policy and procedures for identifying and counting earned income.

B. Policy

1. What Constitutes Earned Income

Earned income may be received in cash and consists of:

- wages
- profit from self-employment

The source and amount of all earned income other than Workforce Investment Act and student income must be verified.

2. Earned Income Exclusions

Earned income exclusions are subtracted from the gross monthly income in determining eligibility.

C. References

- Income From Self-Employment, M0720.200
- Income From Real Property, M0720.250
- Income From Room and Board, M0720.260
- Income From Day Care, M0720.270
- Income From Small Businesses/Cash Crops, M0720.280
- *Income From Uniformed (Military) Services, M0720.290*
- Contract Income, M0720.400
- Earned Income Exclusions, M0720.500

M0720.100 WAGES -- GENERAL

A. Definition

Wages are what an individual receives (before deductions; not "take home" pay) for working as someone else's employee.

NOTE: Under certain circumstances, services performed as an employee are deemed to be self-employment rather than wages.

B. Policy

1. Kinds of Wages

Wages may take the form of:

- contract earnings
- commissions

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- pay for jury duty
- severance pay
- tips
- vacation pay
- sick pay from employer or employer-obtained insurance

2. When to Count

Wages are calculated on a monthly basis and counted at the earliest of the following points:

-
- when they are received, or
- when they are credited to the individual's account, or
- when they are set aside for the individual's use.

Absent evidence to the contrary, if FICA (Federal Insurance Contributions Act) taxes have been deducted from an item, assume it meets the definition of wages. Failure to deduct FICA taxes does not mean the income is not wages.

EXAMPLE #1:
Mrs. Green is employed by Mr. Brown who owns a small business. Mr. Brown does not deduct FICA taxes from Mrs. Green's income. Mrs. Green's income from Mr. Brown is wages.

C. Verification

For all case actions effective *August 26, 2022*, if the income attested to by the applicant is within *20%* of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required. If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return.

Verify wages, salaries, and commissions by pay stubs, pay envelopes, a written statement from the employer, or by the eligibility worker's verbal contact with the employer.

When attempts to verify income are unsuccessful because the person or organization who is to provide the information cannot be located or refuses to provide the information to both the applicant/*enrollee* and the eligibility worker, a third party statement, a collateral contact, or as a last resort, the applicant's/enrollee's written statement can be used as verification and to determine the amount of income to be counted.

Verify tips by a weekly record of the tips prepared by the employed individual.

M0720.105 INCOME FROM A CORPORATION

If a person has incorporated a self-employment enterprise either alone or with other persons and draws a salary from the business, the wages drawn are regular earned income, not self-employment income.

M0720.110 HOW TO COUNT INCOME IN THE RETROACTIVE PERIOD

When evaluating eligibility for a retroactive period, income eligibility is based on income actually received each month in the retroactive period.



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M0720.155 HOW TO ESTIMATE EARNED INCOME

A. General

Ongoing income eligibility is determined based on the income that is anticipated (expected) to be received within the ongoing evaluation period. Income received in prior periods is normally used to determine the amount of income to be received in future periods. Income from the prior period is averaged and converted to a monthly amount. That monthly amount is the amount anticipated to be received in each of the future months. New sources of income may be anticipated based on statements from the provider of the income.

B. Definitions

1. Anticipated Income

Income the individual and local agency are reasonably certain will be received during the ongoing evaluation period.

To be reasonably certain that income will be received determine:

- from whom the income will come (the provider);
- in what month and on what dates it will be received (frequency and payment cycle); and
- how much will be received (rate).

2. Fluctuating Income

Fluctuating income is earned income where neither the pay rate nor hours per pay period can reasonably be predicted.

3. **Income Base Period**

A period of time immediately prior to the month of application/ redetermination that includes one or more pay periods, or the most current equivalent {last four (4) weekly pays, last two (2) bi-weekly pays, or last two (2) semi-monthly pays} that is used to provide an accurate reflection of the individual's future income.

4. **Monthly Income**

Monthly income is the income received in an average month. An average month contains 4.3 weeks. Income received more frequently than monthly is converted to a monthly figure.

5. **Pay Period**

The time period covered by each pay check. A pay period may be weekly, bi-weekly, semi-monthly, monthly or longer periods of time.

C. Income Base Period Used

Use the income received in the month prior to the month of application/redetermination unless the prior month's income cannot by itself provide an accurate indication of anticipated income.

When the prior month's income cannot by itself provide an accurate indication of anticipated income, the applicant/recipient must be given the opportunity to provide the additional information necessary to accurately project monthly income.



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1. **Migrant Or Seasonal Farm Worker**

For migrant and seasonal farm workers, the income that is reasonably certain to be received is based on formal or informal commitments for work for an individual, rather than on the general availability of work in an area.

Base income on the information obtained from the income provider and worker judgment to determine the anticipated income. Document the file to support how the income was anticipated.

Do not base income on an assumption of optimum weather or field conditions.

2. **New or Increased Income**

Use the income provider's statement of the beginning date, the amount of income to be received, the frequency of receipt, and the day/dates of receipt to establish the amount to be received per pay period.

3. **Terminated Income**

Income from a terminated source must only be verified when it was received in a month in which eligibility is being determined *and information is not compatible with information obtained from online system searches*.

4. **Decreased Income**

Use the income provider's statement of the beginning date of the decrease, the new amount of income to be received, the frequency of receipt, and the day/date of receipt to establish the amount to be received per income period. Document the file to support how the income was anticipated.

If an employed person anticipates a decrease in wages that is not supported by evidence in the file, the individual must be advised to report the decrease as soon as it can be verified. Adjustments are made when the decrease is verified.

D. Calculating Estimated Monthly Income

1. ***Average Income***

When the income amounts received in each pay period are different, calculate the average amount of income received per pay period. Average the income received in no more than 3 previous months. Use the income received in previous months that provide an accurate indication of the individual's future income situation.

2. **Full Month's Income**

Total the income received in the Income Base Period. Divide that total by the number of pay periods in the Income Base Period. The result is the average amount to be received per pay period. If the income is received more frequently than monthly, convert the income to a monthly amount.

To convert to monthly income:

- Multiply weekly wage by 4.3; or
- multiply biweekly wage by 2.15; or
- multiply semi-monthly wage by 2.

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3. Partial Month's Income — If less than a full month's income is received or expected to be received, do not convert to a monthly amount. Use the actual amount received or expected to be received.

C. References — How to Estimate Income, M0710.610.

M0720.200 INCOME FROM SELF-EMPLOYMENT

A. Policy — Self-employment is defined as a business, farming or commercial enterprise in which the individual receives income earned by his own efforts, including his active engagement in management of property. Self-employment situations include, but are not limited to, domestic workers, day care providers including babysitters, and chore and companion service providers.

1. Salary from Corporation Owned by Individual — *If an individual has incorporated a self-employment enterprise either alone or with other persons (such as an "S-corporation"), and he draws a salary from the corporation, the wages drawn are regular earned income; they are NOT self-employment income. In such a situation, the person's share of the net worth of the corporation is a resource.*

2. Profit is Earned Income — The profit from self-employment is earned income. Profit from self-employment means the total income received, less the allowable business expenses directly related to producing the goods or services and without which the goods or services could not be produced.

B. Business Expenses

1. Definition — Business expenses are expenses directly related to producing goods or services and without which the goods or services could not be produced. *Allowable business expenses* include, but *are* not limited to, the following:

2. Expenses Included

- payments on the interest of the purchase price of, and loans for, capital assets such as real property, equipment, machinery and other goods of a durable nature;
- insurance premiums;
- legal fees;
- expenses for routine maintenance and repairs;
- advertising costs;
- bookkeeping costs.

3. Expenses NOT Included — Business expenses **do not** include:

- payments on the principal of the purchase price of, and loans for, capital assets, such as real property, equipment, machinery and other goods of a durable nature;



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- the principal and interest on loans for capital improvements of real property;
- net losses from previous periods;
- federal, state, and local taxes;
- personal expenses, entertainment expenses, and personal transportation;
- money set aside for retirement purposes.
- Depreciation of equipment, machinery, or other capital investments necessary to the self-employment enterprise *are NOT deducted in calculating profit from self-employment for covered groups that are NOT subject to Modified Adjusted Gross Income (MAGI) methodology.*

  Depreciation and capital losses ARE deducted when calculating profit from self-employment for covered groups subject to MAGI methodology (see Chapter M04).

C. Verification Verification is proof of the gross amount of income received and proof of the business related expenses. Verify gross income received and business related expenses by self-employment bookkeeping or tax records.

M0720.250 INCOME FROM REAL PROPERTY

A. Policy Income from real property is self-employment income when the individual is actively engaged in the managerial responsibilities of the income producing property. Income from real property is determined on a monthly basis except farm subsidies which are prorated over a twelve month period.

If the individual is not actively involved in the management responsibilities, income received from the property is unearned income. See M0730.505.

When income from real property is received, the case record must clearly indicate the basis for determining whether or not the individual produces it by his own efforts or whether or not he is actively engaged in management.

B. Profit Deduct the amount of the allowable business expenses from the gross income to determine profit from real property.

M0720.260 INCOME FROM ROOM AND BOARD

A. Policy Income from room and board is earned income from self-employment if the applicant/recipient produces the income from his own efforts or carries managerial responsibilities. Income from room and board is determined on a monthly basis.

B. Procedure

1. Verify Gross Income Verify gross income received by self-employment bookkeeping records.

2. Determine Profit

Deduct the amount of allowable business expense from the gross income to determine profit from self-employment.

a. Board

The profit from board is the monthly gross income from boarders less the food allowance for one person living in a group (at 100%) per boarder.

b. Room Rent

The profit from room rent is 65% of the monthly gross income received if heat is furnished, 75% of gross income if heat is not furnished.

c. Room and Board

The profit from room and board is determined by

- subtracting from the monthly gross income the food allowance for one person living in a group (at 100%) per boarder as in a. above, and
- multiplying the balance by 65% if heat is furnished, 75% if heat is not furnished.

M0720.270 INCOME FROM DAY CARE

A. Policy

Income from day care is earned income from self-employment. Income from day care is determined on a monthly basis.

B. Procedure

1. Day Care Provided in Applicant/ Recipient's Home

a. Day Care for Children Living in the Home

Verify gross monthly income by self-employment bookkeeping or tax records or a written statement from the person who pays the day care costs.

Do not deduct the cost of meals and snacks. Profit is sixty-five percent of the gross income from day care.

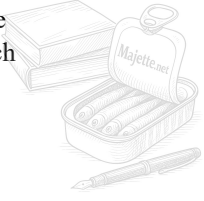
b. Day Care for Children Not Living in the Home

Verify gross monthly income by self-employment bookkeeping or tax records or a written statement from the person who pays the day care costs.

From the average monthly gross income received, deduct the cost of meals and snacks that are provided for the children. Sixty-five percent of the balance is profit from day care.

The cost of meals is determined using the following method:

- Determine the number of days in the month in which meals were provided for each child and the number of meals provided to each child per day;



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- Add to obtain the total number of meals provided for all children during the period;

- Multiply the total meals provided by 40 cents per meal to obtain monthly cost of meals provided for all children.

The cost of snacks is determined using the following method:

- Determine the number of days in the month in which snacks were provided for each child and the number of snacks provided to each child per day;

- Add to obtain the total number of snacks provided for all children during the period;

Multiply the total snacks provided by 20 cents per snack to obtain monthly cost of snacks provided for all children.

2. Day Care Provided Outside Applicant/Recipient's Home

Verify gross monthly income by self-employment bookkeeping or tax records or a written statement from the person who pays the day care costs.

Do not deduct the cost of meals and snacks. Profit is sixty-five percent of the gross income from day care.

M0720.280 INCOME FROM SMALL BUSINESSES/CASH CROPS

A. Policy

Income from the sale of live stock or cash crops, such as tobacco or peanuts, or from federal farm subsidies, or from small businesses, such as but not limited to, vending stands, home beauty shops, or small grocery stores, is earned income from self-employment.

B. Profit

To determine the profit from small businesses and cash crops, deduct the applicable business expenses directly related to producing the goods or services and without which the goods or services could not be produced.

1. Sale of Livestock or Cash Crops

The profit is prorated on an annual basis or over the number of months in which it was earned.

2. Small Businesses

The profit is prorated on an annual basis or over the number of months in which it was earned.

3. Federal Farm Subsidies

The profit is prorated on an annual basis.

C. Verification

Verify gross monthly income by self-employment bookkeeping or tax records.

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M0720.290 INCOME FROM UNIFORMED SERVICES (MILITARY)

A. Introduction

Compensation to most members of the Uniformed Services takes the form of earned income and other payments.

If the military employee receives a payment that is not listed below, contact a Medical Assistance Program Consultant for guidance.

B. Earned Income

The following forms of compensation are countable earned income:

- *basic pay,*
- *subsistence allowance (food)*
- *housing allowance (when not also listed as a deduction on the pay stub),*
- *special and incentive pay, such as bonuses, flight pay, overseas pay.*

C. Payments That Are Not Income

The following payments are not countable income for Medicaid eligibility:

- *clothing*
- *hostile fire pay (combat pay).*

Any amount of income received by or made available to household members for deployment or service in a combat zone will not count as income for Medicaid purposes ***unless the payment was received before the deployment****. This exclusion includes items such as, but not limited to, incentive pay for hazardous duty, special pay for imminent duty or hostile fire duty.*

D. Verification

The Leave and Earnings statement (LES) is the pay slip issued to military service members. The LES shows all types of compensation and deductions.

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M0720.400 CONTRACT INCOME

A. Introduction

Contract income and guaranteed wages are based on a contract between the employer and the employee. The contract specifies the period it covers and the rate and frequency of the pay the employee will receive.

B. Definitions

1. Contract Earnings

Contract earnings are wages guaranteed by a contract. This does not include work on an hourly or piecework basis or self-employment.

2. Guaranteed Wage

A guaranteed wage is one which is received by an individual employed on a contractual basis and paid over a period of time.

C. Policy

Wages received by an individual employed on a contractual basis are prorated over the period of time the contract covers even though the employee elects to receive such payments in **fewer** months than are covered by the contract.

If the income is received in **more** months than is covered by the contract, the income is prorated over the period the income is anticipated to be received.

EXAMPLES:

1. Months Wages Received = Months In Contract
A contract period is November 1997 - June 1998 (8 months). The individual chooses to receive the contract income over the eight-month period. The contract amount is divided by eight months to arrive at the monthly gross income.

2. Months Wages Received = Fewer Months Than In Contract
A contract period is September 1997 - August 1998 (12 months). The individual chooses to receive the contract income over a 10-month period. The contract amount is divided by the contract period of 12 months to arrive at the monthly gross income.

3. Months Wages Received = More Months Than Covered By Contract
A contract period is September 1997 - January 1998 (5 months). The individual receives the contract income monthly over a 12-month period. The contract amount is divided by the number of months in which the income is received (12).

D. Verification

Verify the terms of the contract by obtaining a copy of the contract.

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E. Procedures

1. Additional Earnings

When a contract specifies a set amount to be paid over the contract period, plus additional monies of an uncertain amount if additional work is available and done, only the base contract is prorated. Additional monies earned over and above the base contract are counted as income when they can be anticipated.

2. Decrease in Income

When a contract calls for no pay for those days not worked, the salary for those days should not be counted if it can be anticipated at the time that the prospective determination is made that certain days will be missed. Otherwise, the income calculation is to be based on the maximum salary. If the individual informs the local agency that days are missed, recalculate the countable monthly amount for the entire contract period.

3. Changes in Contract

If the contract amount changes during the contract period, recalculate the amount of income to be received in the contract period. To determine the new monthly income amount, divide the contract amount by the number of months in the original contract period.

EXAMPLES:

a. Decrease In Pay

A school bus driver's 12 month contract states that she will receive $1,250 for the year, but that she will not be paid for days the school is closed or for days she is sick. When she applies on February 10, she has already missed three days for snow in the contract year and she was sick for two days. The contract reads that $10 will be deducted for each day not worked. The case is approved with income of $100 per month.
($1,250 - 50 = $1,200 $1,200 / 12 = $100)

b. Increase In Pay

On December 11, the school bus driver reports that her 12 month contract which began September 1 will be increased by 10% effective January 1. The income that is anticipated to be received is recalculated for the months in the original contract period using the increased figure of $110 ($1,200 X 10% = $120; $1,200 + 120 = $1,320; $1,320 / 12 = $110
$110 will be the contract income for January - August.

EARNED INCOME EXCLUSIONS

M0720.500 GENERAL

A. Policy

The source and amount of all earned income other than Workforce Investment Act and student income must be verified; however, not all earned income counts when determining Medicaid eligibility. Federal and state laws and regulations require that certain types of earned income be totally or partially excluded when determining Medicaid eligibility.

*For covered groups subject to MAGI methodology,the earned income disregards contained in M0720 do **NOT** apply. Follow the policies and procedures in Chapter M04 for determining eligibility for MAGI covered groups.*

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B. Earned Income Exclusions

Income exclusions are applied, in the following order, to earned income for family unit/budget unit (FU/BU) members as appropriate to the covered group.

See Families and Children (F&C) Earned Income Exclusions chart in Appendix 1 to this subchapter.

1. Workforce Investment Act Income

Earned income of an eligible child (less than 18, or 18 and expected to graduate prior to 19) derived from employment in a program under the Workforce Investment Act is excluded. Do not request verification of income from employment under the Workforce Investment Act.

2. Student Income

Earned income of an individual under age 19 who is a student is excluded. Do not request verification of student income.

For this exclusion, a student is any individual under age 19 who is attending any type or level of school, part-time or full-time. Do not verify school attendance; declaration of school attendance is sufficient.

3. *2020* Census Income

Income paid by the U.S. Census Bureau to temporary employees specifically hired for the 2020 census is NOT counted when determining eligibility for medical assistance for *F&C Medically Needy covered groups.*

4. Standard Work Exclusion

A standard work exclusion of the first $90 of gross monthly earned income is excluded for each employed member of the FU/BU whose income is not otherwise exempt. See M0720.520.

5. Child Care/ Incapacitated Adult Care Exclusion

Monthly anticipated child care expenses or incapacitated adult care expenses, up to the appropriate maximums, which are paid for by the caretaker-relative must be excluded. See M0720.540.

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M0720.505 WORKFORCE INVESTMENT ACT INCOME EXCLUSION

A. Policy

Earned income of any eligible child derived from employment under the Workforce Investment Act is excluded. Do not request verification of earnings under the Workforce Investment Act.

M0720.510 STUDENT EARNED INCOME EXCLUSION

A. Policy

Earned income of a*n individual* under age 19 who is a student is excluded. Do not verify school enrollment or request verification of student earned income.

For this exclusion, a student is any individual under age 19 who is attending any type or level of school, part-time or full-time. Declaration of school attendance is sufficient for the student earned income exclusion.

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M0720.520 STANDARD WORK EXCLUSION

A. Policy The first $90 of gross earned income is excluded for each employed individual in the FU/BU whose income is not otherwise exempt regardless of when it is reported.

B. Procedure Apply this exclusion to the amount of earned income

M0720.540 CHILD CARE/INCAPACITATED ADULT CARE EXCLUSION

A. Policy

Anticipated child or incapacitated adult care expenses paid or anticipated to be paid by the family/budget unit for children or incapacitated adults in the family unit, up to the appropriate maximums, must be excluded from earned income in determining Medicaid eligibility when the expenses are necessary because of employment or seeking employment.

When both parents are in the household, both parents must be employed or seeking employment to receive the child care/incapacitated adult care exclusion. The child care/incapacitated adult care exclusion is based on a parent's employment status.

When only one parent is employed and the other parent is not employed or seeking employment and is not able to care for the child(ren) or incapacitated adult, the dependent/incapacitated adult care expense exclusion may be granted when:

1) the paid child or incapacitated adult care is necessary, **and**

2) a physician provides a statement that the parent is disabled and unable to care for the child(ren) or incapacitated adult in question. The doctor's statement must also indicate the anticipated length of time that the parent will be unable to care for the child(ren) or incapacitated adult.

B. Definitions

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

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

3. Not Employed Throughout a Month Not employed throughout a month means an individual began or terminated employment within the month.

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C. Operating Principle

1. Verification

a. Incapacity

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

b. Employment Status

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

c. Expenses

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

2. Amount of Exclusion

a. Full-time Employment

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

b. Part-time Employment

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

c. Not Employed Throughout a Month

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

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

3. Conversion to Monthly Amount

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



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FAMILIES & CHILDREN EARNED INCOME EXCLUSIONS

EXCLUSION	CRITERIA	LIMITATIONS
Workforce Investment Act M720.505	Child < age 19	None
Student Earnings M720.510	Child < age 19 in school	None
$90 Standard Work M720.520	Available for EACH person in the FU/BU whose earnings are being counted	None
Child Care/ Incapacitated Adult Care M720.540	Allowed for child or adult in FU/BU Amount based on employment status of applicant/recipient and age of child or adult = or >30 hours/week or 120 hours/month <2 years= $200 maximum per child >2 years= $175 maximum per child or adult < 30 hours/week or 120 hours/month $120 per child or adult	Allowed as long as child or adult is in FU/BU For child care, if both parents are in home, both must be employed

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CHAPTER M07
FAMILIES AND CHILDREN INCOME
SUBCHAPTER 30

F & C UNEARNED INCOME

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M0730 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-27	4/1/23	Page 1
TN #DMAS-18	1/1/21	Page 3
TN #DMAS-17	7/1/20	Page 7
TN #DMAS-14	10/1/19	Page 1
TN #DMAS-9	7/1/18	Table of Contents Pages 11, 15
TN #DMAS-4	4/1/17	Pages 7, 8
TN #98	10/1/13	Pages 7, 8 Page 8a was removed.
TN #97	9/1/12	Page 10
TN #94	9/1/2010	Pages 7, 8
TN #93	1/1/2010	Page 2
TN #91	5/15/2009	Table of Contents pages 7-8a

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M0730.000 GENERAL-- F&C UNEARNED INCOME
M0730.001 INTRODUCTION TO UNEARNED INCOME

A. Policy - General

Unearned income is all income received by members of the family/budget unit that is not earned income. Unearned income consists of:

- benefits, including public assistance benefits received from another state
- royalties
- child/spousal support
- dividends and interest
- some rental income
- gifts
- some home energy assistance
- contributions
- lump sums

B. Policy - When to Count Unearned Income

Unearned income is counted as income in the earliest month it is:

- received by the individual;
- credited to the individual's account; or
- set aside for the individual's use.

C. Available Income

Retroactive period –available income is the gross income actually received in each month in the retroactive period.

Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months. The applicant's actual gross income received in the application month may be used if the application is processed after the month has passed and the person is eligible only when using the actual gross income for the month. For all case actions as *of August 26, 2022*, attested income may be used if the requirements specified in M0730.001 E. are met.

D. Policy - What Amount of Unearned Income is Counted

The amount of unearned income received is counted as income.

EXCEPTION: When the Medicare Part B premium is deducted from the Social Security or Railroad Retirement benefits, that amount must be added to the actual benefit being received.

E. Verifications

The agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family. For all case actions effective *August 26, 2022*, if the income attested to by the applicant is within *20%* of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required.

If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return.

Verify the amount of the unearned income by an award letter or notice, a benefit payment check, or through contact with the source of the unearned income, unless the source of the unearned income is listed in M0730.099 B. Verification of unearned income that is totally excluded is not required.

F. References

What is income, M0710.003
What is not income, M0715.050
When income is counted, M0710.030
How to estimate income, M0710.610

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M0730.050 OVERVIEW OF EXCLUSIONS

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

B. Policy Exclusions never reduce unearned income below zero. No unused unearned income exclusion may be applied to earned income.

C. Procedure First determine whether what is received is income. Next apply any appropriate exclusions of unearned income listed in this subchapter.

D. Reference What is not income, M0715.050

M0730.099 GUIDE TO EXCLUSIONS

A. Introduction The following provides a list of exclusions of unearned income:

B. List of unearned income exclusions

1. Home Produce Home produce of the individual utilized for his/her family's own consumption is excluded.

2. *SNAP* *Supplemental Nutrition Assistance Program (SNAP)* (formerly *Food Stamps)* benefits are excluded.

3. Commodities The value of foods donated under the U.S.D.A. Commodity Distribution Program, including those furnished through school meal programs, is excluded.

4. Federal Relocation Assistance Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 is excluded.

5. Nutrition Program for the Elderly Any benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965, as amended, are excluded.

6. Grant or Loan Administered by U.S. Secretary of Education Any grant or loan to any undergraduate student for educational purposes made or insured under any program administered by the U.S. Secretary of Education is excluded. Programs that are administered by the U.S. Secretary of Education include: Pell Grant, Supplemental Educational Opportunity Grant, Perkins Loan, Guaranteed Student Loan, including the Virginia Educational Loan, PLUS Loan, Congressional Teacher Scholarship Program, College Scholarship Assistance Program, and the Virginia Transfer Grant Program.

7. College Work Study Programs Any funds derived from the federal College Work Study Program or any other college work study programs are excluded.

***8.* Educational Scholarships and Grants** All educational scholarships and grants are excluded.

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9. Vocational Rehabilitation Training Allowances	Training allowances (transportation, books, required training expenses and motivational allowances) provided by Vocational Rehabilitation for persons participating in Vocational Rehabilitation Programs are excluded. The exclusion is not applicable to the allowances provided by VR to the family of the participating individual.
10. SSI, TANF or Auxiliary Grant	Any portion of an SSI, TANF and/or Auxiliary Grant payment is excluded. *This includes TANF Relative Support Maintenance payments.* A VIEW Transitional Payment (VTP) is NOT TANF and is counted as unearned income.
11. VISTA Payments	Payments to VISTA Volunteers under Title I, when the monetary value of such payments is less than minimum wage as determined by the Director of the action office, and payments for services of reimbursement for out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and other programs pursuant to Titles II and III, of Public Law 93-113, the Domestic Volunteer Service Act of 1973 are excluded. The worker must contact the Action Office at the following address or telephone number when VISTA payments are reported; Action Office, 400 N. 8th Street, Richmond, Virginia 23219, (804) 771-2197.
12. VA Educational Allowances	The Veterans Administration educational amount for the caretaker 18 or older is excluded when it is used specifically for educational purposes. Any additional money included in the benefit amount for dependents is counted as income to the individual for whom intended.
13. Foster Care/ Adoption Assistance Payments	Foster care or adoption assistance payments received by anyone in the assistance unit are excluded.
14. Job Corps Payments to Eligible Children	Any unearned income received from Title IV, Part B (Job Corps) of the Job Training Partnership Act (JTPA) by an eligible child (less than 18 or 18 and expected to graduate by the end of the month in which he turns 19) is excluded as an incentive payment. However, any payment received by any other Job Corps participant or any payment made on behalf of the participant's eligible child(ren) is counted as income to the individual.
15. Fuel Assistance Program	Any payment made under the Fuel Assistance Program is excluded.
16. Child Nutrition Act	The value of supplemental food assistance received under the Child Nutrition Act of 1966 is excluded. This includes all school meal programs, the Women, Infants and Children (WIC) Program, the child care food program, and U.S.D.A. reimbursement payments to day care providers which are authorized by the National School Lunch Act.

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17. HUD Payments

HUD Section 8 and Section 23 payments are excluded.

18. JTPA Income to Eligible Children

Any unearned income received by an eligible child (less than 18 or 18 and expected to graduate by the end of the month in which he turns 19) under Title II, Parts A and B, and Title IV, Part A of the Job Training Partnership Act (JTPA) is excluded.

19. Certain Funds for Indian Tribes

Any funds distributed to, or held in trust for, members of any Indian tribe under Public Law 92-254, 93-134, 94-540, 98-64, 98-123, 98-124 or 97-458 are excluded. Additionally, interest and investment income accrued on such funds while held in trust, and purchases made with such interest and investment income are excluded.

20. Alaska Native Claims Settlement Act

The following of distributions received from a Native Corporation under the Alaska Native Claims Settlement Act (Public Law 100-241) are excluded:

a. Cash (including cash dividends on stock received from a Native Corporation) to the extent that the total received does not exceed $2,000 per individual per calendar year;

b. Stock (including stock issued or distributed by a Native Corporation as a dividend or distribution on stock);

c. A partnership interest;

d. Land or an interest in land (including land or an interest in land received from a Native Corporation as a dividend or distribution on stock); and

e. An interest in a settlement trust.

21. Income from Submarginal Land

Income derived from certain submarginal land of the United States which is held in trust for certain Indian tribes (Public Law 94-114) is excluded.

22. Child/Spousal Support Payments

The first $50 of total child or child and spousal support payments received by the family/budget unit is excluded. The $50 exclusion is only applicable to current child/spousal support payments received each month. (See M0730.400)

23. DCSE Payments of Excluded Support

Payments sent to the recipient by the State which are identified as excluded support are excluded. See M0730.400.

24. Disaster Relief

Federal major disaster and emergency assistance provided under the Disaster Relief and Emergency Assistance Amendments of 1988 and disaster assistance provided by state and local governments and disaster assistance organizations (Public Law 100-707) is excluded.



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25. Certain Payments to Japanese and Aleut

Payments received by individuals of Japanese ancestry under the Civil Liberties Act of 1988, and by Aleut under the Aleutian and Pribilof Islands Restitution Act (Public Law 100-383) are excluded.

26. ESP or VIEW Support Payments

Payments by Employment Services Program or VIEW for support services such as transportation, uniforms, child care, etc. are excluded. *VIEW Transitional Payments (VTP) are NOT excluded; VTP must be counted as unearned income.*

27. Agent Orange Payments

Any payment received from the Agent Orange Settlement Fund or any other fund established in response to the Agent Orange product liability litigation is excluded. To verify whether a payment is an Agent Orange payment, use documents in the individual's possession. If the individual cannot provide verification or the situation is unclear, write to the Agent Orange Veteran Payment Program, P.O. Box 110, Hartford, CT 06104, Attention: Agent Orange Verification. Include in the request the veteran's name and social security number. If a survivor of a qualifying veteran was paid, also provide the survivor's name and social security number.

28. Radiation Exposure Compensation Act Payments

Payment received by individuals under the Radiation Exposure Compensation Act (Public Law 101-426) is excluded.

29. Maine Indians Claims Settlement Act

Funds received pursuant to the Maine Indians Claims Settlement Act of 1980 (Public Law 96-420); and the Aroostook Band of Micmacs Settlement Act (Public Law 102-171) are excluded.

30. Higher Education Act Student Financial Assistance

Student financial assistance received under Title IV of the Higher Education Act. Assistance to be excluded under this provision, whether awarded to an undergraduate or graduate student, includes but is not limited to:

- Pell Grants,
- Supplemental Educational Opportunity Grants,
- State Student Incentive Grants,
- Federal College Work-Study Programs,
- Perkins Loans (formerly National Direct Student Loans), and
- Guaranteed Student Loans (including PLUS loans and Supplemental Loans for Students).

31. Carl D. Perkins Student Financial Assistance

Student financial assistance received under the Carl D. Perkins Vocational and Applied Technology Education Act made available for attendance costs (Public Law 101-392) is excluded. Attendance costs are defined below:

- tuition and fees normally assessed a student carrying the same academic workload as determined by the institution, and including



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costs for rental or purchase of any equipment, materials, or supplies required of all students in the same course of study; and

- an allowance for books, supplies, transportation, dependent care, and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution.

32. HUD Self-Sufficiency Program — Funds paid to an escrow account established under the Family Self-Sufficiency Program of the Department of Housing and Urban Development are excluded.

33. BIA Student Assistance — Student financial assistance received under Bureau of Indian Affairs (BIA) student assistance programs is excluded.

34. Interest on Certain Savings Accounts — Interest earned on a savings account for the purpose of paying for tuition, books, and incidental expenses at any elementary, secondary, or vocational school or any college or university for a family member, for making a down payment on a primary residence, or establishing a business is excluded.

35. Up To $2000/yr. Received by Individual Indians — Up to $2,000 per year of income received by individual Indians, which is derived from leases or other uses of individually-owned trust or restricted lands is excluded.

36. Nazi Persecution Payments — Payments received by victims of Nazi persecution under Public Law 103-286 are excluded.

37. First $30 for Special Occasions — The first $30 received by each individual in the family/budget unit per calendar quarter for special occasions, such as birthdays, Christmas, etc. is excluded. See M0730.520.

38. Lump Sum — A lump sum plus all other earned and unearned income that is less than 100% of need in the locality for the number of members in the FU/BU is excluded from countable unearned income when evaluating lump sum income. See M0730.800.

39. Walker v. Bayer Settlement Payments — Section 4735 of the Balanced Budget Act of 1997 (P.L. 105-33) states that payments described in this subsection from the settlement of the Susan Walker v. Bayer Corp., et.al., class action lawsuit are NOT counted as income in determining eligibility for Medicaid. Payments described in this subsection are:

a. payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corp., et.al., 96-C-5024 (N.D.III.); and

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b. payments made pursuant to a release of all claims in a case that entered into in lieu of the class settlement of Walker v. Bayer Corp., et.al., and that is signed by all affected parties on or before the later of

- December 31, 1997, or
- the date that is 270 days after the date on which such release is first sent to the persons to whom the payment is to be made.

Information received by claimants in this lawsuit shows that claimants can choose to receive the payment in one of three ways – in a lump sum, a structured settlement, or a special needs trust. Regardless of which form the individual chooses, the payment(s) are excluded if the above requirements are met.

Verify the source of the funds from a letter from the individual's attorney or a copy of the check which identifies the payor as a Walker v. Bayer settlement account.

Any interest earned on these funds is NOT excluded. Any interest earned on these funds must be evaluated as unearned income in the month of receipt and as a resource thereafter.

40. Combat Zone Income

Any amount received by or made available to household members for deployment or service in a combat zone will not count as income for Medicaid purposes unless the payment was received before the deployment. This exclusion includes items such as, but not limited to, incentive pay for hazardous duty, special pay for imminent duty or hostile fire duty or certain re-enlistment bonuses, or special pay for certain occupational or educational skills.

M0730.100 MAJOR BENEFIT PROGRAMS

A. Policy

Annuities, pensions, retirement benefits, and disability benefits are unearned income. The amount of unearned income actually being received, not the entitlement amount, is counted as income.

EXCEPTION: When the Medicare Part B premium is deducted from the Social Security or Railroad Retirement benefits, that amount must be added to the actual benefit being received.

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B. Definitions

1. Annuity An annuity is a sum paid yearly or at other specific times in return for the payment of a fixed sum. Annuities may be purchased by an individual or by an employer.

2. Pensions and Retirement Benefits Pensions and retirement benefits are payments to a worker following his retirement from employment. These payments may be paid directly by a former employer, by a trust fund, an insurance company, or other entity.

3. Disability Benefits Disability benefits are payments made because of injury or other disability.

C. List of Benefits The following are examples of benefits:

- Social Security Benefits
- VA Payments – certain types not counted under MAGI methodology (see Chapter M04)
- Worker's Compensation – not counted under MAGI methodology (see Chapter M04)
- Railroad Retirement
- Black Lung Benefits
- Civil Service Payments
- Military Pensions
- VIEW Transitional Payments

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

M0730.200 UNEMPLOYMENT COMPENSATION

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

B. Procedures

1. General Procedures Count Unemployment Compensation as unearned income for all covered groups.

2. *Federal Pandemic Unemployment Compensation Program* *Section 2104 of the Coronavirus Aid, Relief, and Economic Security (Cares) Act (Public Law No. 116-136) provides that under the Federal Pandemic Unemployment Compensation Program, eligible individuals who are collecting certain Unemployment Compensation, including regular unemployment compensation, will receive an additional $600 in federal benefits per week for weeks of unemployment ending on or before July 31, 2020.*

The $600 weekly Pandemic Unemployment Compensation payments (monthly equivalent of $2,580) are disregarded as income.



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M0730.210 TRADE ADJUSTMENT ASSISTANCE ACT INCOME

A. Policy

The Trade Adjustment Assistance Act is administered by the Virginia Employment Commission. The Act allows qualified unemployed individuals to receive additional weeks of Unemployment Compensation (UC). UC benefits are counted as unearned income. The amount counted is the gross benefit before any taxes or deductions.

B. Procedure

See M0730.200, above, for procedures to use in counting UC benefits.

M0730.400 CHILD/SPOUSAL SUPPORT

A. Policy

For covered groups subject to Modified Adjusted Gross Income (MAGI) methodology, child support income is **NOT** counted (see chapter M04). However, spousal support (alimony) **is** counted as unearned income.

For covered groups that are not subject to MAGI methodology, support received by an individual, whether it comes directly from the provider or is redirected to the individual by DCSE, **is** unearned income. The support received by the individual is subject to the $50 Support Exclusion. Use the policies and procedures below.

B. Procedures

1. **Child Living in Home**

Child support payments received for a child who is living in the home is counted as income to the child for a non-MAGI determination.

2. **Child Not Living in Home**

Child support payments received for a child who is not living in the home are counted a income to the person receiving it for a non-MAGI determination if the money is not given to the child.

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M0730.500 DIVIDENDS AND INTEREST

A. Policy Dividends and interest are only counted as unearned income when earned on a countable resource. Dividend and interest income payments on countable resources are counted as income in the month received or anticipated to be received (even if paid quarterly, annually, etc.), unless the interest is earned on an excluded savings account for education, home purchase or establishing a business per M0630.125.

B. Definition Dividends and interest are returns on capital investments such as stocks, bonds, certificates of deposit, or savings accounts.

C. Procedure Verify the amount that is received or is anticipated to be received by documents in the applicant/recipient's possession or through contact with the financial institution where the account or other financial instrument is located.

M0730.505 RENTAL/ROOM AND BOARD INCOME

A. Policy Net rental/boarder income from the rental of real property, or rooms, or board paid when the applicant/recipient is not engaged in a business enterprise or actively involved in management is unearned income. Rental/room and board income is counted in the month in which it is received.

B. Definitions

1. Rent Rent is a payment which an individual received for the use of real or personal property, such as land or housing.

2. Net Rental Income Net rental income is the total amount received less the allowable costs.

3. Board Board is the amount paid for the provision of meals only.

4. Room Room is the amount paid to rent a room only.

5. Room and Board Room and board is the amount paid for room rent and the provision of meals.

C. Calculation of Net Rental/Boarder Income

1. Real or Personal The net rental income is the total amount received less the tax on the property.

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Verify the anticipated income by documents in the applicant's possession or by a statement from the tenant.

Verify the anticipated cost by a tax receipt for the property owned.

2. Room Rent

The net rental income is 65% of the total rent received if heating fuel is furnished by the applicant/recipient. The net rental income is 75% of the total rent received if heating fuel is not furnished.

Verify the rent paid by documents in the applicant/recipient's possession or a statement from the tenant.

3. Boarders

The net rental income is the total board received less the *Supplemental Nutrition Assistance Program (SNAP) benefit allotment for the number of boarders. The SNAP Manual is available at https://jupiter.dss.state.va.us/FoodStampManual/mainpage.jsp#.*

Verify anticipated income from documents in the *individual's* possession or statement from boarder.

4. Roomer/ Boarders

The net rental income from room and board is calculated as follows:

- *Subtract the SNAP benefit allotment for the number of boarders from the monthly gross rental income.*
- *Multiply the balance by .65 (65% of the balance) if heating fuel is furnished or .75 (75% of the balance) if heating fuel is not furnished.*

Verify anticipated income by documents in the applicant/recipient's possession or by a statement from the boarder.

M0730.520 GIFTS

A. Policy

The first $30 received by each individual in the assistance unit per calendar quarter for special occasions, such as birthdays, Christmas, etc. is excluded.

B. Definition

Calendar quarters are:

January - March;
April - June;
July - September;
October - December.

C. Procedure

Any amount in excess of the $30 per calendar quarter anticipated to be received will be counted as unearned income in the month in which it is anticipated to be received.

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M0730.522 CONTRIBUTIONS

A. Policy

1. Contribution from agencies or organization

Any cash contribution made directly to the FU/BU by an agency or organization must be counted as unearned income to the FU/BU if such contribution is for any of the following:

- food, including special diets
- clothing
- personal care
- household supplies and equipment
- insurance
- school supplies and expenses
- laundry
- utilities (including telephone)
- housekeeping and personal services
- obligations incurred within the month of application
- guardianship fees
- average shelter costs appropriate to the locality in which the assistance unit resides (including rent, house payments, taxes, fire or comprehensive insurance repairs, installations, water sewage and trash disposal

NOTE: If the contribution to the assistance unit is for one of the items listed above, it is unearned income and counted dollar for dollar. If it is not for one of the items listed above, it is not unearned income.

2. All Other Cash Contributions

All other cash contributions are counted in amount received as unearned income.

3. Income from Crowdsourcing

For contributions or donations received from crowdfunding source(s) see M0730.900

B. Procedure

- Verify with the administering agency or person contributing, the purpose of the contribution; AND
- Verify the amount of the contribution.

M0730.600 HOME ENERGY ASSISTANCE

A. Policy

Payments made directly to a household for home heating or cooling provided by suppliers of home energy, such as electric and gas companies and fuel oil dealers, must be counted as income.

B. Value of Assistance

When payments are received jointly by a household composed of Medicaid and non-Medicaid applicants/recipients, the FU/BU's pro rata share, based on the total number of persons in the household, must be considered as unearned income to the Medicaid FU/BU.



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M0730.800 TREATMENT OF LUMP SUM INCOME

A. Policy

The receipt (on or after the month of application for Medicaid) of a nonrecurring lump sum payment is counted as income of the individual who received it. It is counted as income to the individual who received it in the month of receipt. If any of the lump sum is retained beyond the month of receipt, the retained portion is counted as a resource to the individual.

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The lump sum is earned income if it meets the definition of earned income, such as an earnings bonus paid annually to an employee. If the lump sum does not meet the definition of earned income, it is unearned income. Most lump sum payments are unearned income.

In the month of receipt, the countable portion of the lump sum (lump sum minus directly related expenses) is added to the individual's other income and counted as income to the individual's family unit and/or budget unit. The countable lump sum amount is also added to all other earned and unearned income in calculating the amount of the deemor parent's income to deem to the F&C child.

B. Definition

A lump sum is one of the following:

- accumulation of benefits for a prior period, including Social Security and Workman's Compensation benefits;
- payments in the nature of a windfall, e.g., inheritances or lottery winnings;
- personal injury awards;
- any portion of a casualty property loss payment which is not used for repair or replacement of the damaged/lost resources;
- life insurance settlement when the policy is owned by someone other than a member of the family/budget unit;
- child support identified as payments paid in excess of public assistance; or
- income from any other nonrecurring source.

NOTE: Money received from the sale or conversion of any real or personal property is not considered a lump sum (see M0610.100, Distinction Between Assets and Resources).

NOTE: A lump sum is a resource if it was received before the month of application for Medicaid or if any amounts are remaining after the period of time it is counted as income. If counted as income, it cannot be counted as a resource even if placed in a savings account for education, home purchase, or establishing a business as described at M0630.125.

C. Procedure

1. Determine Countable Amount of Lump Sum

The gross amount of the lump sum minus directly related expenses, equals the countable amount of the lump sum. The countable amount of the lump sum is income in the month of receipt.

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a. Definition of Directly Related Expenses

Directly related expenses are items such as funeral expenses, medical bills, legal fees, or liens against insured property. Expenses for day-to-day living incurred pending receipt of a lump sum are not directly related expenses.

Lump sum payments received as a result of an accumulation of benefits for a prior period, such as Social Security benefits, will have no directly related expense deduction.

b. Documentation of Directly Related Expenses

The applicant/recipient must promptly provide documented evidence of directly related expenses which were incurred prior to or are anticipated to be incurred within 30 days after receipt of the lump sum.

If verification of the payment of directly related expenses is not provided promptly, the lump sum is counted in full. Subsequent provision of verification of the lump sum payment or the payment of directly related expenses will not change the countable amount of the lump sum. The agency must advise the applicant/recipient of the requirement to count the lump sum in full unless the directly related expenses are actually paid.

2. Determine Total Income

Add all countable earned and countable unearned income to the countable portion of the lump sum to determine the individual's total amount of income for the month of receipt.

3. Evaluate Asset Transfer

Evaluate the spending of a lump sum under the asset transfer policy in subchapter M1450 and document the case record with the amount(s) of compensation received.

D. Example--Lump Sum Received By Adult In Family

EXAMPLE #1: Mr. Fox , who lives in a Group II locality, receives a $5000 lump sum on August 2, 1997. There are 5 members of the family unit. Their other countable earned and unearned income for that month is $200. *The family unit's income for August is $200 + $5000 = $5200.*

$1,730 of the lump sum remains in September. The $1,730 is counted as a resource to Mr. Fox in September.

E. Example--Lump Sum Received By *Adult, Stepparent* In Family

EXAMPLE #2: *Mrs. Bear lives in a Group II locality with her husband, Mr. Bear, and her son from a previous relationship, Baby Bear. Baby Bear has been receiving Medicaid as a Medically Indigent Child Under 6. The parents had not requested Medicaid for themselves. On September 3, 1997, Mrs. Bear receives a $5000 lump sum payment (after directly related expenses are deducted). The family has no earned income, but has unearned income of $1300 per month (retirement for Mr. Bear). Mrs. Bear has no other income. The family unit's income for September is $1300 + 5000 = $6300.*



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The countable income of the family unit is compared to the MI income limit for three people. $6300 exceeds the MI limit for three people ($1477). Since Baby Bear has a stepparent in the home, budget units must be formed. One budget unit contains Mr. and Mrs. Bear; the other budget unit contains Baby Bear.

Deem a portion of Mrs. Bear's income to Baby Bear:

$5000.00 Mrs. Bear's lump sum income
- 128.50 deeming standard (1/2 of 100% standard of assistance for 2 in Group II)
$4871.50 deemable income

Baby Bear's monthly income for September is $4871.50. That amount exceeds the MI Child Under 6 income limit for a budget unit of one ($874) so Baby Bear is not eligible for Medicaid in September. For October, Baby Bear has no countable income because his mother has no income in October; he is eligible for Medicaid again in October as an MI child under age 6.

M0730.900 TREATMENT OF CROWDSOURCING INCOME

A. Policy

Crowdsourcing or crowdfunding is a practice to raise funds online for donations, funding a project, or underwrite a venture, by requesting small amounts of money by a large number of people. Examples of crowdsourcing websites include GoFundME, YouCaring, Kickstarter, or IndieGoGo.

Treatment of funds received depends on the reason the funds were solicited.

B. Definition

If the individual, or someone on their behalf, is raising donations for medical costs or bills, money raised is considered a gift. See M0730.520.

If there is an exchange of goods or services, the money received is considered earned income.

If it is a fundraiser for investing in an invention and the donor gets a product or a return, it is not taxable income and but would be considered "contribution to capital" as the donor has an equity interest in the product.

C. Procedure

Funds deposited into an account to which an individual has access and control over its use would be countable to the individual in the month received. If any of the funds are retained beyond the month of receipt, the retained portion is counted as a resource to the individual.

"Platform fees"are fees or costs that would not be considered part of the income received if the monies are crowdfunding are being considered as income. Fees may include the cost per transaction or percentage of donation the online host site receives and/or costs to a payment processor.



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CHAPTER M08

ABD INCOME

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M08 TOC Changes

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CHAPTER M08
ABD INCOME
SUBCHAPTER 10

GENERAL--ABD INCOME RULES

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M0810 Changes

Changed With	Effective Date	Pages Changed
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TN #DMAS-29	10/1/23	Pages 6, 9
TN #DMAS-28	7/1/23	Pages 2, 6
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GENERAL

M0810.001 INCOME AND ELIGIBILITY

A. Introduction

The following sections explain how to treat income to determine eligibility in the Aged, Blind and Disabled covered groups in the Medicaid program. Virginia Medicaid follows Social Security Administration rules from the SSI section of the Program Operations Manual System (POMS) SSA's Policy Information Site - POMS. Some of the rules are adapted due to state laws and regulations. We have noted in each section if the section follows SSA policy without deviation by adding "per POMS'. This chapter explains how we count income.

B. Policy Principles

1. Who is Eligible

An individual is eligible for Medicaid if the person:

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

2. General Income Rules

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

M0810.002 INCOME LIMITS

A. Income Limits

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

1. Categorically Needy

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

2. Categorically Needy Protected Cases Only

Categorically-Needy Protected Covered Groups Which Use SSI Income Limits		
Family Unit Size	*2025 Monthly Amount*	*2026 Monthly Amount*
1	*$967*	*$994*
2	*1,450*	*$1,491*
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size	*2025 Monthly Amount*	*2026 Monthly Amount*
1	*$645*	*$663*
2	*$967*	*$994*

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3. Categorically Needy 300% of SSI

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

Family Size Unit	*2025 Monthly Amount*	*2026 Monthly Amount*
1	*$2,901*	*$2,982*

4. ABD Medically Needy

a. Group I	7/1/24-6/30/25		7/1/25	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,391.01	$398.50	$2,460.34	$410.05
2	3,043.80	507.30	3,132.06	522.01

b. Group II	7/1/24-6/30/25		7/1/25	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$ 2,758.87	$ 459.81	$ 2,838.87	$ 473.14
2	3,396.83	566.14	3,495.33	582.55

c. Group III	7/1/24-6/30/25		7/1/25	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$3,586.53	$597.76	$3,690.53	$615.08
2	4,323.80	720.63	4,449.18	741.53

5. ABD Categorically Needy

For:

ABD 80% FPL, QMB, SLMB, & QI <u>without</u> Social Security income; all QDWI; effective 1/15/25

ABD 80% FPL, QMB, SLMB, & QI <u>with</u> Social Security income; effective 3/1/25

All Localities	2024		2025	
ABD 80% FPL	Annual	Monthly	Annual	Monthly
1	$12,048	$1,004	$12,520	$1,044
2	16,352	1,363	16,920	1,410
QMB 100% FPL	Annual	Monthly	Annual	Monthly
1	$15,060	$1,255	$15,650	$1,305
2	20,440	1,704	21,150	1,763
SLMB 120% of FPL	Annual	Monthly	Annual	Monthly
1	$18,072	$1,506	$18,780	$1,565
2	24,528	2,044	25,380	2,115
QI 135% FPL	Annual	Monthly	Annual	Monthly
1	$20,331	$1,695	$21,128	$1,761
2	27,594	2,300	28,553	2,380
QDWI 200% of FPL	Annual	Monthly	Annual	Monthly
1	$30,120	$2,510	$31,300	$2,609
2	40,880	3,407	42,300	3,525

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M0810.005 WHAT IS INCOME

A. Policy Principles

1. Definitions

Income is

- cash, or
- its equivalent, unless specifically listed in M0815 as not being income.

Income is counted in U.S. dollars.

2. Amount

Sometimes income includes more or less than is actually received, for example:

- Expenses of obtaining income (less)
- Garnishment (more)
- Gross earnings, before any deductions (more).

B. References

- What is not income, S0815.001ff.
- Garnishment, S0810.025.
- Expenses of obtaining income, S0830.100.
- Wages, S0820.100.

S0810.007 INCOME EXCLUSIONS

A. Introduction

Medicaid eligibility is based on countable income. See S0810.300 B.1. for the definition of countable income (CI). In determining CI, consider any income exclusions.

Some exclusions totally negate the amount of income received. Other exclusions reduce the amount counted. For example, any income may be wholly excluded (not counted) if it meets the criteria for exclusion of income received infrequently or irregularly.

B. Definition

Excluded income is an amount which is income but does not count in determining eligibility.

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C. Policy Principles

1. Income Exclusions under Other Federal Statutes

Some Federal laws other than the Social Security Act prohibit counting some income for Medicaid purposes. See S0830.099.

2. Exclusions under the Social Security Act

Section 1612(b) of the Social Security Act provides for several income exclusions in determining countable income for Medicaid purposes.

D. References

- Income exclusions applicable to both earned and unearned income, S0810.400.
- Earned income exclusions, S0820.500ff.
- Unearned income exclusions, S0830.001ff.
- Order of application of exclusions, S0830.100 C.

S0810.010 RELATIONSHIP OF INCOME TO RESOURCES

A. Operating Policy

In general, anything received in a month, from any source, is income to an individual, subject to the definition of income in S0810.005.

Anything the individual owned prior to the month under consideration is subject to the resource counting rules.

An item received in the current month is income for the current month only. (See exceptions to this general rule in S0810.030.) If held by the individual until the following month, that item is subject to resource counting rules (See exception in S1110.115)

B. Example

Mr. Jones receives a dividend check for $300 at the end of May. He spends $150 immediately and deposits the remaining $150 in his savings accounts. His income for May is $300. The June 1 evaluation of Mr. Jones' resources includes (for the first time) the $150 he saved.

C. References

- Definition of resources, S1110.100 B.1.
- Conversion or sale of a resource, S0815.200.
- Replacement of lost, damaged, or stolen resources, S1130.630.

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S0810.015 TYPES OF INCOME

A. Policy Principles

1. Types of Income

Income is either earned or unearned, and different rules apply to each.

2. Earned Income

Earned income consists of the following types of payments:

- wages
- net earnings from self-employment
- payments for services performed in a sheltered workshop or work activities center.
- royalties earned by an individual in connection with any publication of his/her work and any honoraria received for services rendered.

3. Unearned Income

Unearned income is all income that is not earned income. Some types of unearned income are:

- annuities, pensions, and other periodic payments
- alimony and support payments
- dividends, interest, and royalties (except for royalties mentioned in 2. above)
- rents
- 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
- prizes and awards

B. References

- Definition of countable income, S0810.300.
- Earned income, S0820.001ff.
- Unearned income, S0830.001ff.

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M0810.020 FORMS AND AMOUNTS OF INCOME

A. Operating Policies

Income, whether earned or unearned, may be received in the form of cash--currency, checks, money orders, or electronic funds transfers (EFT), such as:

1. Forms of Income

- Social Security checks
- unemployment compensation checks
- payroll checks or currency.

2. Amounts of Income

The value of cash income is generally the amount of the currency or the face value of checks, money orders or EFT's the individual receives. There are some exceptions listed in B. below.

B. References

- Expenses of obtaining income, S0830.100.
- Determining amount of wages, S0820.100.
- Amounts withheld to recover an overpayment, S0830.110.
- Garnishment or seizure, S0810.025.
- Income exclusions, S0810.400.

S0810.025 EFFECT OF GARNISHMENT OR SEIZURE

A. Definition

A **garnishment** or **seizure** is a withholding of an amount from earned or unearned income in order to satisfy a debt or legal obligation.

B. Policy Principles

Amounts withheld from earned or unearned income to satisfy a debt or legal obligation are income for Medicaid purposes.

C. Related Policy

1. Earned Income

Wages are what an individual receives (before any deductions) for working as someone else's employee. See S0820.100.

2. Unearned Income

See S0830.115 for instructions on determining the amount of unearned income if garnishment or other withholding is involved.

3. Deeming or Court Ordered Payments

When the court orders garnishment of income of an ineligible spouse, parent, ineligible child, or eligible alien (sponsored by an ineligible spouse or parent) to pay court-ordered or title IV-D enforced support payments.

D. Development and Documentation

Determine the type of garnished or seized income and document the gross amount of the income.

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S0810.030 WHEN INCOME IS COUNTED

A. Policy Principles

Generally, we count income at the earliest of the following points:

- when it is received; or,
- when it is credited to an individual's account; or
- when it is set aside for his or her use.

We determine income monthly and count it the month it is received.

B. Operating Policy

1. Exceptions

Occasionally, a regular periodic payment (e.g., wages, Title II, or VA benefits) is received in a month other than the month of normal receipt.

As long as there is no intent to interrupt the regular payment schedule, consider the funds to be income in the normal month of receipt.

The most common situations where this policy applies appear in 2. and 3. below.

2. Advance Dated Checks

When a payor advance dates a check because the regular payment date falls on a weekend or holiday, there is no intent to change the normal delivery date.

Whenever such an advance dated check is received, consider it income to the recipient in the month of normal receipt.

3. Electronic Funds Transfers (EFT)

When an individual's money goes to a bank by direct deposit, the funds may be posted to the account before or after the month they are payable.

Whenever this occurs, treat the electronically transferred funds as income in the month of normal receipt.

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C. Related Policy

1. Counting Advance Dated Checks and EFT's and Resources	Such funds are first subject to evaluation as resources in the month following the month of normal receipt. See S1130.600 for SSI and RSDI retroactive payments as resources.
2. Counting Net Earnings from Self-Employment	Counting net earnings from self-employment (NESE) varies from the general income-counting rule. NESE is allocated evenly into all months of an individual's taxable year. See S0820.200ff.
3. Replacement of Income Already Received	See S0815.450 if income is lost, stolen, or destroyed, and a replacement is received.
4. Recipient Returns a Check He/She Is Not Due	See S0815.460 when the recipient is aware that he/she is not due a payment and returns the money.
5. Reissued Title II Funds in Change of Payee Situations	See S1120.022 when conserved title II benefits are reissued as a result of a change in payees.

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WHOSE INCOME IS IT?

S0810.120 INCOME DETERMINATIONS INVOLVING AGENTS

A. Introduction

This section deals with the actions of agents who conduct financial transactions on behalf of others, and the policies that apply in making determinations of countable income as a result of such transactions.

A Medicaid recipient may be an agent for another person **or have an agent** acting on his or her behalf. Whenever an agent takes part in a financial transaction, the EW must determine whether the transaction was conducted on the agent's behalf or on behalf of the person he or she represents.

NOTE: References in this section to a "Medicaid recipient" also include a Medicaid applicant and individuals whose income and/or resources are subject to deeming.

B. Definition

An "agent" is a person or organization acting on behalf of and/or with the authorization of another person or organization. The term "agent" applies to all individuals who act in a fiduciary capacity, whether formal or informal, regardless of their titles (representative payees, guardians, conservators, etc.)

C. Operating Policies Medicaid Recipient Is an Agent

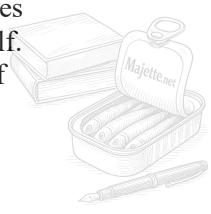
1. General

Monies received by a Medicaid recipient in his/her capacity as an agent are not income to him/her. Regular income rules (S0810.001 ff) apply for counting income a Medicaid recipient receives which is not paid on behalf of another. *A member holding property of any kind for someone else must keep it in a form that clearly shows ownership by the other person*.

2. Agent With Bank Account for Another

a. Account Correctly Titled
When a Medicaid recipient acts as an agent for another and the title or designation of a bank account for the other person reflects the agency relationship, deposits to the account are not income to the Medicaid recipient.

b. Account Incorrectly Titled
If the account is incorrectly titled, deposits to the account are income to the Medicaid recipient--unless the Medicaid recipient makes the deposits for another person and disburses or intends to disburse the money on the other person's behalf. (See S1120.020 for instructions concerning the treatment of resources when an agent is involved.)



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3. Fees Received by an Agent

There may be situations where agents are authorized to keep a part of the funds they receive on behalf of another. **Fees**, commissions, or contributions for services rendered **are unearned income** to a Medicaid recipient acting as an agent.

4. Misuse of Benefits

A Medicaid recipient acting as an agent may misuse another's funds. Monies misused by a Medicaid recipient are unearned income in the month received unless restitution is made.

When misused funds are refunded by a Medicaid recipient acting as an agent, these funds are not counted as income to the recipient.

5. Recipient and Use of Funds From an Absent Household Member

Frequently an individual leaves home (e.g., is confined to a Medicaid facility) and all or part of his/her income is turned over to someone maintaining the home. When funds are turned over to a Medicaid recipient, the guidelines below apply for determining if the recipient is acting as an agent.

a. Absent evidence to the contrary, the Medicaid recipient is assumed to be acting as an agent if he/she alleges that the funds received are being used to maintain the home **or** on behalf of the absent household member in some other manner (e.g., paying the absent individual's life insurance premiums).

NOTE: An example of evidence contrary to the assumption in a. above is a Medicaid recipient who is living at home and who has an absent spouse in a Medicaid facility. If a certain amount of the institutionalized person's income should be "assigned" to the spouse at home and the "assigned" amount is actually made available to the Medicaid recipient, the amount of money available as cash income is unearned income to the Medicaid recipient. (The terms for this income is "spousal monthly income allowance.") In this situation, the Medicaid recipient is not acting as an agent because the money has been assigned to meet the at-home spouse's needs. If a "spousal monthly income allowance" has not been assigned from the institutionalized person's income to the at-home spouse, the presumption in a. above applies.

The amount of money used by a Medicaid recipient on behalf of the absent individual is not cash income to the Medicaid recipient.

b. If the Medicaid recipient alleges that all or part of **funds received** from an absent household member **are for the recipient's personal use**, the amount of cash income diverted to personal use is income to the Medicaid recipient.

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D. Operating Policies-Medicaid Recipient has an Agent

1. General

Treat monies received by an agent acting on behalf of a Medicaid recipient as if the recipient received the monies directly. These monies are counted as income to the recipient when received by the agent, following the income-counting rules in S0810.010 ff.

2. Misuse of Benefits by the Agent

If a Medicaid recipient's agent has been charged with misuse of funds and restitution has not been made, the **amount of funds misused by the agent is not counted as income** to the recipient. If restitution is made by the agent directly to the recipient, the amount restored is income in the month received.

E. Development and Documentation

1. General

When an agent relationship exists between a Medicaid recipient and another individual, the file must be clear as to the relationship between the two parties. In cases where the agent is chosen by a court or governmental agency, retain a copy of any documents verifying the appointment. If no document exists, contact the source of the appointment and record the information in the file. When financial transactions involving an agent take place, the file must reflect why income was or was not counted to the Medicaid recipient.

2. Fees Received By an Agent

Verify fees, commission, or contributions provided to a Medicaid recipient for services rendered as an agent. (See S0820.100 if there is an employer-employee relationship.)

3. Misuse of Benefits

Develop misuse and document case record. Adjust the Medicaid recipient's file to remove income counted which represent funds misused by the recipient's agent. If the agent restores the misused funds to the Medicaid recipient, the recipient will have income counted in the month he/she received the repaid monies.

If restitution of misused funds is made by Medicaid recipient acting as an agent, adjust the recipient's to remove income counted which represent the repaid monies.

4. Receipt of Funds From an Absent Household Member

Document the Medicaid recipient's allegation regarding the use of an absent household member's funds. If evidence is presented which rebuts the presumption that the Medicaid recipient is acting as an agent, keep a copy of the evidence in file.

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F. Examples

1. Agent Uses Money for Self and on Another's Behalf

Clara Dalloway, a Medicaid recipient, is legal guardian for her elderly sister. A friend of the family gives Mrs. Dalloway $120 and tells her that a third of it is for her sister. Mrs. Dalloway keeps $80 for herself and uses the rest to buy clothing for he sister. $80 represents unearned income to Mrs. Dalloway in the form of a gift. The $40 which was paid on her sister's behalf is not income to Mrs. Dalloway because she used this money in her capacity as an agent.

2. Monies From an Absent Household Member Used to Maintain Home and for Personal Use

Christine Duncan, Medicaid recipient, rents an apartment with her cousin who goes into the hospital for an extended stay. Ms. Duncan reports to the EW that her cousin sent $200 to help with the rent and utility bills. Of the $200, Ms. Duncan needed only $175 for the household bills and used the remaining $25 to buy a birthday present for her brother. Because Ms. Duncan was acting as an agent for her cousin, the EW counts only $25 in income since she made personal use of that portion of the $200.

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S0810.130 INCOME DERIVED FROM JOINT BANK ACCOUNTS

A. Introduction

This section explains how to count income in different situations involving the joint bank account of a Medicaid recipient/applicant and/or deemor.

When a Medicaid recipient or applicant has a joint bank account with another individual, **deposits made to the account by other account holders or interest posted to the account are income** to the Medicaid recipient. See B.2. below for an exception.

References in this section to a "Medicaid recipient" also include a Medicaid applicant and individuals whose income and/or resources are subject to deeming.

See S1140.205 for resource determinations involving bank accounts.

B. Operating Policies

1. General

a. **When a joint bank account is held by a Medicaid recipient and an ineligible** individual who is not a deemor, income to the Medicaid recipient includes:

- the full amount of any interest posted to the account and
- the full amount of any deposit made by a third party or by the ineligible bank account holder unless the Medicaid recipient is acting as an agent (see S0810.120 C.1.).

b. **When two or more Medicaid recipients are joint account holders,** deposits made by one individual are not income to the other. Allocate interest equally among the joint holders.

2. Rebuttal Situations

a. If a Medicaid recipient successfully **rebuts ownership of a portion of funds in a joint account** (see S1140.205 C.2.), deposits made by the other account holder are not income to the Medicaid recipient. Interest is counted to the Medicaid recipient in proportion to the percentage of funds that are a resource to the recipient.

b. If a Medicaid recipient successfully **rebuts ownership of all the funds** held in a joint bank account, deposits by the other account holders or interest posted to the account are not income to the recipient.

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COMPUTING COUNTABLE INCOME

S0810.300 GENERAL

A. Introduction

An individual's monthly income is one of the factors which determines eligibility for Medicaid.

B. Definitions

1. Countable Income (CI)

CI is the amount of income that remains after:

- eliminating all amounts that are **not income** (S0815.001ff.); and
- applying all appropriate **exclusions** (S0810.400ff.)

CI is the sum of a month's countable earned and countable unearned income.

2. Countable Earned Income

Countable earned income is the amount of earned income (S0810.015 A.2.) remaining after applying all appropriate income exclusions.

3. Countable Unearned Income

Countable unearned income is the amount of unearned income (S0810.015 A.3.) remaining after applying all appropriate income exclusions.

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S0810.310 HOW TO COMPUTE COUNTABLE INCOME

A. Operating Procedure

1. Evaluate Income	Evaluate all reported or estimated income for the month.
2. Determine What is Not Income	Do not consider certain kinds of payments, property, or services which are not income for Medicaid purposes. See S0815.001ff.
3. Deduct Income Excluded Under Other Federal Statutes	See S0830.055 for these exclusions which are not in title XVI of the Social Security Act. Exclude any of this income in determining countable income.
4. Compute Countable Unearned Income	Subtract applicable exclusions (S0830.100ff.) from unearned income to determine countable unearned income.
5. Compute Countable Earned Income	Subtract applicable exclusions (S0820.500ff.) from earned income to determine countable earned income.
6. Compute Countable Income	Add countable earned income and countable unearned income to arrive at total countable income.

B. References

- Order of application of exclusions, S0830.100 C.

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INCOME EXCLUSIONS WHICH APPLY TO BOTH EARNED AND UNEARNED INCOME

S0810.400 GENERAL

A. Policy Principle

Some statutory exclusions apply only to earned income, some apply only to unearned income, and a few apply to both earned and unearned income.

B. References

The following sections address those exclusions which can apply to both earned and unearned income:

- Infrequent or irregular income exclusion, S0810.410.
- $20 per month general income exclusion, S0810.420.
- PASS exclusion, S0810.430.

S0810.410 INFREQUENT OR IRREGULAR INCOME EXCLUSION

A. Policy

1. The Exclusion

We can apply an exclusion to income which is received either infrequently or irregularly provided the total of such income does not exceed:

- $10 per month of earned income; and/or
- $20 per month of unearned income.

2. Infrequent or Irregular Income--Definition

In order for this exclusion to apply, income need only be one or the other of:

- **infrequent**--An individual receives income on an infrequent basis if he/she receives it no more than once in a calendar quarter from a single source; or
- **irregular**--An individual receives income on an irregular basis if he or she could not reasonably expect to receive it.

3. Interpretation of the Exclusion

a. **Applicable to Both Earned and Unearned Income**--This exclusion can apply to both earned and unearned income in the same month provided the total of each does not exceed the limits in 1. above. Thus it is possible to exclude as much as $30 in a month under this provision.

b. **Total Exceeds the Limit**--This exclusion does not apply to any income received on an infrequent or irregular basis if the total of such income exceeds the amounts in 1. We exclude all infrequent or irregular earned and/or unearned income or none of it, depending on the amount involved. (See G. below concerning income subject to other exclusions.)



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c. **Limit as it Applies to Couples**--The dollar amount of the exclusion does not increase even if both an eligible individual and spouse (eligible or ineligible) have infrequent or irregular income.

d. **To Whom Applicable**--The exclusion is applicable to income received infrequently or irregularly by an eligible individual, eligible or ineligible spouse, and parent of blind or disabled child.

4. Unearned Income--Specific Considerations

In evaluating frequency of receipt of unearned income, we look at receipts of the same type of income from a single source.

B. Definitions

1. Single Source of Income

a. A single source of earned income is an employer, a trade, or a business.

b. A single source of unearned income is an individual, a household, an organization or an investment.

- A household in which an individual lives is a single source even if the household composition changes due to a move by the individual or by other household members (see C.2. below).
- An organization is the Federal Government, a single State or local government, a business or corporation, a charitable agency, or a similar entity which provides an individual with income.
- An investment is a single financial account, life insurance policy, rental property, or any other resource providing a return to its owner. Two separate accounts, even if with a single financial institution, are two different investments.

2. Two Payments from a Financial Institution -- Not a Single Source

An individual may occasionally receive an irregular interest payment by reason of a financial institution's own internal "housekeeping" rules. For example, a bank's rules may require an extra payment when someone closes an account or there may be a special "adjustment" payment due to a change in the accounting system or to closing the books at the end of a fiscal year. These kinds of irregular payments are from the financial institution itself and not from an individual's account with that institution. Therefore, they do not cause a regular (but infrequent) interest payment from an account to be considered "frequent" in that one quarter (see C.3. below).

NOTE: Determinations involving sources of income are only necessary when determining whether income is infrequent (see D.1. and D.2. below).

3. Types of Unearned Income

For purposes of this exclusion, types of unearned income are those listed in S0830.200 - S0830.560.

C. Example of Unearned Income

1. Regular Source Makes Unexpected Payment

An individual has a savings account that pays interest of $15 in the second month of each quarter. The interest has been routinely excluded as infrequent as the individual has no other infrequent or irregular income.

In 1989, without any advance notice to depositors, the bank changes its accounting system. As a result, in June the individual receives a $2.03 one-time payment in addition to his/her regular $15 interest payment in May.

The bank does not intend to interrupt its usual quarterly interest schedule, so the EW correctly views the one-time payment in June as being from a separate source than the regular quarterly payments; i.e., it is a bank adjustment. Therefore, the regular $15 payment is still excludable as infrequent while the unexpected $2.03 payment is irregular. The total is within the $20 limit in the month of receipt and is excludable.

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D. Process-- Identifying Infrequent or Irregular Income

1. Unearned Income Total cannot exceed $20 per month.

If someone receives unearned income....	**and...**	**then its receipt is...**
no more than once in a calendar quarter from a single source	_____	infrequent.
no more than once in a calendar quarter from each of several sources	it is the same type of income in each instance,	infrequent.
no more than once in a calendar quarter from each of several sources	it is a different type of income in each instance,	infrequent.
more than once in a calendar quarter from the same source	it is a different type of income in each instance,	infrequent.
more than once in a calendar quarter from the same source	it is the same type of income in each instance,	**not** infrequent.
any number of times in a month	he could not reasonably have expected or budgeted for it,	irregular.
any number of times in a month	he could reasonably have expected or budgeted for it (even if he did not know the exact amount),	**not** irregular.

2. Earned Income Total cannot exceed $10 per month

When someone receives earned income....	then its receipt is...
no more than once in a calendar quarter from a single source,	infrequent.
no more than once in a calendar quarter from each of several sources,	infrequent.
more than once in a calendar quarter from each of several sources,	**not** infrequent.
any number of times in a month and he could not reasonably have expected or budgeted for it,	irregular.
any number of times in a month and he could reasonably have expected or budgeted for it (even if he did not know the exact amount).	**not** irregular.

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E. Process --Applying The Exclusion

The following process is for any earned income but only for unearned income which is not subject to other exclusions (see F. below).

When someone receives infrequent or irregular...	**and...**	**then this exclusion...**
unearned income	the total in a month does not exceed $20	applies.
unearned income	the total in a month exceeds $20,	does not apply.
earned income	the total in a month exceeds $10,	does not apply.
earned **and** unearned income	the monthly earned income total does not exceed $10 and the monthly unearned income total does not exceed $20,	applies to **both** earned and unearned income.
earned **and** unearned income	the monthly earned income total exceeds $10 but the monthly unearned income total does not exceed $20,	applies to the unearned income but not to the earned.
earned **and** unearned income	the monthly earned income total does not exceed $10 but the monthly unearned income total exceeds $20,	applies to the earned income but not to the unearned.
earned **and** unearned income	the monthly earned income total exceeds $10 and the monthly unearned income total exceeds $20,	does **not** apply.

F. Procedure

1. Initial Applications

a. **Infrequent**--If income is regular but may qualify for exclusion as infrequent, evaluate its receipt for the three months prior to the month of application.

b. **Irregular**--If income may qualify for exclusion as irregular, evaluate the predictability of its receipt beginning with the month of application.

2. All Situations

a. **Individual's *Attestation***
Obtain a statement over the individual's signature concerning the type, amount, frequency, or predictability of income. The statement or similar information on the application or redetermination form is sufficient documentation. Absent evidence to the contrary, accept the individual's *attestation*.

b. **Evidence Disagrees with *Attestation***
If there is evidence which disagrees with the individual's *attestations*, develop and document under the appropriate income rules.

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c. **Frequency of Receipt**Even though infrequent income has a monthly dollar limit, evaluate the frequency of receipt over a calendar quarter.

d. **Evaluating Income Received From More Than One Source--Some on a Monthly Basis, Some Only Once in a Calendar Quarter**
Compare only the income received **once in a calendar quarter** against the $10/$20 monthly limits (see e. below).

e. **Amount of Income**
- Add all of the **earned** income received on an infrequent or irregular basis and compare the total against the $10 monthly limit; and/or

- Add all of the **unearned** income received on an infrequent or irregular basis and compare the total against the $20 monthly limit.

G. Examples

1. Infrequent Income--Quarterly Income Only

a. **Situation:** The recipient owns two bank accounts, both of which pay interest only in the last month of each calendar quarter. The combined interest does not exceed $20 in the month of payment.

b. **Analysis:** Since interest on each account is received no more than once a quarter, its receipt is infrequent. Since the total of all the unearned infrequent income does not exceed $20 in a month, all the interest may be excluded under the infrequent income provision.

c. **Situation:** An individual opens up a checking account on February 27. The account pays interest on a monthly basis. The individual applies for Medicaid the next month, in March, and receives his first checking account interest payment on March 31 in the amount of $10.

d. **Analysis:** The $10 interest payment is excludable as infrequent in **March only**, since it was received only once in the January-March quarter.

The monthly interest received in April and subsequent months is not excludable as infrequent or irregular since the interest is received more often than once in a calendar quarter.

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2. Infrequent/ Irregular Income-- Monthly and Quarterly Income

a. **Situation:** The recipient owns two bank accounts, a checking account that pays interest of $2 a month and a savings account that pays interest of $19 once a quarter.

b. **Analysis:** The checking account interest is received more than once a quarter and is therefore not infrequent and not excludable under this provision. The savings account interest is received only once a quarter and is, therefore, infrequent. Since the total of all the unearned infrequent income does not exceed $20 in a month, the savings account interest may be excluded under this provision.

Note that in determining whether any interest income in this situation can be excluded as infrequent, we consider only the amount of income received **once in a calendar quarter** and compare that amount to the $20 unearned income limit for the infrequent/irregular income exclusion. Accordingly, in this situation, we do **not** add the $2 monthly checking account interest to the $19 savings account interest.

Also note that if the individual in this example has no income other than the savings and checking account interest, the checking interest is excludable under the $20 general income exclusion. See S0810.420 for a discussion of the general income exclusion.

c. **Situation:** An eligible couple owns the three bank accounts which pay interest in the month of September 1992 as described below.

Type	Interest is …	Paid in 9/92
Time deposit	compounded quarterly paid annually	$10
Savings	compounded monthly, paid quarterly	$2.50
Checking	compounded daily, paid monthly	$1.50

The wife receives a monthly title II check of $150. The husband received an unexpected birthday gift of $7 in cash in 9/92 from his daughter as a birthday gift.

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d. **Analysis:** The time deposit interest and savings interest are received only once (or less) per quarter. Therefore they are both infrequent. The $7 gift is irregular income. Since the total of the irregular/infrequent income received by the couple in 9/92 does not exceed $20 ($10 + $2.50 + $7), the income from these sources may be excluded.

Both the checking interest and the title II benefit are paid monthly. Therefore, neither type of income is excludable as infrequent or irregular.

NOTE: The frequency with which interest is **compounded** is not material to how often it is paid. Daily, monthly, or quarterly compounding are methods of **computing** (not paying) interest.

3. Infrequent/ Irregular Income-- Amount Exceeds Limit

a. **Situation:** The recipient owns a savings account which pays interest of no more than $8 in the first month of each quarter. Also in the first month of every quarter, the recipient's sister gives her $16 in cash to help her pay utility bills.

b. **Analysis:** Although both the income from her savings account and the income from her sister are received infrequently, the total of the infrequent income exceeds $20 in a month. Therefore, none of the income is excludable under this provision.

Note that were the sister to give the recipient $16 in the second or third month of every quarter (i.e., not in the same month the interest income is received), **both** types of income could be excluded under the infrequent income provision.

H. References

Relation of the infrequent/irregular exclusion to other income exclusions, S0830.050.

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S0810.420 $20 PER MONTH GENERAL INCOME EXCLUSION

A. Policy

1. Unearned Income

We exclude the first $20 per month of any unearned income other than income based on need (IBON).

Do not increase the dollar amount of this exclusion when both an eligible individual and his/her eligible spouse have income. An eligible couple receives one $20 exclusion per month.

2. Income Based on Need

Income based on need is a benefit that uses financial need as measured by income as a factor to determine eligibility.

The $20 exclusion does **not** apply to a benefit based on need that is totally or partially funded by the Federal Government or by a nongovernmental agency.

3. Earned Income

If an individual (or couple) has less than $20 of unearned income (other than IBON) in a month and also has earned income in that month, the remainder of the $20 exclusion reduces the amount of the earned income.

B. References

- Income Based On Need (IBON), S0830.170
- Assistance Based On Need (ABON), S0830.175

*M*0810.430 PLAN FOR ACHIEVING SELF-SUPPORT (PASS)

A. Policy

Income, whether earned or unearned, of a blind or disabled recipient may be excluded if such income is needed to fulfill a plan for achieving self-support (PASS). The Social Security Administration determines if an SSI recipient is entitled to a PASS exclusion.

This exclusion does not apply to a blind or disabled individual age 65 or older, unless he/she was receiving SSI or State disability or blind payments for the month before he/she became age 65.

B. How PASS Works In Brief

PASS is an income and resource exclusion that allows a disabled or blind person to set aside income and/or resources for a work goal such as education, vocational training, or starting a business. Individuals can *also* set aside funds to purchase work-related equipment.

PASS can help an individual establish or maintain SSI eligibility and can also help increase or help maintain the individual's SSI payment amount. *The PASS exclusion applies to the individual's SSI eligibility and is not evaluated by the Medicaid eligibility worker.*

C. References

- IRWE and PASS exclusions both apply, S0820.545 B.3.

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VERIFYING AND ESTIMATING INCOME

S0810.500 INCOME VERIFICATION

A. Policy Principles

1. Why Verification is Necessary

Although Medicaid does not determine Medicaid eligibility solely on the basis of statements concerning eligibility factors by applicants and recipients, for all case actions as of October 26, 2019, attestation of income will be accepted absent evidence to the contrary. We verify relevant information from independent or collateral sources and obtain additional information as necessary to be sure that eligibility is determined correctly. The agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information, and information from SSA through SVES or SOLQ-I. Verification of income from available sources, including the VEC, may be used if it is dated within the previous *6* months. See M0130.001.B.3.

For all case actions effective August 26, 2022, if the income attested to by the applicant is within 20% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required. If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return.

2. All Situations

a. **Individual's Attestation**
Obtain a statement over the individual's signature concerning the type, amount, frequency, or predictability of income. The statement or similar information on the application or redetermination form, is sufficient documentation. Absent evidence to the contrary, accept the individual's attestation.

b. **Evidence Disagrees with Attestation**
If there is evidence which disagrees with the individual's attestations, develop and document under the appropriate income rules.

2. Applicants/ Recipient's Responsibility

A person applying for or receiving Medicaid must give the local Department of Social Services (LDSS) any requested information and show necessary documents or other evidence to establish the amount of the individual's income.

B. Operating Policy

1. Burden of Proof

Applicants and recipients (or their representative payees) are responsible for providing LDSS with proof of income if requested and for reporting any changes in income.

2. Additional Verification Requirements

See the instructions for the particular type of income involved for additional verification requirements.

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3. Initial Applications Versus Post eligibility Situations

Unless instructions dealing with particular types of income state otherwise, verification requirements for initial applications also apply in post eligibility situations.

C. References

- Estimating future wages, S0820.150.
- Verification Requirements:
  Unearned income, S0830.005.
  Wages, S0820.135.
  Self-employment, S0820.220.
  Sheltered workshop earnings, S0820.300.
  Sick pay, S0820.005.

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M0810.600 PERIOD FOR WHICH AN ESTIMATE IS REQUIRED

A. Operating Policy

1. Period for Which Estimate is Required

Develop and record the best possible estimates of anticipated income, month-by-month, for the month of application or for the month of redetermination and for the next 11 months.

2. Exceptions

a. **Earlier Redetermination or Review of Income**
Some applications or cases will undergo a review of income sooner than the period mentioned in 1. above.

- **For initial applications**
estimate future income for the month of application through the month the next review of income will be completed.

- **For redeterminations, or reviews of income,** estimate future income through the month the next review of income will be completed.

b. **Net Earnings from Self-Employment**
Estimate net earnings from self-employment on the basis of a taxable year. See S0820.230 for more information on estimating net earnings from self-employment.

B. Documentation

If the period for estimating income is shortened because of one of the exceptions in A.2. above, show in the file the basis for using these procedures (e.g., that a critical birthday is upcoming or that an individual's estimated earned income for each month never exceeds $65).

C. Examples

1. Initial Application Deferred Development

Mr. Sam Polk files for Medicaid in March based on disability. His only income consists of rental income which varies from month-to-month. The EW obtains estimates of Mr. Polk's net rental income for the period from the month of application until a review of income will be completed (based on the EW's judgement).

2. Review of Income

Ms. Jennifer Wilks, an aged individual, undergoes a redetermination in October. Her only income consists of fluctuating wages from a part-time seasonal job. Since Ms. Wilks' job will end in January, the EW documents that and notes the case for a special review.

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M0810.610 HOW TO ESTIMATE INCOME

A. Operating Policy

1. Monthly Estimates

Estimate future income monthly.

2. Fluctuating Income

When income fluctuates, use previous months' actual receipts or written attestation to project future anticipated monthly income.

a. Individual's Attestation

Obtain a statement over the individual's signature concerning the type, amount, frequency, or predictability of income. The statement or similar information on the application or redetermination form, is sufficient documentation. Absent evidence to the contrary, accept the individual's attestation.

b. Evidence Disagrees with Attestation

If there is evidence which disagrees with the individual's attestations, develop and document under the appropriate income rules. The anticipated income should be an accurate indication of the individual's future income situation.

3. Income Expected Less Than Once a Month

Determine the specific month(s) of receipt and use the amount(s) estimated for the appropriate month(s).

4. Converting to Monthly Totals

To estimate income for Medically Needy Income evaluation convert to a monthly total, then multiply by number of months in the spenddown time frame.

- Weekly income is multiplied by 4.3,
- Biweekly income is multiplied by 2.15,
- dividing biweekly wages by 2 and multiplying by 4.3., or
- semi-monthly income multiplied by 2.

B. Operating Procedure

1. When a Change Occurs

An anticipated change in income occurs when you expect an individual's income to start, to stop, or to come in at a different rate in the future.

2. How to Develop a Change

When you anticipate an increase in income, use only that income which the individual is reasonably sure he will receive. *When a change in income occurs, redetermine Medicaid eligibility. Countable earned and unearned income is only verified if reasonable compatibility does not exist or the applicant's attested income or information from electronic data sources is over the income limit for his covered group.*

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3. Example

Anticipated Decrease in Income
Mr. Danny Kelp, a student child, receives support payments from an absent parent. These payments are $160 a month. In March, Danny's father begins a new job which pays less money. Danny notifies his EW that, based on his father's decrease in salary, he expects his support payments to decrease to $125 a month. The EW includes $125 unearned income in Danny's countable income computation.

C. Documentation

1. What the File Must Contain

If income verification is requested and received, verify and document the case record regarding the rate and frequency of payment (i.e., weekly, biweekly, semi-monthly, monthly, etc.) and the payment cycle (i.e., on what day the client is paid). The file must contain the estimates used.

2. Who May Provide an Estimate

Estimates of income may come from the applicant/recipient, representative, worker, or deemor.

3. Resolve any Discrepancy

If information received from an employer concerning current or future rate of pay is discrepant with an estimate provided by the applicant/recipient, representative payee, worker, or deemor, you must resolve the discrepancy.

4. Additional Documentation Requirements

See the specific sections dealing with the type(s) of income involved to determine if there are additional documentation requirements.

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INCOME OF MEMBERS OF RELIGIOUS ORDERS WHO TAKE A VOW OF POVERTY

M0810.700 GENERAL

A. Introduction

The policy and procedures in this section apply only to members of religious orders who have taken a vow of poverty. No other special provisions apply to Medicaid eligibility determinations for members of religious orders.

The existence of a vow of poverty is a factor in determining whether cash earnings are considered wages or net earnings from self-employment. The existence of a vow of poverty is also a factor in determining if payments made by a member to the order can be considered contributions for food, clothing, or shelter.

B. Policy

The treatment of income to members of religious orders who take a vow of poverty is determined by the source and nature of such income.

1. Earned Income -- Wages

Cash for members of religious orders who take a vow of poverty is considered wages in any of the following situations:

An individual receives compensation from the order as an active, working member of that order, whether or not the religious order has elected title II coverage.

EXAMPLE: A member of an order works at a hospital which is owned and operated by the order. The member's compensation of $150 per month from the order is earned income.

An active, working member of a religious order receives compensation for performing services from an agency of the church supervising the order or from an affiliated institution, whether or not the religious order has elected title II coverage.

EXAMPLE: A member of an order teaches at a school which is an affiliate of the order's supervising church. The school pays the member $300 per month which is turned over to the order. This amount is earned income.

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A member of a religious order receives compensation from a third party for services performed as an employee.
EXAMPLE: A member of a religious order also works for a private firm which pays her $250 per month as a computer programmer. This amount is earned income.

2. Earned Income -- NESE

Remuneration for members of religious order who take a vow of poverty is considered earnings from self-employment only when a member engages in self-employment unrelated to his/her membership in the order.

EXAMPLE: A member of a religious order, who is a recognized ornithological expert, submits articles to a magazine, on a free lance basis, for publication. Any remuneration received is treated as net earnings from self-employment.

3. Unearned Income--From the Order

Any income provided by the order to a member who has taken a vow of poverty, which does not fall under 1. and 2. above, is unearned income to the member even if turned over to the order.

EXAMPLE: A cash stipend paid to an inactive member, or a payment unrelated to a member's work, that is made by the order to a member is unearned income.

Food, clothing, or shelter that is not considered part of a member's wages is in-kind support and maintenance and is not considered income.

Any income or resources turned over by the member to the order are considered to be in fulfillment of the vow of poverty and are **not** considered contributions for food, clothing, or shelter received from the order.

4. Unearned Income--From Outside the Order

Unearned income received by a member from any source other than the order (e.g., title II or VA benefits) is income to the member even if the member turns it over to the order.

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C. Procedure

Use the following steps to process initial applications and post-eligibility changes involving income of members of religious orders who have taken the vow of poverty.

1. Vow of Poverty Allegation

Accept an individual's allegation that he/she has taken a vow of poverty unless there is a reason to doubt the allegation.

2. Wages-- Performing Services For the Order

When a member is performing services for the order, contact the order and document the value of remuneration received in cash as wages per S0820.130

3. Wages -- Performing Services Outside the Order

When a member is performing services for an affiliate of the order, and/or is employed by a third party, develop and document these earnings as wages per S0820.130.

4. Other Income

Apply the appropriate operating instructions pertaining to other types of earned and unearned income.

D. References

- Definition of wages, S0820.100
- NESE, S0820.200
- Unearned income, S0830.001
- Wage verification, S0820.130

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CHAPTER M08
INCOME
SUBCHAPTER 15

WHAT IS NOT INCOME

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M0815 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-35	7/1/25	Page 12
TN #DMAS-31	4/1/24	TOC page i
TN #DMAS-20	7/1/21	Pages 11, 12
TN #DMAS-17	7/1/20	Table of Contents Pages 11, 12
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WHAT IS NOT INCOME

M0815.001 WHAT IS NOT INCOME-GENERAL

A. Introduction

Some items that an individual receives are not income because they do not meet the definition of income in S0810.005 A. Other items are income but are excluded by statute (see S0830.099). In making income determinations, the eligibility worker (EW) must distinguish between an income exclusion and an item which is not income by definition. Only those items specifically listed in the law and regulations can be excluded from income.

B. Policy

An item received is not **income** if it is not cash, or its equivalent, or listed in this chapter. Contributions of in-kind items are not income.

An item which is not income when received by an individual, if retained until the following month, is subject to evaluation as a resource as of the first of the month after the month of receipt. (See S1110.600.)

C. Procedure

1. Is the Item Income?

In evaluating whether an item meets the definition of income, determine if it is:

- cash, *or its equivalent*
- **not** listed in this subchapter

If the item is **neither** of the above, consider it as not income.

2. Need to Document

Do not document the receipt of those items listed in this subchapter which are not income unless:

- Documentation is required by specific operating instructions elsewhere (e.g., rebates and refunds in S0815.250); or
- It is material to an eligibility computation.

D. References

- Treatment of income which is subject to garnishment, S0810.025.
- Treatment of contributions made to and benefits received from a cafeteria plan, *M*0820.102.

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S0815.050 MEDICAL AND SOCIAL SERVICES, RELATED CASH AND IN-KIND ITEMS

A. General

Policy Principle: Medical and social services are **not income** for purposes of the Medicaid program. Under the circumstance specified in this section, cash and in-kind items received in conjunction with medical and social services are not income for Medicaid purposes.

1. Governmental Services

Assume that government medical and social service programs which provide cash or in-kind items are authorized to provide such items only in order to provide a medical or social service. Therefore, when an individual alleges receiving cash or in-kind items from a governmental medical or social service program, develop only the source of the item, not its purpose.

2. Non-governmental Services

Do not assume, however, that cash or in-kind items provided by a nongovernmental medical or social service organization can only be for medical or social service purposes. When a nongovernmental medical or social service organization is involved, develop both the source and the purpose of the cash or in-kind item. Subsection B. through E. explain the guidelines for determining whether or not the cash or item is income.

3. Do Count-Sheltered Workshop Income And Incentive Payments

Do not apply the rules in this section to two kinds of payments which, although commonly associated with medical or social services, are income, regardless of the source of payment.

1. Remuneration for work or for activities performed as a participant in a program conducted by a sheltered workshop or work activities center is earned income. See S0820.300.

2. Incentive payments to encourage individuals to utilize specified facilities or to participate in specified medical or social service programs are unearned income, to the extent that these payments are unrestricted as to use and are not reimbursement for medical or social services already received. Accept the individual's allegation as to the purpose and the amount of the payment; however, if the person does not know this information or if there is reason to question his statement, verify the information by obtaining documentary evidence or by contacting the source of the payment.

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B. Medical Services

1. General

a. Definition

Medical services are those services which are directed toward diagnostic, preventive, therapeutic, or palliative treatment of a medical condition and which are performed, directed, or supervised by a State licensed health professional. The term "medical services" also includes any room and board (i.e., food and shelter) provided during a medical confinement (S0815.100), as well as in-kind medical items such as prescription drugs, eyeglasses, prosthetics and their maintenance, etc. For Medicaid purposes, in-kind medical items also include devices intended to bring the physical abilities of a handicapped individual to a par with a nonhandicapped unaided individual (e.g., electric wheelchairs, modified scooters). Furthermore, for Medicaid purposes, in-kind medical items include specifically trained animals (e.g., seeing eye dogs) and their maintenance (e.g., dog food). Under the definition, an automobile or van intended for street use would not be considered wholly a medical item but any modifications made to an automobile or van in order to accommodate a physically handicap individual would be a medical item and there fore the modification would not be income upon receipt. (See S1120.110 ff. for resource guidelines.) Transportation to and from medical treatment is also considered a medical services.

b. **Sources of Medical Services**

Medical services may be provided directly by treatment facilities or practitioners. They may also be made available indirectly through a variety of other sources. Some examples of Federal medical services programs are Medicare and CHAMPUS (Civilian Health and Medical Plan for the Uniformed Services). Similar medical services may be provided by or made available through other Federal programs, State and local government programs, private profit and nonprofit organizations (including charities, special funds benefiting an individual or a limited group of people, and medical insurers) and private individuals.

2. Treatment of Medical Services as Income

Medical services (which include in-kind medical items) are never income regardless of the source of the service or the source of payment for the service.

When cash or an in-kind item (other than a medical item, as defined above) is received by an individual in conjunction with a medical service, see D. below in order to determine whether the item is income.
NOTE: Payments by a third party or an individual's medical insurance premiums are not considered a medical service; however, these payments are not income per S0815.400. Also, items which do not qualify as a medical service may qualify as items received in conjunction with a social service and may not be income. See D. below.



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C. Social Services

1. General

For Medicaid purposes, use the following definition for a social service: A social service is any service (other than medical) which is intended to assist a handicapped or socially disadvantaged individual to function in society on a level comparable to that of an individual who does not have such a handicap or disadvantage.

Cash received from a medical or social services program or organization is **not income** under the conditions described below.

2. Several Examples of Frequently Encountered Social Services Programs

a. Title XX of the Social Security Act provides services directed at the following goals:

1) Achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;

2) Achieving or maintaining self-sufficiency, including reduction or prevention of dependency;

3) Preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests; or preserving, rehabilitating, or reuniting families;

4) Preventing or reducing in appropriate institutional care by providing for community-based case, home-based care, or other forms of less intensive care; and

5) Securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals for institutions.

b. Title IV-B of the Social Security Act, Child Welfare Services, provides for:

1) Public social services which supplement, or substitute for, parental care and supervision for the purpose of preventing, remedying, or assisting in the solution of problems which may result in the neglect, abuse, exploitation, or delinquency of children;

2) Protecting and caring for homeless, dependent, or neglected children;

3) Protecting and promoting the welfare of children working of mothers; and

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4) Otherwise protecting and promoting the welfare of children.

c. Title V of the Social Security Act, Maternal and Child Health and Crippled Children's Services, provides:

1) Services of reducing infant mortality and otherwise promoting the health of mothers and children;

2) Medical, surgical, corrective, and other services; and

3) Care and facilities for diagnosis, hospitalization, and aftercare to children who are crippled or who are suffering from conditions leading to crippling.

d. The Rehabilitation Act of 1973 provides:

1) Vocational rehabilitation services to handicapped individuals;

2) Services that may improve their ability to live with greater independence by self-sufficiency;

3) Services to the handicapped individuals who are homebound or institutionalized; and

4) Services to promote and expand employment opportunities in the public or private sectors for handicapped individuals and to place such individuals in employment.

e. Some examples of governmental programs which may provide medical and social services in combination are: programs under the Lanterman Developmental Disabilities Services Act of 1976 (California), Texas State Mental Health and Mental Retardation Programs, programs under the Pennsylvania Juvenile Act, and State alcoholism programs. Typical or nongovernmental organizations that may provide medical and social services in combination are the Salvation Army and the American Red Cross. The above is not an all-inclusive list. There are social services similar to those described above that are provided by, or made available through, other Federal, State, and local government programs, private profit and nonprofit organizations (including charities) and private individuals.

3. Several Examples of What is Not a Social Services

a. Education such as that provided by the public schools and (and essentially similar programs by private and parochial schools) is generally accepted to be in a category of its own and is not considered to be a social services.

b. Training for a specific job skill or trade (vocational training) is not a social service. Do not confuse vocational training with vocational rehabilitation. Vocational rehabilitation refers to set of social services (not income) that is directed at bringing the abilities of the handicapped up to par with those of the non-handicapped. However, if part of the vocational rehabilitation includes vocational training, treat both as a social service (i.e., not income).

c. Governmental income maintenance programs are not considered social services programs (e.g., Aid to Families with Dependent Children, Bureau of Indian Affairs General Assistance and/or Child Welfare Assistance, State general assistance, and Veterans Administration compensation or pension benefits).

d. Provision of food, shelter, laundry and recreational facilities in any combination is not by itself a social services.

D. Cash Received in Conjunction with Medical or Social Services

Cash received from a medical or social services program or organization is **not income** under the conditions described below:

1. Governmental Medical or Social Services Program

a. Rule

Any cash (other than remuneration for sheltered employment and incentive payments) provided by a governmental medical or social services program is not income. To be considered "governmental" in this context, the program must be authorized by Federal, State or local law to make payments for medical or social services purposes. Payment from a governmental program, which is disbursed by a nongovernmental agency, is considered a payment from a governmental program for purposes of this section.

b. Development

Document the file that the source of the cash is a governmental medical or social services program. Obtain evidence from the individual that the source of the cash is a governmental medical or social services program (e.g., program identification card, notice, or award letter). If the individual has no evidence available, contact the agency or organization alleged to be providing the cash and verify it is the source of the cash.

However, if it has been established that the program's fundamental purposed is medical or social services and the program agency or organization furnishes little or no documentary evidence to the claimant, then it is not necessary to contact the agency or organization. In these circumstances, obtain a signed statement from the individual indicating the source and amount of payments or in-kind items.



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When it is not obvious that the governmental program is a medical or social services program (e.g., when medical and/or social services are provided in conjunction with other assistance or unrelated activities), look to the stated fundamental purpose of the program which is the direct provider of the cash as stated in its authorizing law, statute, or ordinance. (For the purpose of this section, an intervening vendor is not considered the direct provider of the cash.) If the fundamental purpose of the governmental program is to provide medical or social service assistance, the cash is not income.

If you are unable to determine the fundamental purpose of the governmental program (e.g., the authorizing statute provides more than one purpose, one of which is not medial or social services, and it does not identify which one is the fundamental purpose), make your determination based on the particular case facts and circumstances involved. If unable to make such a determination, refer the case facts to the Regional Specialist for a decision.

2. Nongovernmental Medical or Social Services Organization

a. Cash Provided for Medical of Social Services Already Received

1) Rule

Any cash provided by a nongovernmental medical or social services organization (including medical and liability insurers) for medical or social services already received by the individual and approved by the organization is **not income**. However, if the individual alleges (or evidence indicates) the receipt of amounts in excess of the medical or social services expenses incurred, count the cash received in excess of the expenses as unearned income.

2) Development

Document the file that the source of cash is a nongovernment medical or social services organization. Look to the fundamental purpose of the organization in its articles of incorporation or certification as a nonprofit organization under section 501 (c) of the Internal Revenue Code.

Also document the file with a statement by the organization as to the purpose of providing the cash. If you verify the source of the cash is a nongovernment medical or social services organization and the purpose of the cash is to provide a medical or social services, the cash is not income.

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b. Cash Provided as a Payment Restricted to Future Use

1) Rule

Any cash provided by a nongovernment medical or social services organization (including medical and liability insurers) as a payment restricted to the future purchase of a medical or social services, or related excludable in-kind items, is not income.

2) Development

Document the file that the cash is provided by a nongovernment organization in accordance with the guidelines in a.2) above. Also document the file as to the purpose of a medical or social services) and that the providing program requires followup to verify that the funds were spent for the purpose given (e.g., the provider contacts the vendor or requests a receipt).

c. Flat Rate Benefit Payments from a Insurance Policy

1) Rule

Cash from any insurance policy which pays a flat rate benefit to the recipient without regard to the actual charges or expenses incurred is income. Examples of these types of insurance policies are per diem hospitalization or disability insurance, or cancer or dismemberment policies.

2) Development

When cash from a flat rate benefit insurance policy is received by a claimant/recipient, document the file as to the source and amount of the cash.

E. In-Kind Items Received in Conjunction with Medical or Social Services

1. Government Medical or Social Services Program

a. Rule

Any in-kind items (including food, clothing, or shelter) provided by a governmental medical or social services program (e.g., recreational equipment, magazines, toiletries) are not income unless provided as a remuneration for sheltered employment or as incentive payments. Note that in-kind medical items are **never income** regardless of their source (see B. above).

To be considered "government" in this context, the program must be authorized by Federal, State or local law, statute, or ordinance to provide medical or social services.



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b. Development

Unless an in-kind medical item is involved, follow the general guidelines in D.1.b) above, and document the file that the purpose of the governmental program involved is to provide medical or social services. Do not count as income any in-kind items provided by the government medical or social services program. It is not necessary to develop for the reason the in-kind items are provided when a governmental medical or social services program is involved. It is necessary only to develop the source.

In-kind medical items are **not income** regardless of their source. If an item meets the definition of an in-kind medical item as defined in B. above, no further development is needed.

2. Nongovernment Medical or Social Services Organization

a. Rule

In-kind items (other than food, clothing or shelter) provided by a nongovernmental medical or social services program (e.g., recreational equipment, magazines, toiletries) for medical or social services purposes are **not income**.

b. Development

In-kind medical items are not income regardless of their source, if an item meets the definition of an in-kind medical item as defined in B. above, no further development is needed. When other in-kind items (not including food, clothing, or shelter) are alleged to be received in conjunction with a medical or social service, document the file that the item is provided by a nongovernmental medical or social services organization for medical or social services purposes in accordance with the guidelines in D.2.a.2) above. If you verify the source of the cash is a nongovernmental medical or social services organization and the purpose of the time is to provide a medical or social services, the item is **not income.**

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F. Summary of Rules on Cash and In-Kind Items Received in Conjunction With Medical or Social Services

What follows is a summary of the rules for cash received in conjunction with medical or social services.

1. Cash Received in Conjunction with Medical or Social Services

a. Any cash provided by a governmental medical or social services program is **not income.**

b. Any cash from a nongovernmental medical or social services organization is **not income** when:

1. the cash is for medical or social services already received by the individual and approved by the organization; or

2. the cash is a payment restricted to the future purchase of a medical or social service.

c. Cash from any insurance policy which pays a flat rate benefit to the recipient without regard to the actual charges or expenses incurred is **income.**

2. In-Kind Items Received in Conjunction with Medical or Social Services

a. In-kind items which meet the definition of medical services in B. above are **not income** regardless of their source.

b. Room and board providing during a medical confinement (S0815.100) is **not income.**

c. Any in-kind items (including food, clothing, or shelter) provided by a government medical or social services program are **not income**.

d. In-kind items (other than food, clothing, or shelter) providing a nongovernment medical or social services organization for medical or social services purposes are **not income**.

S0815.150 PERSONAL SERVICES

A. Policy

A personal service performed for an individual is not income.

B. Examples

Examples of personal services for an individual which are **not income are:**

- Mowing the lawn;
- Doing housecleaning;
- Going to the grocery; and
- Babysitting.

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M0815.200 CONVERSION OR SALE OF A RESOURCE

A. Policy

Receipts from the sale, exchange, or replacement of a resource are **not income** but are resources that have changed their form.

This includes any cash or in-kind items that is provided to replace or repair a resource that has been lost, damaged, or stolen

Capital gains, which are profits made from the sale of capital assets (long-term assets such as land or buildings), are also not income. Any proceeds that remain the month after this type of sale must be evaluated as a resource.

B. Reference

See S1110.600 B.4. for a complete discussion of the policy.

C. Example

Jerry Wallace sells his 1974 Plymouth Satellite for $300. The money he receives is not income but a resource which has been converted from one form (a car) to another form (cash).

M0815.250 REBATES AND REFUNDS

A. Policy

When an individual receives a rebate, refund, or other return of money he or she has already paid, the money returned is **not income.**

CAUTION: The key idea is applying this policy is a return of an individual's own money. Some "rebates" do not fit that category. For example, if a cooperative operating as a jointly-owned business pays a "rebate" as a return on a member's investment, this money is unearned income similar to a dividend. Developmental guidelines for interest and dividends are in S0830.500.

See M0815.270 for the treatment of *COVID-19 relief payments provided under federal law*

B. Procedure

1. General

Unless you have reason to question the situation, accept an individual's signed allegation that a rebate or refund of money is a return of money already paid and do not count it as income.

2. Questionable Situation

In questionable situations, make copies for the file of any documents in the individual's possession, and contact the source of the payment, etc. to verify that the payment is a return of money already paid.

C. Example

Rose Woods, an elderly recipient, pays property taxes on the home she lives in. Because of her low income, the city government returns part of Mrs. Woods' property taxes in the form of a check. This return of money already paid by Mrs. Woods is not income.

D. References

See S0830.705 for rules on the exclusion of certain taxes.

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S0815.270 INCOME TAX REFUNDS AND CREDITS

A. Policy

1. General Any amount refunded on income taxes already paid is **not income**.

2. Tax Withheld Prior to Application Date Income tax refunds are not income even if the income from which the tax was withheld or paid was received in a period prior to application for Medicaid.

3. Tax Refunds and Blind Work Expenses Income tax refunds are **not income** even if the income taxes were included as work expenses of the blind. (See S0820.535 B.3.)

4. COVID-19 Relief Payments COVID-19 relief payments provided under federal law are considered tax credits and are **not countable as income *OR* resources.** See M1130.675. Interest earned on the retained payments is countable as interest income.

S0815.300 CREDIT LIFE OR CREDIT DISABILITY INSURANCE PAYMENTS

A. Definition of Credit Life/Disability Insurance Credit life and credit disability insurance policies are issued to or on behalf of borrowers, to cover payments on loans, mortgages, etc. in the event of death or disability. These insurance payments are made directly to loan or mortgage companies, etc. and are not available to the individual.

B. Policy

- Payments made under a credit life or credit disability insurance policy on behalf of an individual are **not income.**
- Food, clothing, or shelter received as the result of a credit life or credit disability payment is **not income.**

C. Example Frank Fritz, a Medicaid recipient, purchased credit disability insurance when he bought his home. Subsequently Mr. Fritz was in a car accident and became totally disabled. Because of his disability, the insurance company pays off the home mortgage. Neither the payment nor the increased equity in the home is income to Mr. Fritz.

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S0815.350 PROCEEDS OF A LOAN

A. Introduction

Proceeds of a loan are **not income** to the borrower because of the borrower's obligation to repay.

B. Policy

1. Loan Not Income

Money that a person borrows or money received as repayment of the principal of a loan is **not income.**

2. Loan Not Bona Fide

If a loan is not bona fide, the proceeds are unearned income in the month received.

3. Interest on a Loan

Interest received on money loaned is **income.**
(See S830.500 C.)

4. Buying on Credit

Items bought on credit are treated as though the individual were borrowing money and are not income.

C. References

- Definition of Bona Fide loan, S1120.220A
- Resource policy when the Medicaid applicant/recipient is the lender, S1120.220B., S1140.300.

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S0815.400 BILLS PAID BY A THIRD PARTY

A. Policy.

Payment of an individual's bills (including supplementary medical insurance under title XVIII or other medical insurance premiums) by a third party directly to the supplier is **not income.**

B. Examples

1. Third Party Payment Does Not Result in Income

Joshua Hall, a Medicaid recipient, is unable to pay his phone bill so his sister pays the phone company with her money. Neither the payment to the phone company nor the telephone service received as a result of the payment is income because it is not food, clothing, or shelter.

C. References

- Gifts received as a result of another's payments of bills, S0830.520.
- Instructions on vendor payments which are a form of certain home energy assistance or support and maintenance assistance, S830.605.

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S0815.450 REPLACEMENT OF INCOME ALREADY RECEIVED

A. Policy

- If an individual's income is lost, stolen, or destroyed and the individual receives a replacement, the replacement is **not income.**
- Once a payment has been issued and treated as income in determination an individual's eligibility for Medicaid, the reissuance of that same payment is **not income.** For instance, if one member of a couple receives income and dies before the check is cashed, the reissued check is not income to the surviving spouse.
- On the other hand, if the original payment is not used to determine the surviving spouse's eligibility (e.g., because the couple is separated), the reissued check **is income** to the surviving spouse. (See S830.545 for the treatment of death benefits.)

B. References

- Income rules regarding replacement of a resource, S0815.200.
- Rules on erroneous payment which the individual returns, S0815.460.

C. Example

Bob Akers, a Medicaid recipient, received a replacement title II check after his regular monthly title II check was damaged in the mail. The replacement check is not income to Mr. Akers. (Mr. Akers income was counted the month the regular title II check was paid.)

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S0815.460 RETURN OF ERRONEOUS PAYMENTS

A. Policy

A payment is **not income** when the individual is aware that he/she is not due the money and returns the check uncashed or otherwise refunds all of the erroneously received money.

B. Procedure

1. Timely Return

If the individual returns or refunds an erroneous payment in the same or following month of receipt, accept the allegation that the money was returned and do not count the erroneous payment as income.

2. Delayed Return

If there is a delay in the return of an erroneous payment beyond the month following the month of receipt:

- verify return of the payment;
- document the reason for the delay (e.g., lengthy hospital stay) and any other relevant facts; and
- record your determination in the file.

C. Example

In August, Bob Brown states that he received his regular January VA pension check of $290. However, during the latter part of January, he received another $290 VA check along with a letter explaining that his January check had been delayed due to a computer error. Mr. Brown explains that he knew the second check was a duplicate and says he had not been able to return it sooner due to illness. The EW verifies the return of the $290 check in July as well as Mr. Brown's illness. The EW then makes a determination concerning Mr. Brown's income and records it in the file.

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S0815.500 WEATHERIZATION ASSISTANCE

A. Policy

Weatherization assistance (e.g., insulation, storm doors, and windows, etc.) is **not income.**

B. Reference

- Treatment of certain home energy assistance and support and maintenance assistance, S0830.605.

S0815.600 WAGE-RELATED PAYMENTS

A. Introduction

Employers make various payments on behalf of their employees which are not earnings and are not available to meet the employee's needs of food, clothing, or shelter.

B. Policy

The following payments by an employer are **not income** unless the funds for them are deducted from the employee's salary:

- funds the employer uses to purchase qualified benefits under a cafeteria plan;
- employer contributions to a health-insurance or retirement fund;
- the **employer's** share of FICA taxes or unemployment compensation taxes, in all cases;
- the **employer's** share of FICA taxes or unemployment compensation taxes paid by the employer on wages for **domestic service in the private home of the employer or for agricultural labor only**, to the extent that the employee does not reimburse the employer.

C. References

- What is income, S0810.005
- What is not income, S0815.001
- Cafeteria plans, S0820.102

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CHAPTER M08
INCOME
SUBCHAPTER 20

EARNED INCOME

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M0820 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Pages 30, 31
TN #DMAS-34	1/1/25	Pages 30, 31
TN #DMAS-31	4/1/24	TOC i, Pages 15a, 31
TN #DMAS-29	10/1/23	Pages 3, 4, 11, add 15a, 17, 28, 29
TN #DMAS-28	7/1/23	Pages 4, 11, 17, 29. Page 12 is a runover page.
TN #DMAS-23	1/1/23	Pages 30, 31
TN #DMAS-22	1/1/22	Pages 30, 31
TN #DMAS-18	1/1/21	Pages 30, 31
TN #DMAS-12	4/1/20	Page 29
TN #DMAS-15	1/1/20	Pages 30, 31
TN #DMAS-14	10/1/19	Pages 10, 11, 13, 22, 24
TN #DMAS-12	4/1/19	Page 21
TN #DMAS-11	1/1/19	Pages 30, 31
TN #DMAS-7	1/1/18	Page 11, 30-32
TN #DMAS-5	7/1/17	Pages 11, 13, 29, 30 Page 12 is a runover page.
TN #DMAS-3	1/1/17	Pages 30, 31
TN #DMAS-1	6/1/16	Pages 30, 31, 47
TN #100	5/1/15	Pages 30, 31, 47 Page 48 is a runover page.
TN #99	1/1/14	Pages 30, 31
UP #9	4/1/13	Pages 30, 31
Update (UP) #6	4/1/12	Pages 30, 31
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M0820.000 EARNED INCOME

S0820.001 GENERAL

A. Policy

1. What Constitutes Earned Income

Earned income may be received in cash and consists of:

- Wages
- Net earnings from self-employment (NESE)
- Payments for services performed in a sheltered workshop or work activities center
- Earned Income Tax Credit (EITC) payments, excluded effective January 1, 1991
- Royalties earned by an individual in connection with any publication of his/her work and any honoraria received for services rendered, effective December 1, 1991.

2. Earned Income Exclusions

Although we must know the source and amount of all earned income, we do not count all of it in determining eligibility

B. References

- Wages, S0820.100
- NESE, S0820.200
- Sheltered workshop payments, S0820.300
- EITC payments, S0820.400.
- EITC exclusion effective January 1, 1991, S0820.570.
- Royalties/honoraria as earned income, S0820.450.
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S0820.005 SICK PAY

A. Definition

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.

B. Policy

Sick pay is either wages or unearned income. (Payments to an employee under a workers' compensation law are neither wages nor sick pay.)

The following chart shows how to treat sick pay .

WHEN RECEIVED	ATTRIBUTABLE TO EMPLOYEE'S OWN CONTRIBUTION	TYPE OF INCOME
More than 6 months after stopping work	**N/A**	**Unearned Income**
Within 6 months after stopping work	**No** **Yes**	**Wages** **Unearned Income**

C. Procedure

1. Development

To determine the 6-month period after stopping work:

- Begin with the first day of nonwork.
- Include the remainder of the calendar month in which work stops.
- Include the next 6 full calendar months.

EXAMPLE: If an individual stops work on May 5, the 6-month period begins on May 6 and runs through November 30.

2. Verification

a. **General**
Verify sick pay which is wages by using the wage verification procedure in S0820.135.

b. **Last Day (or Month) Worked**
Verify the last day (or month) worked with the employer or knowledgeable third party.

3. Documentation

Document the file with the employer/third party's statement or record contact showing the last day (or month) worked.

D. References

- Workers' compensation, S0830.235.
- Sick pay as unearned income, S0830.543.

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WAGES
S0820.100 GENERAL

A. Definition

Wages are what an individual receives (before deductions) for working as someone else's employee.

NOTE: Under certain circumstances, services performed as an employee are deemed to be self-employment rather than wages (e.g., ministers, real estate agents, sharefarmers, *newspaper vendors*, etc.). *An S Corporation may pay wages to an individual who performs work-related services and is considered an employee of the S Corporation (i.e. President), even if the individual is a shareholder of the S Corporation.*

B. Policy

1. Kinds of Wages

Wages may take the form of:

a. **Salaries--**These are payments (fixed or hourly rate) received for work performed for an employer.

b. **Commissions--**These are fees paid to an employee for performing a service (e.g., a percentage of sales).

c. **Bonuses--**These are amounts paid by employers as extra for past employment (e.g., for outstanding work, length of service, holidays, etc.)

d. **Severance pay--**This payment made by an employer to an employee whose employment is terminated independently of his wishes.

e. **Military basic pay--**This is the service member's wages, which is based solely on the member's pay grade and length of service. See S0830.540 C.3.

f. **Special payments received because of employment.**

g. **Sick pay received within 6 months after stopping work, which is not attributable to the employee's contribution--**See S0820.005

h. *food, clothing, shelter, or other items received in lieu of cash is counted as earned income if not considered as in-kind payments and counted as unearned income*

2. When To Count

Wages for each month count at the earliest of the following points:

- when they are received, or
- when they are credited to the individual's account, or
- when they are set aside for the individual's use.

C. Procedure

Absent evidence to the contrary, if FICA taxes have been deducted from an item, assume it meets the definition of wages. If FICA taxes have not been deducted from an item, determine if it is wages per S0820.102.

D. References

- Work related unearned income, S0830.530.
- Advance dated checks, S0810.030 B.2.
- Wage advances and deferred wages, S0820.115.

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S0820.102 CAFETERIA PLANS

A. Definitions

A cafeteria plan is a written benefit plan offered by an employer in which:

1. Cafeteria Plans

- all participants are employees; and
- participants can choose, cafeteria-style, from a menu of two or more cash or qualified benefits.

2. Qualified Benefits

A qualified benefit is a benefit that the Internal Revenue Service (IRS), by express provision of Section 125 of Chapter 1 of the Internal Revenue Code (IRC) or IRS regulations, does not consider part of an employee's gross income. Qualified benefits include, but are not limited to:

- accident and health plans (including medical plans, vision plans, dental plans, accident and disability insurance);
- group term life insurance plans (up to $50,000);
- dependent care assistance plans; and
- certain stock bonus plans under section 401(k)(2) of the IRC (but not 401(k)(1) plans).

Cash is **not** a qualified benefit.

3. Salary Reduction

A salary reduction agreement is an agreement between employer and employee whereby the employee, in exchange for the right to participate in a cafeteria plan, accepts a lower salary or forgoes a salary increase.

B. Background

1. IRS Authority

Section 125 of the IRC permits cafeteria plans.

2. Monitoring

IRS relies on employers to ensure that IRS-approved plans continue to meet the requirements of Section 125 of the IRC.

3. Funding

Most cafeteria plans are funded by salary-reduction agreements**.** *However, employers may contribute to fund basic benefit levels under a cafeteria plan without a salary-reduction agreement.*

4. Significance for Tax Purposes

Because Section 125 of the IRC provides that qualified benefits and the amount of a salary-reduction agreement are not part of gross income, they are not subject to Social Security/Medicare and income taxes.

5. Cafeteria Plan Indicators

It can be difficult to tell whether payslip entries represent payroll deductions, which are part of gross wages, or cafeteria-plan itemizations, which are not. The following indicators suggest a cafeteria plan.

a. A payslip / *paystubs may* uses terms such as:
   - FLEX
   - CHOICES
   - Sec. 125
   - Cafe Plan

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b. The Social Security/Medicare tax shown is less than the tax rate (7.65%) times the gross wages shown.
EXAMPLE: A payslip shows $402.07 gross and $26.73 withheld for Social Security/Medicare taxes, but 7.65% of $402.07 is $30.76.

NOTE: Another reason the Social Security/Medicare tax can be less is that part of the gross may not be covered wages for title II purposes. Examples include:

- earnings from noncovered employment;
- wages excluded from coverage because of quarterly or calendar-year minimums in such areas as agricultural labor, domestic employment, etc., and
- wages excluded from coverage because they are above the yearly maximum.

C. Policy

1. General A plan is not a cafeteria plan unless it meets the requirements of Sec. 125 of the IRC.

2. Salary Reductions Amounts used to purchase cafeteria-plan benefits under a salary-reduction agreement **are not** the employee's wages and **are not** earned income for Medicaid purposes.

3. Payroll Deductions Payroll deductions used to purchase cafeteria-plan benefits in addition to or instead of as provided under a salary-reduction agreement **are** the employee's wags and **are** earned income.

IMPORTANT: Payslips that appear to show payroll deductions may actually show how funds from a salary reduction agreement have been allotted among qualified benefits.

4. Cash Received Under a Cafeteria Plan

a. **In Lieu of Benefits**
Cash received under a cafeteria plan in lieu of benefits is wages.

b. **Reimbursement for Expenses**
Cash received as reimbursement for qualified-benefit expenses, such as child care, is not income.

5. Qualified Benefits Qualified benefits are neither earned nor unearned income.

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D. Procedure

1. Assumption of Compliance

Assume that a cafeteria plan complies with IRS requirement, unless you become aware that IRS has determined otherwise.

2. How to Develop Cafeteria Plan Precedents

If a precedent is needed per 3. below, contact the employer (by phone, if possible) and ask if the employer offers a cafeteria plan. Proceed as follows:

a. **Employer Does Not Offer a Cafeteria Plan**

Prepare and retain in files a precedent showing:

- employer name, address, and phone number;
- name and title of person contacted; and
- a statement that the employer does not offer a cafeteria plan.

b. **Employer Offers a Cafeteria Plan**

Prepare and retain in the files a precedent showing:

- employer name, address, and phone number;
- name and title of person contacted;
- effective date of the plan;
- employee positions covered by the plan;
- benefits offered under the plan;
- which deductions on the payslips are nontaxable; and
- any additional information needed to determine countable gross wages from payslips.

NOTE: Precedents should be updated periodically.

3. Case Development and Documentation

Follow the steps below to:

- decide whether cafeteria-plan development is needed and, if so,
- establish whether a cafeteria plan is involved and, if so,
- determine countable wages.

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NOTE: It is not necessary to separately document responses to the questions in the chart below, except where indicated.

STEP	ACTION
1	Are payslips available to verify wages? • If you, go to step 2. • If no, verify wages with the employer per S0820.130. STOP.
2	Does a cafeteria-plan precedent exist for this employer? • If yes, use it to compute countable wages and go to Step 7. • If no, go to Step 3.
3	Ask the individual if he/she participates in a cafeteria plan. • **If yes or uncertain,** or there is any indicator of a cafeteria plan, such as those in B.5. above go to Step 4. • If **no**, and there is no other indication of a cafeteria plan, compute countable wages accordingly. STOP.
4	Is the employer's payroll office located in your service area? • If yes, go to Step 6. • If no, go to Step 5.
5	Request a precedent from the employer's servicing your area. If none exists, ask the servicing RO to develop one per D.2. above. Upon receipt of the precedent, compute wages. Retain a copy of the precedent. Go to Step 7. **NOTE:** If a precedent cannot be established (e.g., employer will not cooperate), do not attempt to determine whether certain payslip entries represent cafeteria-plan itemizations; verify wages with the employer per S0820.130. STOP.
6	Contact the employer and develop a precedent per D.2. above. • If **a precedent can be established** (including a negative precedent), use it to compute countable wages, retain it, and go to Step 7. • If **a precedent cannot be established** (e.g., employer refuses to cooperate), do not attempt to determine whether or not payslip entries represent cafeteria-plan itemization; verify wages with the employer per S0820.130. STOP.
7	Document the case file with a statement that a precedent exists and that there is or is not a cafeteria plan.



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E. Examples

1. Employee Chooses Not to Join a Cafeteria Plan

ABC, Inc. offers a cafeteria plan funded through a salary-reduction agreement. An employee who decides not to participate receives cash equal to or less than the amount the employer would have contributed as a premium on behalf of the employee. Mr. Green takes the cash. The cash is wages.

2. Salary Reduction

Mr. Black has the option of accepting a $100-a-month raise or participating in a cafeteria plan by entering into a salary-reduction agreement and allowing his employer to use $100 to help fund the plan. He enters into the salary-reduction agreement. The $100 is not part of his wages.

3. No Salary Reduction, But Contributions Allowed

The XYZ Company contributes $50 a week to fund basic benefit levels under a cafeteria plan that offers cash and a variety of insurance coverages. There is no salary-reduction agreement.

Employees who want more than the basic benefits may pay the additional cost through voluntary payroll deductions.

Mrs. Grey chooses health insurance and life insurance costing $83 per week. XYZ's $50 contribution is not wages. The $83 Mrs. Grey pays is part of her gross wages.

4. Cash in Lieu of Benefits

Same background as in 3. above. Mr. Brown selects insurance that costs $35 a week and opts for a weekly cash payment of $15 in lieu of additional coverage. XYZ's $35 contribution is not wages, but the $15 cash payment is.

5. Cash as Reimbursement for Plan-Approved Expenses

Same background as in 3. and 4. above. Mrs. White selects insurance that costs $30 a week and childcare benefits that cost $20 a week. Neither XYZ's contribution nor the reimbursements of childcare costs are wages.

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S0820.115 WAGE ADVANCES AND DEFERRED WAGES

A. Definitions

1. Wage Advances — Advances are payments by an employer to an individual for work to be done in the future.

2. Deferred Wages — Wages are considered "deferred" if they are received later than their normal payment date. Types of wage payments which may be deferred include vacation pay, dismissal and severance pay, back pay, bonuses, etc.

B. Policy

1. Wage Advances — An advance is wages in the month received.

2. Deferred Wages

a. Wages that are deferred **due to circumstances beyond the control of the employee** are considered earned income when actually received.

b. Wages that are deferred **at the employee's request or by mutual agreement with the employer** are considered earned income when they would have been received had they not been deferred.

C. Procedure

1. Wage Advance — Assume that an advance on wages meets the definition of wages (as opposed to being a loan), absent evidence to the contrary. Count such advances on wages as income when received.

NOTE: Advance military pay is a cash loan. See S0830.540 B.9.

2. Deferred Wages — If the individual alleges or other evidence shows that wages were deferred, request from the employer an explanation of the reason for the deferment.

IF the employer . . .	**THEN . . .**
provides an explanation	document the file with the employer's explanation.
is uncooperative but the individual satisfactorily explains	document the file with the individual's signed statement.
is uncooperative and the individual cannot satisfactorily explain	document the file with a statement to that effect and assume that the wages were available to the employee when they would have been received had they not been deferred.

D. References

- Advance pay to members of the Uniformed Services, S0830.540 B.10.
- Loans, S0815.350.

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M0820.125 WAGE VERIFICATION IS REQUIRED

A. Policy

1. When to Verify Wages

Verification of wage amounts and frequency of receipt is required whenever an individual alleges (or you believe) he received wages, sick pay, or temporary disability. *For all case actions effective October 26, 2019, a written attestation may be used to project future anticipated monthly income.*

a. Individual's Attestation
Obtain a statement over the individual's signature concerning the type, amount, frequency, or predictability of income. The statement or similar information on the application or redetermination form is sufficient documentation. Absent evidence to the contrary, accept the individual's attestation.

b. Evidence Disagrees with Attestation
If there is evidence which disagrees with the individual's attestations, develop and document under the appropriate income rules. The anticipated income should be an accurate indication of the individual's future income situation.

2. When Not to Verify Wages

Wage Verification Is Not Required When:

- *No available evidence disagrees with the individual's attestation, or*
- *The individual* alleges he has not worked or received earnings (e.g., wage/sick pay) in any month from the first month of the retroactive period through the application month and you have no reason to question the allegation, or
- *The individual* is being denied Medicaid for reasons other than earnings/income.

M0820.127 PERIOD FOR WAGE VERIFICATION

Procedure

If income *reasonable compatibility* cannot be verified using electronic data sources, including the Federal Data Hub, the Virginia Employment Commission, *or* the Work Number, verify:

At initial application

- wages received in all retroactive months, (if a medical expense exists),
- wages for the month of application, if the applicant alleges that wages have been paid.
- wages received in the month of application, and
- wages received after month of application but prior to processing the application **if** the applicant alleges that a change in wages has occurred.
- wages used to estimate anticipated income.

At redetermination or review of income

- all unverified wages through the month immediately preceding the month the redetermination or review of income is initiated, unless
- employment began in current month.

NOTE: Obtain employer statement regarding wages (i.e., hourly wage, number of work hours per pay period, receipt of pay.



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M0820.130 EVIDENCE OF WAGES OR TERMINATION OF WAGES

A. Policy

1. Primary Evidence of Wages

The following proofs, in order of priority, are acceptable evidence of wages:

a. Verifications of income *received from or reasonable compatibility* with electronic data sources, including the Virginia Employment Commission (VEC), *Federal Data HUB or The Work Number*. *If worker discovers a discrepancy in the wage data, resolve the discrepancy by obtaining other primary and secondary data.*

b. Pay slips--Must contain the individual's name or Social Security number, gross wages, and period of time covered by the earnings.

c. Oral statement from employer, recorded in case record.

d. Written statement from employer.

2. Secondary Evidence of Wages

If primary evidence is not available, the following proofs, in order of priority, are acceptable evidence of wages:

a. W-2 forms, Federal or State income tax forms showing annual wage amounts.

b. Individual's signed allegation of amount and frequency of wages.

3. Acceptable Evidence of Termination of Wages

The following proofs, in order of priority, are acceptable evidence of termination of wages:

a. Verifications from electronic data sources, including the Virginia Employment Commission (VEC).

b. Oral statement from employer, recorded in case record.

c. Written statement from employer.

d. Individual's signed allegation of termination of wages (including termination date and date last paid).

B. Procedure

1. Order of Priority

Seek type "a" evidence before type "b," etc.

2. Pay Slips

a. Stress to the individual that he/she is responsible for providing proof of wages *if not available from an electronic source* and is expected to retain all pay stubs and provide them as requested.

b. Accept the individual's signed allegation of when earnings were received if it is not shown on the pay slip.

NOTE: If not all pay slips are available, but the wages attributable to the missing pay slip(s) can be determined by other evidence (e.g., year-to-date totals), it is not necessary to obtain the missing pay slip.



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NOTE: Pay slips which do not contain all the required information may be used in conjunction with other evidence; however, any discrepancies must be resolved.

If not all pay slips are available, but the wages attributable to the missing pay slip(s) can be determined by other evidence (e.g., year-to-date totals), it is not necessary to obtain the missing pay slip.

3. Employer Reports

If an employer returns a statement to the EW unsigned, do not recontact the employer for a signature unless the EW questions the statement's validity (e.g., the income verification form was hand-carried to the LDSS by the applicant rather than mailed directly to the LDSS).

4. Evidence Reflects Only an Annual Wage Amount

If the evidence that can be obtained reflects only an **annual** wage amount, divide the annual amount by 12 to get monthly wage amounts.

C. References

- Military pay and allowances, S0830.540.

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M0820.135 WAGE VERIFICATION

A. Procedure

1. Chart

This chart describes the procedure for verifying wages per month *when wages cannot be verified through an online data source, or attested income is not reasonably compatible with information obtained through an electronic source.*

STEP	ACTION
1	Does the individual have acceptable pay slips for some or all of the period being verified? (See s0820.130 A. 1. a.) • If yes, go to Step 2. • If no, go to Step 8.
2	Were any wages deferred during the period covered by the pay slips? • If yes, go to Step 3. • If no, go to Step 4.
3	• Count deferred wages per S0820.115 B.2. • Document the file. • Go to Step 5.
4	• Count wages when received. • Go to Step 5.
5	Do the pay slips cover earnings for the entire period being verified or, if not, can the wages attributable to the missing pay slip(s) be determined by other evidence (e.g., year-to-date totals)? • If yes, go to Step 6. • If no, go to Step 7.
6	• Document the file with a copy or certification of the pay slips, and signed allegation (if necessary per S0820.130 B.2.) • STOP

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A. Procedure

1. Chart (cont.)

STEP	ACTION	
7	• Document the file with a copy or certification of the pay slips, and signed allegation (if necessary per S0820.130 B.2.) • Go to Step 8 to verify any wages for which acceptable pay slips are unavailable.	
8	Phone employer to verify wages.	
	If the employer….	**THEN**...
	verifies wages and no deferred wages are involved	• count wages when received • document the file • STOP
	verifies wages and de-ferred wages are involved	• count deferred wages per S0820.115B.2. • count remainder of wages when received • document the file • STOP
	verifies wages but you believe an oral state-ment is sufficient	• go to Step 9.
	is uncooperative or un-able to be reached by phone	• go to Step 9.
	s	

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A. Procedure
1. Chart (cont.)

STEP	ACTION
9	Send Income Verification Form to employer.
	IF the employer… / **THEN…** verifies wages and no deferred wages are involved • count wages when received • document the file with the Income Verification Form • STOP
	verifies wages and deferred wages are involved • count deferred wages per S0820.115 B.2. • count remainder of wages when received • document the file with the Income Verification Form • STOP
	is uncooperative or cannot be located go to Step 10.
10	• Obtain the individual's signed allegation of amount and frequency of wages (and Form W-2, if available). **NOTE:** If the only evidence is an individual's signed allegation of **annual** wages and/or W-2 (e.g., migrant workers), divide the annual wage amount by the number of months for which work is alleged to arrive at a "verified" wage amount to be counted for each of those months. • Count wages as alleged in this step. • Document the file with the individual's signed statement and a copy of Form W-2 (if available). • STOP

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*M*0820.147 WAGE VERIFICATION COMPAN*IES*

A. Introduction

Employment and wage verification companies generally maintain an up-to-date database of wage information for employers who subscribe to the service. They provide an efficient means to verify wages. Obtaining information from wage verification companies may reduce time-consuming contacts with participating employers when pay stubs are not readily available.

- Consider wage information from The Work Number *or the Federal Data HUB* as valid wage verification, unless the evidence contains missing or discrepant information.
- If you discover a discrepancy in the wage data, resolve the discrepancy by obtaining additional primary or secondary evidence.
- Applicant/Member can provide consent for the worker to access all approved online resources when applying.

IMPORTANT: Application/Members are not required to provide this authorization. Do not request information from *wage verification sources* for individuals who refuse to provide or who have revoked wage and employment information authorization. It will be the applicant/members responsibility to provide the required verifications.

Wage verification companies do not always provide cafeteria plan information and income from tips.

If evidence on the record (e.g., the Wages page, prior pay stubs, etc.) or evidence from the wage verification company indicates that a cafeteria plan may exist, and the wage evidence does not provide exact amounts and evidence on record or evidence from the wage verification company indicates unreported tips, obtain additional primary or secondary evidence.

B. Documentation

Document evidence from a wage verification company as follows:

- Document verified wages in case record.
- Download the verified wage information in the electronic record.
- If a discrepancy exists between the information provided by the wage verification company and other wage evidence obtained, you must resolve the discrepancy by obtaining other wage evidence.

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S0820.150 ESTIMATING FUTURE WAGES

A. Policy

You must obtain an estimate of future wages during an initial application, redetermination, or review of income. The period for which an estimate is required is set forth in B. below.

B. Procedure-- Estimating Period

Use the following chart to determine the period for which an estimate is required.

IF the action is ...	**THEN ...**
an initial application	estimate future wages for the month of application and for each of the following months until next month of review. For Medically Needy evaluations, estimate future wages for the month of application and the following 5 months (or prorated spenddown period). **EXCEPTIONS:** **Earlier Review of Income**-- When a review of income will occur before the next redetermination or before the spenddown period have elapsed , estimate future wages for the month of application through the month the next review of income will be completed. **All Wages Paid for Month**--When an individual alleges that all wages for a month have been paid, verify wages for that month (S0820.127).
a redetermination or review of income	estimate future wages for the month of initiation of redetermination or review of income and for each of the remaining months until the next review or until the end of the spenddown period.

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M0820.155 HOW TO ARRIVE AT AN ESTIMATE

A. Procedure-- General

1. Consider Known Facts

a. Consider any **recent work history,** unless inappropriate to the current situation (e.g., work stopped due to retirement or disability).

b. Try to establish a **logical wage pattern** by reviewing with the recipient, representative, or worker the

- rate of pay,
- hours worked per week,
- number of pay periods in each month, and
- *the scheduled receipt dates (weekly, biweekly, bimonthly)*

c. Be alert to individuals who perform **seasonal work** (e.g., school bus drivers).

d. Take into account any Blind Work Expenses/Impairment Related Work Expenses (**BWE/IRWE)** the individual anticipates he/she will incur.

2. Obtain More Information

Contact the employer by telephone, or by mail **only if you cannot establish an estimate using 1. above.**

3. Determine Estimate

Use the information obtained above and your own judgement to determine an estimate.

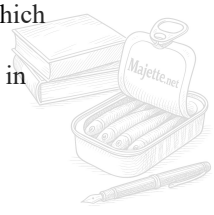
To convert to monthly income:

- multiply weekly wage by 4.3; or
- multiply biweekly wage by 2.15, or
- divide biweekly wage by 2 and multiply result by 4.3; or
- multiply semi-monthly wage by 2.

B. Procedure-- Anticipated Decrease in Wages

If a worker anticipates a decrease *or increase* in wages which is not supported by evidence in the file, tell the individual to inform us as soon as the decrease *or increase* can be verified. We will make any adjustments at that time. An example of this situation would be a wage cutback which is still being negotiated.

Meanwhile, use your judgement in selecting the verified period on which to base the estimate. For example, it could be the total period just redetermined, or a shorter period if there has been a pertinent change in circumstances such as a transfer.



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C. Procedure-- Documentation

1. General

Document the file to support the estimate.

2. Estimate Not Supported by Evidence

In any case where the estimate does not fall within the range indicated by the evidence of wages on file, document the file with an explanation of the basis for the estimate.

3. Examples— Estimate Not Supported by Evidence

- A worker estimates that wages for the coming year will differ from the total verified over the past 12 months. He states he will be switched in 2 months to a shift which pays a 10 percent differential payment. Document the file with this information.

- A worker states he anticipates a cost-of-living increase in his wages. Record this fact along with any other pertinent details (such as the expected adjustment percentage and effective date) for the file.

D. References

- General instructions on estimating income, S0810.600-.620.
- Anticipated changes in income, S0810.610 B.

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NET EARNINGS FROM SELF-EMPLOYMENT

S0820.200 NET EARNINGS FROM SELF-EMPLOYMENT (NESE)

Definition NESE is the **gross income** from any trade or business **less allowable deductions** for that trade or business. NESE also includes any profit or loss in a partnership.

S0820.210 HOW TO DETERMINE NET EARNINGS FROM SELF-EMPLOYMENT (NESE)

A. Policy

1. Determining Monthly NESE NESE is determined on a taxable year basis. Then, the yearly NESE is divided equally among the months in the taxable year to get the NESE for each month.

2. Offsetting Net Loss Any verified net losses from self-employment are divided over the taxable year in the same way as net earnings. Then each month's net loss is deducted only from other earned income of the individual or spouse in that month.

3. Deduction for Taxable Years After 1989 For taxable years beginning after 1989, a 7.65 percent deduction is applied to net profit in determining NESE. Therefore, net profit is multiplied by .9235 to determine NESE. (See S0820.220 for where to find the correct NESE amount on the Federal income tax forms.)

NOTE: This deduction recognizes, as a business expense, part of the Social Security taxes paid. If Social Security tax is not paid (e.g., in situations involving less than $400 per year in NESE, net losses, and when no tax return was filed), the deduction does not apply.

4. Minimum/ Maximum Accounts Creditable NESE is earned income for Medicaid purposes without regard to the minimum and maximum amounts creditable for title II coverage purposes.

5. Computing NESE Only the actual net earnings are used in determining NESE for Medicaid.

6. Exemptions from Coverage NESE is earned income for Medicaid purposes regardless of whether the earnings are exempt from Social Security coverage.

7. Partnership Any distributive share (whether or not distributed) of income or loss from a trade or business carried on by a partnership is included in NESE.

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B. Procedure

1. Determining Monthly NESE

Divide the entire taxable year's NESE equally among the number of months in the taxable year, even if the business:

- is seasonal;
- starts during the year;
- ceases operation before the end of the taxable year; or
- ceases operation prior to initial application for Medicaid.

2. Offsetting Net Loss

Divide any **verified** net loss for a taxable year evenly over the months in the taxable year. Subtract each resulting monthly amount from the individual's or couple's other earnings in the same month. Apply this procedure whether a couple filed a joint income tax return or separate returns, and regardless of which member of the couples listed below incurred the loss:

- an eligible couple;
- an eligible individual with an ineligible spouse;
- two parents.

3. Work Expenses

If an individual is self-employed (whether or not he/she is also a wage earner.), reduce his/her earned income by any allowable work expenses which have not already been used to compute NESE. (See S0820.545 B.1. for necessary work expense development.)

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4. Withdrawals for Personal Use

When an individual alleges (or you discover) that cash or in-kind items are withdrawn from a business for personal use, proceed as follows:

a. Ask the individual whether the withdrawals were **properly accounted for** in determining NESE. That is, were they either deducted on the individual's Federal income tax return in determining the cost of goods sold or the cost of expenses incurred, or deducted on his business records?

b. Accept the individual's allegation of whether the withdrawals were properly accounted for.

IF THE WITHDRAWALS ARE…	THEN…
Properly accounted for	Do not count them again as income.
Not properly accounted for	• Ask the individual to estimate the value of the cash or in-kind withdrawals. Deduct that amount from the cost of goods sold or the cost of expenses incurred on the profit and loss statement to arrive at the proper NESE. • If the individual cannot or will not provide the profit and loss statement, but alleges an amount of NESE, add the value of the withdrawals to the individual's allegation of NESE.

C. References

- *Property* essential to self-support, S1130.500.

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M0820.220 HOW TO VERIFY NET EARNINGS FROM SELF-EMPLOYMENT (NESE)

A. Introduction

Acceptable evidence of NESE, in order of priority, is listed in B.1. through B.3. below. C.2.describes situations in which verification is not required.

B. Policy

The Federal income tax return contains evidence of NESE in the following schedules:

1. Federal Income Tax Return

a. **Schedule SE**

- Net earnings--Section A, line 4 or Section B, line 4.C.

  NOTE: If line 4 or 4.C. shows a positive amount of less than $400, then line 3 is used, even if the amount on line 3 is greater than $400. For example, line 3 shows $410 and line 4/4.C. shows $378. Line 3 should be used because no tax was due.

- Net loss--Section A, line 3 or Section B, line 4.C.

b. **Schedule C**--Line entitled "Net Profit or Loss."
c. **Schedule C--EZ**—Line entitled "Net Profit"
c. **Schedule F**--Line entitled "Net Profit or Loss."

2. Business Records

Business records are acceptable evidence of NESE.

3. Individual's Signed Allegation

The individual's signed allegation of NESE is acceptable evidence of NESE if no other evidence can be obtained.

C. Procedure

1. When to Verify

Verify NESE per 2. below whenever self-employment is alleged or otherwise indicated, unless the individual:

- *reports income that is reasonably compatible with an accepted electronic source;*
- alleges starting a new business, and that he/she was not self-employed in the prior taxable year; or
- is being denied Medicaid for reasons other than income.

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2. How to Verify

a. Priority Order
Attempt to secure the evidence in the order shown in B. above.

b. NESE of Less Than $400
Do not apply the 7.65 percent deduction in determining countable NESE if the NESE amount after the deduction would be less than $400.

c. Business Records
- Assume that any deductions taken on business records are allowable per IRS, absent evidence to the contrary.

- Do not apply the 7.65 percent deduction in determining countable NESE, unless you have evidence that a tax return was filed and Social Security taxes were paid on the NESE.

d. Schedule C, C-EZ or F
Do not apply the 7.65 percent deduction in determining countable NESE, unless you have evidence that Social Security taxes were paid on the NESE.

e. Individual's Signed Allegation
Do not apply the 7.65 percent deduction to the alleged amount of NESE in determining the countable NESE unless you have evidence that Social Security taxes were paid on the NESE.

4. Period for Which Verification Is Required

Follow the chart below when verification is required per 1. above.

SITUATION	VERIFICATION PERIOD
Initial Application	Verify NESE for the prior taxable year. **NOTE:** Accept the individual's signed allegation that self-employment terminated if: • the month of application is in the current taxable year, and • the individual alleges his/her self-employment ceased in the prior taxable year.
Redetermination or Review of Income	Verify all unverified NESE through the prior taxable year.

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M0820.230 HOW TO ESTIMATE NESE FOR CURRENT TAXABLE YEAR

A. Procedure

1. When an Estimate Is Needed

Unless the reported income meets the reasonable compatibility standard, estimate NESE for the current taxable year for an initial application, redetermination, or review of income when an individual alleges (or you believe) he/she is (or has been) engaged in self-employment during the current taxable year.

2. Inform the Individual

Inform the individual:

- how his/her estimated NESE was determined and its effect on eligibility.
- to promptly contact the LDSS office if any change occurs which could affect the amount of his/her estimated NESE.
- to maintain business records until a Federal income tax return is available, so he/she can report any changes promptly (when any method other than the first two in the chart in 4. below is used).
- to provide a copy of his/her Federal income tax return when it becomes available.

3. Net Loss

Do not take into account an **estimated** net loss when estimating NESE for the current taxable year.

NOTE: A net loss can only be used to offset other earnings **after** it has been verified.

4. How to Estimate NESE

Use the first of the following methods in the sequence below, which is applicable.

When the estimate is obtained using business records or the individual's allegation, ask the individual if he/she plans to file a tax return.

- If **yes** and the estimated net profit is $400 or more after applying the multiplier, multiply the net profit by .9235 to determine the countable NESE estimate.
- If **yes** and the estimated net profit is less than $400 after applying the multiplier, do not apply the multiplier.
- If **no,** count the net profit as the NESE estimate. Do **not** apply the multiplier.

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4. How to Estimate NESE (cont.)

WHEN TO USE	METHOD
When an individual: • has been conducting the same trade or business for several years; • has had NESE which has been fairly constant from year-to-year; and • anticipates no change or gives no satisfactory explanation of why current NESE would be substantially lower than past NESE	**Current Year's Estimate Based on Prior Year's Profit** Use the NESE from the prior year as an estimate for the current taxable year.
When an individual: • is engaged in the same business that he/she had **only** in the preceding taxable year; and • anticipates no change or gives no satisfactory explanation of why current NESE would be substantially different from what it has been in the past	**Gross-Net Ratio** • Calculate from the individual's tax return or business records the ratio between net profit and gross receipts for the last year. **EXAMPLE:** Net profit of $1,200 for $6,000 gross income or 20 percent. • Calculate from his/her records the actual gross receipts for the current taxable year and project it for the remainder of the year. **EXAMPLE:** $4,000 in current year's receipts for the first 6 months gives an assumed gross of $8,000 for the entire year. • Apply the previously calculated gross-net ratio to the current year's assumed gross to arrive at the estimated NESE. **EXAMPLE:** 20 percent of $8,000 is $1,600. **EXCEPTION:** Do not use this method for businesses which are seasonal, or have unusual income peaks at certain times of the year; go to next applicable procedure.
When an individual is engaged in a new business	**Projecting Partial Year's Profit for Whole Year** • Obtain the individual's profit and loss statement or other business records for his/her taxable year to date. • Ascertain his/her net profit to date. • Project that net profit for the entire taxable year. **EXCEPTION:** Do not use this method for businesses which are seasonal, or have unusual income peaks at certain times of the year; go to next applicable procedure.

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4. How to Estimate NESE (cont.)

WHEN TO USE	METHOD
When: • an individual is engaged in a new business and records are not yet available; or • the business has been going on for some time but no records were kept	**Individual's Estimate** Use a signed allegation of the individual's best estimate.
When an individual: • alleges his/her NESE for the current year will vary from NESE for past years; and • gives a satisfactory explanation for the variation	**Current Year's Estimate Varies from Past Records** • Obtain a written statement from the individual explaining the basis for the variation. • If the individual's estimate of NESE for the current year is higher than that of the prior years, and the individual satisfactorily explains why, accept the individual's estimate of NESE. **EXAMPLE:** Individual recently added new products to his mail order sales catalog and sales have picked up dramatically. • If the individual's estimate of NESE for the current year is lower than that of prior years, and the individual satisfactorily explains why, request any relevant documentation for the file and accept the lower estimate. **EXAMPLES:** • Satisfactory Explanation--the business has suffered a heavy loss or damage due to fire, flood, burglary, serious illness or disability of the owner, or other catastrophic event. • Relevant Documentation--copies of newspaper accounts of the event, police reports, etc. **NOTE:** In some cases (e.g., downturns in the economy) there may not be any documentation of the event. In such cases, the individual's written statement explaining the basis for the variation in sufficient documentation.

5. Documentation Document the file sufficiently so that it supports the estimate made by the eligibility worker.

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SHELTERED WORKSHOP OR WORK ACTIVITIES CENTER PAYMENTS

S0820.300 PAYMENTS FOR SERVICES PERFORMED IN A SHELTERED WORKSHOP OR WORK ACTIVITIES CENTER

A. Policy

Payments for services performed in a sheltered workshop or work activities center are what an individual receives for participating in a program designed to help him become self-supporting.

Payments for such services are a type of earned income.

Payments for such services are counted when received or when set aside for an individual's use.

B. Definitions

1. Sheltered Work-Shop

A sheltered workshop is a nonprofit organization or institution whose purpose is:

- to carry out a recognized program of rehabilitation for handicapped workers; and/or
- to provide such individuals with remunerative employment or other occupational rehabilitating activity of an educational or therapeutic nature.

2. Work Activities Center

A work activities center is :

- a sheltered workshop, or
- a physically separated department of a sheltered workshop having an identifiable program, and separate supervision and records.

A work activities center is planned and designed exclusively to provide therapeutic activities for handicapped workers, whose physical or mental impairment is so severe as to make their productive capacity inconsequential.

3. Therapeutic Activities

Therapeutic activities are custodial activities (such as activities where the focus is on teaching the basic skills of living), and any purposeful activity so long as work or production is not the main purpose.

C. Procedure

Follow S0820.115 - S0820.150 to develop, document, verify and estimate remuneration for services performed in a sheltered workshop or work activities center program.

NOTE: If there is any doubt that a sheltered workshop or work activities center is involved, contact the organization for verification.

For receipt of cash or items which are not remuneration for services and therefore are not earned income, see S0810.005 A. regarding whether items of this type meet the basic definition of income for Medicaid purposes. If so, develop such income as unearned income (S0830.001).



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EARNED INCOME TAX CREDITS

S0820.400 EARNED INCOME TAX CREDITS

A. Definition The earned income tax credit (EITC) is 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 to the taxpayer. EITC payments can be received as an advance from an employer or as a refund from IRS.

B. Policy Effective January 1, 1991 Exclude from income any EITC payments received January 1, 1991 or later, either as an advance or as a refund, regardless of the tax year involved.

C. Procedure No development necessary.

ROYALTIES AND HONORARIA

S0820.450 ROYALTIES AND HONORARIA

A. Definitions

1. Royalties *Royalties include compensation paid to the owner for the use of property, usually copyrighted material (e.g., books, music, or art) or natural resources (e.g., minerals, oil, gravel, or timber). Royalty compensation may be expressed as a percentage of receipts from using the property or as an amount per unit produced.*

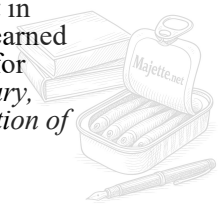
Note: An outright sale of natural resources by the owner of the land or by the owner of rights to use the land constitutes conversion of a resource. Proceeds from the conversion of a resource are not income.

2. Honorarium An honorarium is an honorary payment, reward, or donation usually received in consideration of services rendered (e.g., guest speaker), for which no payment can be enforced by law. However, the amount also may include payment for items other than services rendered (e.g., travel expenses and lodging).

B. Policy

1. Royalties Royalties earned by an individual in connection with any publication of his/her work are earned income (e.g., publication of a manuscript, magazine article, artwork, etc.) *or received as a part of a trade or business*

2. Honoraria The portion of any honorarium **which is received in consideration of services rendered** is earned income. An honorarium which is **not** in consideration of services rendered (e.g., for travel expenses) is unearned income to the extent that it exceeds expense. (See S0830.100 B. for expenses of obtaining income.) *Note: Absent evidence to the contrary, assume that the amount of any honorarium received is in consideration of the actual services provided by the individual.*



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C. Procedure

1. Verification

a. Verify these payments by examining documents in the individual's possession which reflect:

- the amount of the payment,
- the date(s) received, and
- *the reason for payment*
- the frequency of payment, if appropriate.

b. If the individual has no such evidence in his possession, contact the source of the payment.

c. If verification cannot be obtained by the above means, accept any evidence permitted by either S0820.130 A. or S0820.220.

2. Assumption

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

3. Expenses of Obtaining Income

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

4. Documentation

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

D. References

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

EARNED INCOME EXCLUSIONS

M0820.500 GENERAL

A. Policy

1. General

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

2. Other Federal Laws

First, income is excluded as authorized by other Federal laws.

3. *2020* Census Income

Income paid by the U.S. Census Bureau to temporary employees specifically hired for the *2020* census is NOT counted when determining eligibility for medical assistance.

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4. Other Earned Income

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

a. Federal earned income tax credit payments.

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

c. *For 2026, up to $2,410 per month, but not more than $9,730 in a calendar year, of the earned income of a blind or disabled child.*

For 2025, up to $2,350 per month, but not more than $9,460 in a calendar year, of the earned income of a blind or disabled student child.

For 2024, up to $2,290 per month, but not more than $9,230 in a calendar year, of the earned income of a blind or disabled child.

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

e. $65 of earned income in a month.

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

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

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

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

5. Unused Exclusion

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

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

5. Couples

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

B. References

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

- S0810.410 for infrequent/irregular income
- S0810.420 $20 general exclusion
- M0810.430 amount to fulfill a plan for achieving self-support

For exclusions applicable only to earned income, see S0820.510 - S0820.570.



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M0820.510 STUDENT CHILD EARNED INCOME EXCLUSION

A. Policy

1. General

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

For Months	Up to per month	But not more than in a calendar year
In calendar year 2026	*$2,410*	*$9,730*
In calendar year 2025	$2,350	$9,460
In calendar year 2024	$2,290	$9,230
In calendar year 2023	$2,220	$8,950

2. Qualifying for the Exclusion

The individual must be:

- a child under age 22; and
- a student regularly attending school.

3. Earnings Received Prior to Month of Eligibility

Earnings received prior to the month of eligibility do not count toward the yearly limit.

4. Future Increases

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

B. Procedure

1. Application of the Exclusion

Apply the exclusion:

- consecutively to months in which there is earned income until the exclusion is exhausted or the individual is no longer a child; and
- only to a student child's own income.

2. School Attendance and Earnings

Develop the following factors and record them:

- whether the child was regularly attending school in at least 1 month of the current calendar quarter, or expects to attend school for at least 1 month in the next calendar quarter, and
- the amount of the child's earned income (including payments from Neighborhood Youth corps, Work-Study, and similar programs).

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

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C. References

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

D. Example ***(Using January 2018 Figures)***

Jim Thayer, a student child, starts working in June at a local hardware store. He had no prior earnings during the year, and he has no unearned income. Jim earns *$2,100* a month in June, July and August. In September, when he returns to school, Jim continues working part-time. He earns *$1,100* a month in September and October. Jim's countable income computation for June through October is as follows:

June, July and August
$2100.00 gross earnings
- 1820.00 student child exclusion
$ 280.00
- 20.00 general income exclusion
$ 260.00
- 65.00 earned income exclusion
$ 195.00
- 97.50 one-half remainder
$ 97.50 countable income

Jim has used *$5,460 ($1,820* in each of the three months) of his *$7,350* yearly student child earned income exclusion.

September
$1100.00 gross earnings
- 1100.00 student child exclusion
0 countable income

Jim has now used *$6,560 ($5460 +1100)* of his *$7,350* yearly student child earned income exclusion.

October
$1100.00 gross earnings
- 790.00 student child exclusion *remaining ($7,350-$6,560=$790)*
$310.00
- 20.00 general income exclusion
$290.00
- 65.00 earned income exclusion
$225.00
- 112.50 one-half remainder
$*112.50* countable income

Jim has exhausted his entire *$7,350* yearly student child earned income exclusion. The exclusion cannot be applied to any additional earnings during the calendar year.

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S0820.520 $65 PLUS ONE-HALF REMAINDER PER MONTH EARNED INCOME EXCLUSION

A. Policy

1. Amount Excluded $65 per month of earned income plus one-half of the remaining earned income in the month is excluded.

2. Order of Exclusion The exclusion is applied in the order shown S0820.500 A.3.

B. References IRWE exclusions, S0820.540.

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S0820.535 BLIND WORK EXPENSES (BWE)

A. Definition BWE represent any earned income of a blind person which is used to meet any expenses reasonably attributable to earning the income.

B. Policy BWE are deducted from earned income if the blind person:

1. Eligibility Requirements

- is under age 65; or
- is age 65 or older; and
- received Medicaid due to blindness (or received payments under a former State plan for aid to the blind) for the month before attaining age 65.

2. Application of Exclusion

a. The BWE exclusion applies only to earned income. BWE in excess of the earned income an individual receives during the month are never deducted from unearned income.

b. The BWE exclusion is applied to earned income immediately after applying:

- any portion of the general income exclusion which has not been deducted from unearned income; and
- all other earned income exclusion except the exclusion of income used to fulfill an approved plan for achieving self-support (PASS).

3. Deductible Items

a. Except for items in 4. below, the cost of any work-related item paid by a blind person may be deducted as BWE, regardless of:

- any nonwork benefit that may be derived from the item; **or**
- the item's relationship to the person's blindness.

b. A blind individual can claim the amount withheld for Federal, State, and local income taxes even though other factors may affect his or her tax liability (e.g., number of dependents, business loss, etc.).

c. Examples of items which may be deductible as BWE are identified in S0820.555.

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4. Nondeductible Items

The following items cannot be deducted from earned income as BWE:

- In-kind payments
- Expenses deducted under other provisions (e.g., PASS)
- Expenses which will be reimbursed
- Life maintenance expenses. Although not all inclusive, life maintenance items include the following:

  meals consumed outside of work hours;

  self-care items (including items of cosmetic rather than work-related nature);

  general educational development;

  savings plan (e.g., Individual Retirement Accounts (IRA'S) or voluntary pensions);

  life and health insurance premiums
- Items furnished by others that are needed in order to work (the value of such items is not income)
- Expenses claimed on a self-employment tax return (see S0820.545B.1 for further discussion regarding this issue)

EXAMPLE: Mrs. Terry Peters, a blind individual, works as a typist. A community organization bought her a special typewriter that she needed to perform satisfactorily on the job. The value of the typewriter is not income to Mrs. Peters, nor is it deducted as a BWE since she did not pay for it.

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S0820.540 IMPAIRMENT-RELATED WORK EXPENSES (IRWE)

A. Definition

IRWE are expenses for items or services which are directly related to enabling a person with a disability to work and which are necessarily incurred by that individual because of a physical or mental impairment.

B. Policy

1. General

We may deduct IRWE to determine countable earned income in both initial applications and posteligibility situations regardless of whether we previously established the person's eligibility without considering IRWE.

2. Eligibility Requirements

A payment for a service or item is excludable as IRWE for eligibility purposes when:

- the individual:

  is disabled (but not blind); **and**

  is under age 65; **or**

  received SSI as a disabled individual (or received disability payments under a former State plan) for the month before attaining age 65; **and**

- the severity of the impairment requires the individual to purchase or rent items and services in order to work; **and**

- the expense is reasonable; **and**

- the cost is paid in cash (including checks or other forms of money such as money orders, credit and/or charge cards) by the individual and is not reimbursable from another source (e.g., Medicare, private insurance); **and**

- the payment is made in a month the individual receives earned income for a month in which he/she **both** worked **and** received the services or used the item; **or**

  the individual is working but makes a payment before the earned income is received.

(See S0820.560B. for instructions on deducting expenses paid while working. See S0820.560C. for instructions on deducting expense paid prior to work. For instructions on deducting expenses paid after work has stopped, see S0820.560D.)

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3. IRWE Used for Other Daily Activities

Any expense may meet the criteria for an IRWE even if it also is used for daily activities other than work.

4. Application of Exclusion

a. The IRWE exclusion only applies to earned income. IRWE in excess of the earned income an individual receives during the month are never deducted from unearned income. (See S0820.560 for allocating expenses.)

b. The IRWE exclusion is applied to earned income in the sequence below:

- immediately **after** deducting:

  any portion of the general income exclusion which has not been deducted from unearned income; **and**

  the $65 earned income exclusion; **and**

- immediately **before** deducting one-half of the remaining earned income.

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M0820.545 WORK EXPENSES – INTERACTION WITH OTHER POLICIES

A. Introduction

This section discusses the interaction of other policies with work expenses.

B. Policy-Items Deductible Under Other Provision

1. Self-Employment

If the cost of an item has been deducted in figuring net earnings from self-employment (NESE) as described in S0820.200, it cannot be deducted as a work expense.

2. Community Residence

When an individual resides in a community residence, the individual's payments for work related attendant care can be used to reduce countable earnings.

3. PASS

a. A PASS permits an individual to set aside income and resources for a limited period of time in order to reach a work goal. (For a more comprehensive discussion on PASS, see M0810.430)

b. Income used to pay for a particular work-related item may not be excluded from countable income under the PASS and the BWE or IRWE provisions simultaneously.

c. Unlike BWE or IRWE, a PASS may be used to reduce countable unearned income and resources.

C. Policy – Deeming

In determining how much of an ineligible spouse's or parent's income is subject to deeming, earnings which are used to meet work expenses are not counted, if the ineligible spouse or parent is blind or disabled. Accept the individual's allegation of blindness or disability. Work expenses should be documented and verified according to S0820.550.

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S0820.550 WORK EXPENSE DEVELOPMENT AND DOCUMENTATION

A. Policy

All allegations and/or evidence of BWE and IRWE must be documented in file.

B. Procedure—Documentation

Document BWE and IRWE respectively per 1. and 2. below.

1. Allegation of BWE

Document BWE as described below:

STEP	ACTION
1	Assume that any working blind individual earning income more than $65 a month has BWE. For example, most earnings are subject to income taxes which qualify as BWEs.
2	If earnings are above $65 per month, obtain an allegation from the individual that either: • claims a BWE, specifying the type and amount of expense; or • explains why he/she has no BWE.
3	Record this statement in the case record.

2. Allegation of IRWE

Document IRWE according to the following steps:

STEP	ACTION
1	Ask about IRWE when: • a disabled individual's earned income exceeds $65 in any month; or • at least one member of an ineligible couple is disabled and has earned income, and the couple's total earned income exceeds $65 in any month; or • a disabled individual has earned income of $65 or less, the individual is subject to spouse-to-spouse deeming, and the couple's total earned income exceeds $65.
2	Record the individual's response with a statement describing the IRWE claimed or that no IRWE is alleged.

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3. When to Develop

Develop work expenses per 1. and 2. above when you:

- complete an initial application or a redetermination; **or**
- receive a report that the recipient has started working; **or**
- receive a report that the expenses have changed.

NOTE: A change in the amount of earnings of a blind worker implies a change in expenses since the amount of taxes deducted probably changed.

4. Allocation of Work Expenses

Document the file to support your allocation of work expenses. (See S0820.560 for instructions on allocating work expenses.)

NOTE: You may use the worksheet in S0820.565, which may be reproduced locally, to document the type and allocation of BWE.

C. Procedure—Verification

1. Evidence of BWE

a. Verifying that criteria for BWE are met

- Stop file documentation when the expense is listed on the chart in S0820.555. The items listed on the chart meet the criteria for a BWE.
- Document the file to reflect how an item is reasonably attributable to the earning of income when the item is not listed on the chart.

b. Verifying cost of BWE

- Document the file with photocopies of bills, receipts, etc., from the individual to corroborate the allegations.

  Inform every working blind individual of the requirement to maintain records of work expenses and to produce such records when requested. Explain why we need to see these records.

- Accept the individual's allegation of the expense amount when:

  bills, receipts, etc., cannot be obtained (e.g., lack of receipts for food purchased for a dog guide, meals, transportation, etc.) **and**

  the allegation appears reasonable.

  NOTE: You may use the worksheet in S0820.565 as an aid in calculating BWE.

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2. Evidence of IRWE

a. Document the need for an item or service

- Refer to the chart in S0820.555 for guidance in common types of expenses deductible as IRWE.

- Accept an allegation, as **verification of need**, that a prescription drug is used to control the disabling condition, enabling the individual to function at work, when:

  there is a paid bill for the drug; and

  the information on the container indicates that:

  a physician and a licensed pharmacist were involved in providing the drug; and

  the drug is for the individual.

b. Verifying cost of an item or service

- Accept the individual's allegation as to the recurring use and cost of an IRWE when:

  at least one available receipt of documenting the cost is submitted;

  additional receipts are unavailable for the recurring expense (e.g., hearing aid batteries, incontinence pads, etc.); **and**

  the allegation of use is consistent with the nature of the expense (e.g., the individual states that he has only a couple of receipts for the box of 60 incontinence pads he buys every month as his condition requires him to use two pads a day).

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3. Posteligibility Situations

a. BWE/IRWE previously developed

If BWE/IRWE were developed previously, compare the recipient's (and spouse's, if applicable) responses with information in the case record. Then, proceed as follows:

IF	AND...	THEN...
the alleged amounts and dates of work expense information agree with the verified information	no changes are alleged	no further BWE/IRWE development is necessary.
	changes are alleged	develop and verify BWE/IRWE per 1 and 2 above.
information is unverified	------	develop and verify BWE/IRWE per 1 and 2 above.

b. BWE/IRWE not previously developed

Develop and verify per 1 and 2 above.

D. Procedure--Special Considerations

1. More Than One Employer Involved

Add total earnings from all employers. Deduct combined work expenses from this total.

NOTE: There is no need to relate a specific expense to a particular source of earnings.

2. Self-Employment

Carefully review records and/or the portion of the tax return used to determine NESE per S0820.210. Check that none of the expenses deducted in determining NESE are also being claimed as work expenses.

Determine what expenses can be excluded from earned income as work expenses. If necessary, refer the individual to the Internal Revenue Service (IRS) for information about permissible self-employment deductions.

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D. Procedure—Special Cconsiderations

2. Self-Employment (cont.)

EXAMPLE: Individual is self-employed and a wage earner.

FACTS: Mr. Griffin, a blind Medicaid recipient, is self-employed selling brushes. He also works one night a week as an employee typing transcripts from recordings. Mr. Griffin's self-employment requires him to travel by cab (at a cost of $60 per month) to the brush manufacturer to pick up samples. He also must travel by cab, at a cost of $40 per month, to the office where he is employed.

CONCLUSION: You determine that the $60 monthly cab fare to pick up samples has been used in arriving at his NESE and cannot be deducted from his earned income as a work expense. You deduct as a work expense the $40 monthly cabfare for travel to and from the office where he is employed.

3. Work Expenses of a Couple

If both members of a couple are eligible and both work, deduct from the couple's earned income each individual's work expenses to the extent that they do not exceed that individual's earnings. Do not deduct excess work expenses of one member of the couple from the earned income of his or her spouse. (See B.2. above when it is necessary to document IRWE in couple's cases and S0820.545C when deeming is an issue.)

4. Estimating Future Work Expenses

a. Estimate an individual's future expenses based on expenses paid in the most recent period per S0810.600-610. This could be the period just redetermined or a shorter period if there has been a pertinent change in circumstances, such as additional expenses.

   For example, if the individual had more expenses in the last 3 months than in previous months and those expenses are expected to continue, use that amount in your determination. Consider any expected decrease in expenses (e.g., installment payments on tools that will be paid off).

b. Do not estimate an anticipated expense in the near future (e.g., purchase of more equipment) until there is proof that the expense exists. Tell the individual to let you know as soon as a new expense develops so you can make any appropriate adjustments at that time.

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S0820.555 LIST OF TYPE AND AMOUNT OF DEDUCTIBLE WORK EXPENSES

The following chart provides guidance on types of expenses which are deductible as BWE, IRWE, or both, and the amount deductible. The chart is not intended to be all-inclusive. Refer to the policy discussed in S0820.535, S0820.540.

TYPE OF EXPENSES	DEDUCTIBLE AS		AMOUNT OF DEDUCTIBLE
	BWE	IRWE	
Attendant care services which are rendered in the: • home; • process of assisting an individual in making the trip to and from work; or • work setting	X	X	The amount paid.
Drugs and medical services which are essential to enable the individual to work (e.g., medication to control epileptic seizures)	X	X	The amount paid.
Expendable medical supplies Examples • Bandages • Catheters • Face masks • Incontinence pads	X	X	The amount paid. See M0820.550 C.1 and C.2.
Federal, State and local income taxes and Social Security taxes	X		The amount withheld. Assume the amount withheld reflects the individual's tax liability.
Dog Guide	X	X	The cost of purchasing the dog and all associated expenses (e.g., its food, breast straps, licenses, veterinary services, etc.)
Fees Examples: • Licensee • Professional association dues • Union dues	X		The amount paid.

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TYPE OF EXPENSES	DEDUCTIBLE AS		AMOUNT OF DEDUCTIBLE
	BWE	IRWE	
Mandatory contributions Examples: • Pensions • Disability	X		The actual amount of the mandatory contribution. For example, mandatory pension contributions are considered reasonably attributable to earning income and, therefore, deductible. Voluntary pension contributions are considered savings plans and, as such, are life maintenance expenses and not deductible.
Meals consumed during work hours	X		The actual value of the meals whether bought during work hours or brough from home.
Medical devices Examples: • Braces • Inhalers • Pacemakers • Respirator • Wheelchair	X	X	The cost of the items plus maintenance and repair of such items whether the individual works at home or at employer's place of business.
Nonmedical equipment/services Examples: • Air cleaners • Air conditioners • Child care costs • Humidifiers • Portable room heaters • Posture chairs • Safety shoes • Tools used on the job • Uniforms	X		The cost of the item plus maintenance and repair of such items whether the individual works at home or at the employer's place of business
Other work-related equipment/services Examples: • One-handed typewriters • Special tools designed to accommodate an individual's impairment • Telecommunications devices for the deaf • Translation of materials into braille • Typing aids (e.g., page turning devices) • Vision and sensory aids for the blind	X	X	The cost of the item plus maintenance and repair of such item whether the individual works at home or at the employer's place of business.
Physical therapy	X	X	The amount paid.

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TYPE OF EXPENSES	DEDUCTIBLE AS		AMOUNT OF DEDUCTIBLE
	BWE	IRWE	
Prosthesis	X	X	The cost of the item plus maintenance and repair of such item.
Structural modifications to the individual's home to create a work space or to allow the individual to get to and from work.	X	X	The cost of the modifications.
Training to use an impairment-related item or an item which is reasonably attributed to work Examples: • Braille • Cane travel • Computer program course for a computer operator • Grammar • Stenotype instruction for a typist • Use of one-handed typewriter • Use of special equipment • Use of vision and sensory aids for the blind NOTE: Training does not include general education courses. Such courses may be excluded under a PASS.	X	X	The cost of the training plus travel expenses to and rom the training facility. Compute travel expenses to and from the training facility in the same manner as transportation to and from work (shown previously in this chart)

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TYPE OF EXPENSES	DEDUCTIBLE AS		AMOUNT OF DEDUCTIBLE
	BWE	IRWE	
Transportation to and from work	X	*X*	• In own vehicle the rate is the Internal Revenue Service (IRS) standard mileage rate: *2016 – 54 cents per mile* 2015 – 57.5 cents per mile • For other than in own vehicle the actual cost of the bus, car, pool, or cab fare.
Vehicle modification	X	X	Whatever seems reasonable.

M0820.560 ALLOCATING WORK EXPENSES

A. Policy- Deduct (or begin allocating) the amount paid in the first month income is received.

B. Procedure

1. Expenses Paid Prior to Receipt of Income

a. No downpayment involved

Deduct the amount of a monthly recurring work expense in the month in which the expense is paid.

2. Monthly Recurring Expenses

b. Downpayment involved

- Have the individual decide whether the downpayment is to be deducted in the month paid; **or** prorated over a consecutive 12-month period.
- If the downpayment is to be deducted in the month paid, deduct the regular recurring monthly expense when paid.
- If the downpayment is being prorated, divide by number of months.

3. Other Recurring Expenses

a. **Less frequently than monthly**
Have the individual decide whether the work expense is to be deducted in the month paid or prorated for the months in the billing period.

b. **Daily/Weekly/Biweekly**
- Use the submitted receipts, bills, etc., in conjunction with any allegation obtained per S0820.550 C to determine the number of days the expense is paid each month; **and** whether the expense fluctuates or remains the same.
- Multiply the amount of the expense by the number of days the expense is paid each month if the expense remains the same.
- Add the individual amounts paid in each month if the expense fluctuates.



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NOTE: If the computation is being based on the individual's allegation, assume that the expense remains the same.

4. Expense Is One-Time Payment

Have the individual decide whether the work expense is to be:

- deducted entirely in the month of payment; or
- prorated over a consecutive 12-month period beginning with the month of payment.

5. Self-Employment

Deduct the work expenses related to a self-employed activity for an individual who is blind and self-employment, provided the expenses were not used to complete the net earnings from self-employment (NESE). If it is to the person's advantage, prorate the work expenses over all the months of the tax year; otherwise, follow 1-4 above, as appropriate.

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C. Procedure-- Expenses Paid Prior to Work

Follow the steps below, whenever a work expense was paid before work began:

STEP	ACTION
1	Determine whether the item that was purchased: • is work-related; **and** • is durable (see DI 10520.015 in Appendix, for a definition of durable items); **and** • had a payment made on it in the 11-month period immediately preceding the first month of employment.
2	If the item meets all the criteria in step 1, go on to step 3. If not, stop. The expense cannot be deducted.
3	Determine the total amount paid towards the item during the 11 months preceding the month that work began.
4	Determine the **deductible portion** according to the following chart.

No. of Months Prior to Work That First Payment is Made	Deductible Portion of Payment
1	11/12 (.916)
2	5/6 (.833)
3	3/4 (.750)
4	2/3 (666)
5	7/12 (.581)
6	1/2 (.500)
7	5/12 (.415)
8	1/3 (.333)
9	1/4 (.250)
10	1/6 (.166)
11	1/12 (.083)

NOTE: See E. below for an example of how to use this chart.

5	Have the individual decide whether the deductible portion from step 4 is to be allocated: • only to the first month that earned income is received; **or** • over a consecutive 12-month period beginning with the first month that earned income is received. **NOTE:** The deductible amount is **in addition to** amounts actually paid after beginning work.

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D. Procedure-- Expenses Paid After Work Stops

1. Expense Paid Before Earned Income Stops

Deduct a work expense that is paid in a month after work has stopped from earned income received in a month after work has stopped only when:

- the income is based on work activity (e.g., not income received as a silent partner in a business); and
- the work activity was performed in a period when the individual required the item or service.

2. Expense Paid After Earned Income Stops

Deduct the work expense from the earned income received in the last month of work when:

- the work expense is paid in a month after the individual last worked and received earned income; and
- the payment was for an item or service used while working.

E. Procedure— Expenses Paid by Credit Card

- Treat a credit/charge care purchase as a nonrecurring expense and follow the appropriate instructions in B.4, C or D above.

  EXCEPTION: You may treat the actual payments as a recurring expense per B.2-3 above when the IRWE was the only charge on the account during the time the charge was being paid; i.e., there was a zero balance when the IRWE was charged and no other charges were made before the payments were completed.

- Apply the credit card's annual interest rate to the cost of the IRWE purchase when:

  there is already a balance on the account when the IRWE is purchased;

  another purchase is made before the IRWE charge is paid off; or

  there is the likelihood of another purchase before the IRWE charge is paid off,

- Deduct the IRWE charge amount plus the calculated interest.

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F. Procedure--Documenting Allocation Decision

Obtain a signed statement to document individual's decision regarding the allocation of expenses to one month or a 12-month period **only if** it would not be discernable from the file that the method of allocation is advantageous to the individual.

G. EXAMPLES

1. IRWE Charged While Working

Mr. Applegate, a disabled Medicaid recipient who is working, charges an IRWE which costs $240 (i.e., purchase price plus applicable tax) on a credit card that has an annual interest rate of 18%. Because there was already a balance on the account prior to the IRWE purchase, you treat the IRWE as a nonrecurring expense.

You calculate the interest on the IRWE purchase to be $43.20 ($240 x 18%). You determine the deductible IRWE amount to be $283.20.

You ask Mr. Applegate whether he wants the IRWE amount deducted entirely in the month charged or prorated over a consecutive 12-month period. He decides to have it prorated. You deduct a $23.60 ($283.20/12) a month as IRWE for 12 consecutive months beginning with the month the IRWE was charged.

2. IRWE Charged Before Working

Similar circumstances to the above example, except that Mr. Applegate charges the IRWE on his credit card 6 months before he begins working.

You use the chart in C. above to determine that only $141.60 is deductible as IRWE (one-half of $283.20)

You ask Mr. Applegate whether he wishes to have the IRWE deducted in the first month he receives earned income or during the 12 month period at $11.80 a month ($141.60/12). He elects to have it deducted in the first month.

S0820.565 BWE WORKSHEET

A. When to UseB. Exhibit

The BWE worksheet in B. below may be reproduced and used to develop blind work expenses. Refer to S0820.550 and S0820.555 for detailed instructions on the type of deductible expenses and the amount of deductible.

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B. Exhibit

BLIND WORK EXPENSES WORKSHEET						
NAME PART I	AMOUNT($) OF TAXES			SSN PART III	TOTALS	
Month/ Year	Federal, State Local	FICA (Social Security)	Other Mandatory Deductions (e.g., mandatory pension contri-butions)	A (Add Columns Part I)	B (from Part II)	C (Combine A and B)

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PART II Amount ($) by Type of Other Expenses

	Medical		Nonmedical					Total
Month/ Year	Drugs and Other Expendable Supplies	Other see* below) (List Item)	Attendant care services	Dog Guide	Food Eaten During Work Hours (e.g., lunch)	Transpor-tation To and From Work	Other (see** below) (List Item)	Add Columns and Transfers to Part III

* Other
- Medical Devices (e.g., wheelchair, respirator)
- Medical Services
- Physical Therapy
- Prostesis

** Other nomedical BWE:
- Fees (e.g., union dues, licenses)
- Modifications to vehicle and/or structure of home
- Nomedical equipment/services (e.g., uniforms, child care)
- Other work related equipment/services/ (e.g., one-handed typewriters, translations into Braille)
- Training (e.g., use of one-handed typewriter)

NOTE: The above items do not reflect an all-inclusive list of deductible expenses.



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S0820.570 EARNED INCOME TAX CREDIT (EITC) PAYMENTS EXCLUSION

A. Definition

The earned income tax credit (EITC) is 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 to the taxpayer. EITC payments can be received as an advance from an employer or as a refund from IRS.

B. Policy

Exclude from income any EITC payments received as an advance or as a refund, regardless of the tax year involved.

C. References

- EITC resource exclusion S1130.675.
- EITC, S0820.400

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CHAPTER M08
INCOME
SUBCHAPTER 30

UNEARNED INCOME

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M0830 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-35	7/1/25	Pages 27 and 114
TN #DMAS-31	4/1/24	TOC pages i, ii
TN #DMAS-28	7/1/23	Table of Contents, pages i,iv. Pages 8, 9, 23, 83, 84, 86. 87, 124, 124a. Add Pages 32a, 123a, 123b, 124b.
TN #DMAS-27	4/1/23	Pages 7, 124a
TN #DMAS-25	1/1/23	Pages 24, 24a, 50
TN #DMAS-24	7/1/22	Page 114
TN #DMAS-23	4/1/22	Page 78
TN #DMAS-17	7/1/20	Page 29
TN #DMAS-12	4/1/19	Page 113
TN #DMAS-7	1/1/18	Table of Contents, page iii, iv. Pages 7-8, 17-18, 20, 29, 48, 79a, 82, 124a-124b, 125.
TN #DMAS-4	4/1/17	Table of Contents, page i Pages 24, 24c
TN #DMAS-2	10/1/16	On page 109, updated the format of the header. Neither the date nor the policy was changed.
TN #DMAS-1	3/23/16	Table of Contents, page iii Pages 18, 82
Update #7	7/1/12	Page 24
TN #94	9/1/10	Page 29
TN #93	1/1/10	Table of Contents, page iv Pages 28, 67, 119-120 Pages 122-125
TN #91	5/15/09	Table of Contents, page i Page 29

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UNEARNED INCOME

GENERAL

S0830.001 INTRODUCTION TO UNEARNED INCOME

A. Policy

Unearned income is all income that is not earned income.

B. Description of the Subchapter

The instructions in this subchapter apply to unearned income and unearned income exclusions.

The subchapter is organized so that payments which are similar in nature are grouped together. Unearned income exclusions and counting rules are not all in one place. Those related to a specific type of payment are discussed in sections about the payment itself.

C. References

Users should be familiar with the general income rules found in subchapters 10 and 15, particularly:

What is income (S0810.005);

What is not income (S0815.001.);

Whose income is it (S0810.120.);

When income is counted (S0810.030)

Income verification (S0810.500); and

How to estimate income (S0810.600-620).

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S0830.005 GENERAL RULES FOR DEVELOPING UNEARNED INCOME

A. Procedure

Some types of income require particular development as explained in later sections in this subchapter. Apply the instructions in this subsection where no specific instructions exist.

1. Clearly Ineligible

Do not develop unearned income where the individual is clearly ineligible for a non-financial reason or excess resources.

2. File

Document the case file so that it **fully** supports every eligibility decision.

3. Allegations

Document any **material** allegation. **.**

You do not need to document an attempt to obtain information from **other sources**

4. Verification

- In general, verify the **amount, frequency** of receipt and **source** and/or type of unearned income.
- Unless required elsewhere, verify only the source and/or type of a **totally excluded** payment.
- **Request evidence first** from the recipient and then, if necessary, from other sources.

5. Evidence Not Readily Available

When evidence is not readily available, and if the individual has cooperated:

a. obtain a **signed statement** from the individual as to the amount, source and frequency of receipt of the payment;
b. **process the case** on the basis of the individual's statement if all other eligibility factors are met and there is no reason to doubt the allegation;
c. **clearly document** the file as to why the information is not readily available; and
d. obtain the evidence **postadjudicatively.**

6. Evidence In Doubt Or Contradictory

a. Request **supporting evidence** from the individual or the source of the income.
b. If all available evidence leaves a question, weigh the evidence and **make a decision**. The file must reflect the basis for this decision.

7. Classification Unknown

a. If you are unable to determine whether an item or amount should be classified as income or whether income is earned or unearned, **contact the regional office.**

8. Mailing Time

When a payment is mailed, assume that the payment is received 5 days after the payment or mailing date unless the individual alleges a different date, in which case accept any credible allegation.

B. References

Developmental rules for posteligibility situations, S0830.007

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S0830.007 DEVELOPMENTAL RULES IN POSTELIGIBILITY SITUATIONS

A. Introduction

Some types of income and income exclusions have special rules that apply in posteligibility (PE) situations. For example, in the section on rental income, if a Medicaid recipient with rental income reports a new expense, the remaining income estimates may need to be recalculated.

When no specific instructions exist, however, the general rules in this subsection apply.

B. Procedure

1. General

Unless specific instructions indicate otherwise, the general rules for developing unearned income found in S0830.005 also apply in PE situations.

C. References

General rules for developing unearned income, S0830.005

Rental Income, S0830.505

S0830.010 WHEN TO COUNT UNEARNED INCOME

A. Policy -- General

Unearned income is counted as income in the earliest month it is:

- received by the individual;
- credited to the individual's account; or
- set aside for the individual's use.

B. Policy--When to Count Retroactive RSDI Benefits

Other than the following exceptions (1.- 2. below), retroactive RSDI benefits, whether paid in one lump sum or by installment, are counted as unearned income in the month payment is received.

NOTE: Reissued conserved funds, whether paid in a lump sum or in installments, are not considered unearned income in the month of reissuance since such funds were previously considered in the month of original receipt (S1120.022.B.2.).

1. Retroactive RSDI Benefits Paid By Installment When DAA is Material

Retroactive RSDI benefits must be paid in installments when paid to representative payees of individuals who are eligible because of drug addiction or alcoholism (DAA). In such cases involving DAA beneficiaries, the total of retroactive RSDI benefits paid in installment is treated as if paid in a lump sum in the usual manner. The total of such benefits paid in installments is considered unearned income in the month in which the first installment is made.

In certain posteligibility situations involving DAA beneficiaries, a subsequent amount of retroactive RSDI benefits to be paid in installments cannot be paid because the beneficiary is receiving installment payments



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from a previous retroactive RSDI benefit. In such situations, the total of the subsequent retroactive RSDI amount is counted as unearned income in the month such total would have normally been paid (i.e., as if the lump sum had been paid in the usual manner.)

NOTE: For resource purposes, each installment is subject to regular resource rules in the month following receipt (see S1130.600 for exclusion of RSDI underpayments).

2. Retroactive RSDI Benefits Paid By Installment At Recipient's Request

In certain situations, SSA will agree **at the recipient's request** to pay by installment retroactive RSDI benefits that would otherwise be paid in one lump sum. In such cases, the total of retroactive RSDI benefits (except for amounts considered paid in a windfall offset period per 1. above) is counted as unearned income in the month such benefits were set aside for the individual's use.

C. References

- Counting advance dated checks and electronic fund transfers, S0810.030
- Reissuance of conserved finds, S1120.022B.2.
- Resource exclusion of RSDI underpayments, S1130.600

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UNEARNED INCOME EXCLUSIONS - GENERAL

S0830.050 OVERVIEW OF EXCLUSIONS

A. Definition

An **exclusion** is an amount of income which does not count in determining eligibility.

B. Policy

Exclusions never reduce unearned income below zero. Except for the $20 general exclusion (S0810.420), no unused unearned income exclusion may be applied to earned income.

C. Procedure

First, determine whether what is received is income. Next apply any appropriate exclusions to unearned income as discussed in this subchapter.

1. Exclusions in Relation to the Infrequent/ Irregular/ Exclusion

Apply the exclusions in this subchapter separately from the infrequent or irregular exclusion (S0810.410). However, do not apply the infrequent or irregular exclusion to an amount remaining after another exclusion has been applied to a particular type of income (e.g., the remaining amount of child support after one third has been excluded).

You may apply the infrequent or irregular exclusion to an individual's total unearned income if the entire amount can be excluded under that provision.

2. Application of Other Exclusions

After applying the specific exclusions discussed in this subchapter, apply the $20 general income exclusion (S0810.420). If there is also earned income, apply the earned income exclusions between the $20 general income exclusion.

D. Reference

What is not income, S0815.001.

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S0830.055 EXCLUSIONS UNDER OTHER FEDERAL STATUTES

A. Introduction

1. General

Federal statutes other than the Social Security Act sometimes provide that the Medicaid program must exclude from income (or income and resources) assistance provided under those statutes.

2. New Exclusions

Be aware that new or different assistance programs may have Federal involvement and be subject to an exclusion. (Central office does not always immediately know when exclusions are enacted if they are handled by another agency.) Follow the guidelines in B. below when a program is questionable or someone alleges a new exclusion or type of assistance.

B. Procedure - Exclusion New or Questionable

1. Contact RO

Contact the regional office (RO) if there is reason to believe an exclusion exists for a program with Federal involvement or if you learn of a new exclusion.

2. Helpful Information

The name of the local program or agency may not be sufficient information to make a determination. As possible, provide the RO with the following information:

- the name of the program and what it does;
- the public law (name and number) which authorizes the program (e.g., P.L. 99-498, the Higher Education Amendments of 1986);
- the section number(s) in the public law which pertain to the program; and
- the Federal agency which is responsible for Federal involvement in the program.

C. Reference

List of exclusions under other Federal statutes and related instructions, S0830.099.

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S0830.099 GUIDE TO EXCLUSIONS

A. Introduction

The following provides a list of those instructions which address a partial or total exclusion of unearned income. Those in **bold print** involve an exclusion under another Federal statute.

B. List of Instructions About Unearned Income Exclusions

Agent Programs **S0830.610**
Agent Orange Settlement Payments S0830.730

Austrian Social Insurance Payments S0830.715
BIA Student Assistance S0830.460
Capital Gains M0815.200
Child Support S0830.420

Disaster Assistance S0830.620

Educational Assistance S0830.450
Energy Assistance S0830.600
Energy Employees Occupational Illness Compensation Plan (EEOICP) *S0830.741*
EUGENICS STERILIZATION COMPENSATION (VESC) *S0830.745*

Farmers Home Administration Housing Assistance (FMHA) S0830.630
Food/Meal Programs S0830.635
Food Stamps S0830.635
Foster Grandparents Program S0830.610

General Assistance (General Relief) S0830.175
German Reparation Payments S0830.710
Gifts Occasioned by a Death S0830.545
Gifts of Domestic Travel Tickets S0830.521
Grants, Scholarships, and Fellowships S0830.455

HUD Subsidies S0830.630
Home Energy Assistance S0830.605
Home Produce S0830.700
Hostile Fire Pay from the Uniformed Services S0830.540
Housing Assistance S0830.630
Interest on Excluded Burial Funds S0830.501

Japanese-American and Aleutian Restitution Payments S0830.720

Low Income Energy Assistance S0830.600

Meals for Older Americans S0830.635
Milk Programs S0830.635



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National Defense Student Loans (NDSL) S0830.460

Pell Grants S0830.460
Private Non-profit Assistance S0830.605

Radiation Exposure Compensation Trust Fund (RECTF) Payments S0830.740
Refunds of Taxes Paid on Real Property or Food S0830.705
Relocation Assistance S0830.655
Ricky Ray Hemophilia Relief Fund Payments S0830.755
Retired Senior Volunteer Program (RSVP) S0830.610

School Breakfasts S0830.635
School Lunches S0830.635
Senior Companion Program S0830.610
Supplemental Education Opportunity Grant (SEOG) S0830.460
Special and Demonstration Volunteer Program……..... S0830.610
State Annuities for Certain Veterans S0830.260
State Student Incentive Grants (SSIG) S0830.460
State Assistance Based on Need. S0830.175

University Year for Action (UYA) S0830.610

Victim's Compensation Payments S0830.660
Volunteers in Service to America (VISTA) S0830.610

Walker v. Bayer Settlement Payments M0830.760
Women, Infants, and Children Program (WIC) S0830.635

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AMOUNT OF UNEARNED INCOME

S0830.100 EXPENSES OF OBTAINING INCOME

A. Definition

An **expense** as used in this section is one that is an essential factor in obtaining a particular payment(s).

B. Policy

Unearned income does not include that part of a payment which is for an essential expense incurred in getting the payment.

1. Treatment of Expenses

- From a payment received for damages in connection with an accident, we subtract **legal, medical, and other expenses** connected with the accident.

- From a retroactive check from a benefit program other than SSI, we subtract **legal fees** connected with that claim, *which may also include out- of-pocket expenses that are not part of the fee, but are paid by, or billed to, the member.*

2. How to Deduct Expenses-- General

Except as noted in 3. below, expenses are deducted from the first and any subsequent amounts of related income until you have completely eliminated all expenses.

3. Expense Money -- Assumption

You may assume that the following payments for expenses do not exceed the expenses and thus do not result in income:

- payments by a government agency for expenses related to obtaining a service or participating in a program (e.g., $10 expense money provided to jurors); and

- lump sum advances or reimbursements by employers to cover expenses of employment paid by the employee (e.g., employee receives a per diem allowance, school bus driver is paid $100 per month allowance to pay for gas and maintenance).

NOTE: See C.2. below for verification requirements when this assumption is applied.

4. Repayment of Legal Fees When Equal Access to Justice Act Payments are Involved

An attorney who receives duplicate fees under the Equal Access to Justice Act (EAJA) and section 206(b) of the Social Security Act is obligated to return the smaller fee to the recipient. Any such payment to the recipient is income, provided that the amount of the fee previously had been deducted from income.

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C. Procedure

Use bills, receipts, contact with the provider, etc., to verify all essential expenses.

1. Verifying Expenses -- General

If an expense has been incurred but not paid, assume that the individual will pay the expense unless you have reason to question the situation.

NOTE: You do not need to follow up if this assumption applies.

2. Verifying Expenses -- Assumption in B.4. Applies

If the assumption in B.3. above applies, be aware that you do not need to verify expense or follow up on how the money was spent.

3. Deducting Allowable Expenses

Deduct any expenses which have been verified as essential from the first and any subsequent amount(s) of related income. Deduct even 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.

NOTE: The remainder is unearned income subject to the general rules pertaining to income and income exclusions.

D. Examples -- Essential Expenses

A fee to acquire documentation to establish that an individual has a right to certain income (e.g., a fee for a birth certificate or medical examination) is an essential expense.

1. Document Fees

2. Guardianship Fees

A guardianship fee is an essential expense **only** if the presence of a guardian is a requirement for receiving the income.

NOTE: Guardianship fees are **never** an essential expense for obtaining title II or title XVI benefits because the appointment of a legal guardian is never an SSA requirement.

E. References

- Medical and social services, S0815.050.
- Receipts from the sale, exchange, or replacement of a resource, S1110.600 B.4.
- Treatment of gambling losses, S0830.525 A.

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S0803.105 PAYMENTS IN FOREIGN CURRENCY

A. Introduction

Occasionally, an individual receives income tendered to him/her in a monetary unit other than U.S. dollars. This usually will be in the form of a check or a direct deposit to a bank.

B. Policy

1. Amount of Income

The U.S. dollar value of a payment made in foreign currency, less expenses, is income.

2. When Counted

We count foreign currency payments when received unless the individual alleges and can establish that the payment was received too late in the month for conversion prior to the following month.

C. Procedure

1. Verify Receipt and Amount

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.

2. Evidence Not Available

If the evidence is not readily available, or if translation of the documents would require a delay beyond the receipt of the next payment, then:

- adjudicate the case based on the individual's signed allegation (if there is not reason to doubt the allegation); and
- ask the individual to present his next check before cashing it.

3. Conversion to U.S. Dollars

Verify the exchange rate for conversion of the foreign currency into U.S. dollars using:

- A receipt for the individual's last exchange; or
- A telephone call to a local bank or currency exchange.

4. Changes in Exchange Rate

Presume that an established exchange rate remains constant until the next redetermination, at which time verify the rate again. If at this point, the exchange rate has changed, presume the change occurred in the month of verification and that it remains constant until the next redetermination.

EXCEPTION: If the individual reports that the exchange rate has changed, verify the change and adjust the income counted to reflect the new rate.

D. References

Annuities, pensions, retirement or disability payments--General, S0830.160

German reparations payments, S0830.710

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S0830.110 OVERPAYMENT INVOLVED

A. Policy

1. General Rule

Unearned income includes that part of another benefit payment (such as RSDI) which has been withheld to recover a previous overpayment.

2. Exception

The amount withheld is not income when the payment is received if:

- the individual received both Medicaid and the other benefit at the time the overpayment of the other benefit occurred; **and**
- the overpaid amount was included in figuring the Medicaid eligibility at that time.
- This exception applies only if the eligible individual actually received Medicaid while the overpayment was occurring (even if the payments were erroneous). It does **not** apply if the overpayment was used to determine eligibility and the individual was determined to be ineligible.

The exception avoids counting the income twice or "double counting."

3. Which Benefits are Affected

This policy applies to the following benefits:

- annuities and pensions;
- retirement or disability benefits (including veterans' pensions and compensation);
- workers' compensation;
- social security benefits;
- railroad retirement annuities;
- unemployment insurance benefits; and
- black lung benefits.

NOTE: A reduction of title II due to workers' compensation offset or work deductions, is not an overpayment and is **not affected** by this policy.

4. Overpayment-- - Definition

Overpayment for purposes of this section means overpayment as defined by the entity paying the benefit and includes overpayments made to someone other than the individual whose benefits are withheld.

5. Unable to Determine Double-- Counting

Unearned income does not include the amount being withheld to recover an overpayment if, after all development is completed, we are unable to determine whether the exception in A.2. above applies.

6. Multiple Overpayments

When two or more overpayments are being recovered at the same time, we assume the amounts are first withheld to repay any overpayments not subject to the exception in A.2. above. This is regardless of the chronological order in which the overpayments occurred.



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B. Procedure

1. Ask About Overpayments

When someone receives benefits under a program listed in A.3. above, ask him/her whether any benefits otherwise due are being withheld to recover an overpayment.

If the answer is	Then
No	Stop. No written documentation or further development is required.
Yes	...Explain the policy and exception. Ask if the Medicaid recipient/applicant was receiving Medicaid at the time of the overpayment. • If no, go to B.2. • If yes or unknown, go to B.3.

2. Medicaid Not Received at Time of Overpayment

Accept the individual's allegation that Medicaid coverage was not being received at the time of the overpayment. Obtain a signed statement that:

- Medical assistance was not being received when the overpayment occurred;
- the policy and the exception have been explained; and
- the individual understands that the amounts withheld from the other benefit are considered part of the recipient's/applicant's income.

3. Medicaid Received at Time of Overpayment (or Unknown)

If the individual alleges that medical assistance was being received at the time of overpayment, or the individual does not know, verify Medicaid coverage. Use documents in the individual's possession or contact with the appropriate office or agency to verify:

- when the overpayment occurred;
- the rate of recovery; and
- the period of time of recovery.

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C. Examples

1. Exception Applies

Joe Jones received title II benefits and Medicaid beginning January 1987. In November 1988, Mr. Jones learned he was overpaid $100 on his title II claim from April 1988 through August 1988. From January 1989 through May 1989, $20 is withheld from his title II benefit to recover the overpayment. Since the overpayment was already included in unearned income, the EW does not count the $20/month being withheld from January 1989 through May 1989.

2. Overpayment Makes Person Ineligible

Alex Martin received Medicaid payments and VA benefits starting in August 1987. His monthly VA benefit increased to $300 in August 1988. The VA benefit increase, combined with other income, caused Mr. Martin to become ineligible for Medicaid beginning in August 1988. He continued to be ineligible until January 1989 when VA determined his benefit should have been $200 since August 1988. Therefore, Mr. Martin was overpaid a total of $500 by VA for August 1988 through December 1988. Mr. Martin began receiving Medicaid in January 1989. To recover the VA overpayment, Mr. Martin's VA benefit is reduced by $100/month from March 1989 through July 1989. Since Mr. Martin received no Medicaid coverage during the time he was overpaid, the $100/month withheld to recover the overpayment is included in Mr. Martin's current income.

3. Another Person's Overpayment Included in Deeming Computation

Alice Brown has been receiving Medicaid since December 1986. Carl Brown is her ineligible spouse whose income is subject to deeming. In April 1989, Mr. Brown learns he incurred a $250 title II overpayment in November 1988. SSA recovers the overpayment by withholding $50 a month from the benefits Mr. Brown receives in June 1989 through October 1989. For deeming purposes, Mr. Brown's current income does not include the $50/month withheld from his title II since it has already been used in deeming computation for a prior period.

4. Another Person's Overpayment Not Previously Used in Deeming Computation

Mary Smith has been receiving Medicaid since December 1986. Harry Smith, her ineligible spouse, was separated from Mary Smith when he died in 1989. His income was never subject to deeming. Mr. Smith incurred a $100 title II overpayment in November 1988. Since Mrs. Smith is also a title II beneficiary, SSA recovers Mr. Smith's overpayment by withholding $50 a month from Mrs. Smith's benefit in July and August 1989. Since none of Mr. Smith's income was subject to deeming when the overpayment occurred, the EW includes in Mrs. Smith's current income the $50/month withheld from her title II benefit.

D. References

For office or agency addresses see:

- OPM, S0830.220 C.4.
- VA, S0830.320.
- DOD, S0830.240 C.2.

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S0830.115 GARNISHMENT OR OTHER WITHHOLDING

A. Policy

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

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

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

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

B. Kinds of Withholding

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

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

C. Procedure

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

D. Reference

Overpayment involved, S0830.110

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BROAD CATEGORIES OF UNEARNED INCOME

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

A. Definitions

1. Annuity

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

2. Pensions and Retirement Benefits

Pensions and retirement benefits are payments to a worker following his retirement from employment. These payments may be paid directly by a former employer, by a trust fund, an insurance company, or other entity.

3. Disability Benefits

Disability benefits are payments made because of injury or other disability.

B. Policy

1. General Rule

Annuities, pensions, retirement, and disability benefits are unearned income.

2. Exceptions

Certain accident disability benefit paid within the first 6 months after the month an employee last worked are earned income. For a further explanation of sickness and accident disability payments, see S0820.005.

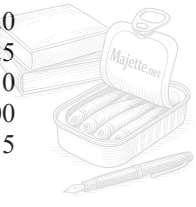
A Qualified Domestic Relations Order (QDRO) is a court order, usually the result of a divorce or separation proceeding that changes the ownership of the pension asset and the income stream from one individual to another. To be valid, a QDRO must:1) be a decree issued by a state court; 2) provide the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

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

C. List of Payments

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

Black Lung Benefits..... S0830.215
Foreign Payments..... S0830.105
German Reparations Payments S0830.710
Military Pensions S0830.240
Office of Personnel Management (Civil Service and
Federal Employment Retirement System) Payments..... S0830.220
Railroad Retirement Payments..... S0830.225
Title II Payments S0830.210
VA Payments S0830.300
Worker's Compensation Payments..... S0830.235



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D. Procedure

1. Initial Applications

In initial applications, be alert for clues which may indicate a receipt of or potential eligibility for an annuity, pension, or similar payment; e.g., long employment with a particular industry or a government agency, military service, membership in a union.

2. Check Specific Instructions

Check for specific policy instructions pertaining to the payment involved. (See C. above.)

3. Overpayment Question

Ask if any benefits otherwise due are being withheld to recover an overpayment. If the answer is yes, see S0830.110.

4. Verification/ General

If there are no specific policy instructions for the payment, use award letters or other documentation in the individual's possession or contact the source to verify:

- the type, source, and amount of payment;
- *recipient of the payment;*
- if necessary, the frequency of payment.

5. Verification/ Frequency

It is not necessary to verify the frequency of the payment if you are familiar with the type of payment involved either through direct experience or a precedent.

6. Verification/ Use of Check

If the individual does not possess an award letter or other document, a **check** may be used to verify the payment amount if it is clear that the amount shown represents the gross amount.

7. Contact with the Source

If the individual has no evidence in his/her possession, contact the source of the payment.

E. References

Determining the amount of unearned income, S0830.100

Contributions by an employer into a retirement fund, S0815.600

Retirement funds as resources, S1120.210 E.

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S0830.165 ASSISTANCE PROGRAMS WITH GOVERNMENTAL INVOLVEMENT -- GENERAL

A. Introduction

Federal, State, and local governments are involved in a number of programs which provide assistance (cash or in-kind goods and services) to Medicaid recipients. For Medicaid purposes, treatment of this assistance will vary depending on the nature of the program and the payment. Sections S0830.170, S0830.175 and S0830.180 provide guidelines for determining the nature of these programs and the income, if any, to count when program specific instructions do not exist elsewhere. A guide is provided in B. below.

B. Programs-Specific Instructions

Use this table to locate specific instructions pertaining to frequently encountered programs with governmental involvement.

Adoption assistance S0830.415
Action Programs S0830.610
Aid to Families with Dependent Children (AFDC) S0830.400
Bureau of Indian Affairs General Assistance (BIAGA) S0830.800
Community Services Block Grant S0830.615
Community Work Experience Program (CWEP) S0830.185
Cuban/Haitian Entrant Cash Assistance S0830.645
Disaster Assistance S0830.620
Educational Assistance S0830.450
Emergency Assistance Under Title IV A S0830.405
Federal Emergency Management Agency (FEMA) S0830.625
Food Stamps S0830.635
Foster Care S0830.410
Foster Grandparents Program S0830.610
General Assistance, Home, Relief, etc S0830.175
Housing Assistance S0830.630
Workforce Innovation and Opportunity Act (Formerly Workforce Investment Act) S0830.535
Low Income Home Energy Assistance Program (LIHEAP) S0830.600
Older Americans Act S0830.640
Refugee Cash Assistance S0830.645
Refugee Reception and Placement Grants S0830.650
Refugee Matching Grants S0830.650
Rehabilitation Act of 1973 ..... S0815.050
Relocation Assistance S0830.655
School Lunches S0830.635
Social Service Block Grant (Title XX) S0815.050
State Assistance Based on Need S0830.175
VA Benefits S0830.300
Work Relied (Workfare) Programs S0830.185

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S0830.170 INCOME BASED ON NEED (IBON)

A. Definition

Income based on need (IBON) is assistance:

1. provided under a program which uses income as a factor of eligibility; and

2. funded wholly or partially by the Federal government or a nongovernmental agency (e.g., Catholic Charities or the Salvation Army) for the purpose of meeting basic needs (i.e., the funds are provided specifically for a formalized program whose general purpose is similar to that of the SSI program).

EXCEPTION: State supplementary payments made to refugees are not IBON (S0830.175), despite involvement of Federal funds.

B. Policy Principle

Income based on need is counted as income dollar for dollar, unless it is totally excluded by statute (e.g., food stamps) or excluded under a PASS (S0870.001.). The $20 general income exclusion (S0810.420) does not apply to IBON.

NOTE: If a nongovernmental agency is involved, consider whether the assistance qualifies for exclusion as Home Energy Assistance and Support and Maintenance Assistance (HEA/SMA, S0830.605) or meets the definition of a social service (S0815.050).

C. Operating Procedures

NOTE: These instructions apply when there are no separate instructions pertaining specifically to the program in question.

1. Verify with the administering agency personnel and/or program descriptions that the assistance meets the definition of income based on need.

2. Verify the amount of the assistance for each month with the administering agency or through documents in the individual's possession.

3. If income based on need is paid to or on behalf of a group of people, determine one individual's income by the incremental method (i.e., the individual's income is the difference between the amount paid and the amount which would have been paid had the individual not been included).

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S0830.175 ASSISTANCE BASED ON NEED (ABON)

A. Definitions

ABON is assistance:

1. Assistance Based on Need (ABON)

- provided under a program which uses income as a factor of **eligibility**; and
- funded **wholly** by a State (including the District of Columbia, Indian tribes and the Northern Mariana Islands), a political subdivision of a State, or a combination of such jurisdictions.

EXCEPTIONS: State supplementary payments, made to refugees are considered to be ABON even if the Federal government reimburses the State.

NOTE: If a program uses income to determine payment amount but not eligibility, it is not ABON (e.g., some crime victims compensation programs).

2. Federal Funds

For purposes of this section, Federal funds means monies supplied and directed by the Federal government for a specific use or specific type of program (e.g., community service block grants, Federal matching funds for AFDC). Monies not allocated for specific purposes are not considered Federal funds.

EXAMPLES: Nonspecific Funding

Revenue sharing funds are not "Federal funds" for purposes of this section and programs using these funds are considered wholly Sate funded.

B. Policy

Assistance based on need is excluded from income.

C. Procedure

1. Precedent Exists

If a precedent exists:

- **Accept** the claimant's **allegation** as to the type and source of assistance and exclude it without further development.
- **Document** the file to show that a precedent exists **only** if you use a local precedent.

2. No Precedent Exists

If a precedent does not exist:

- Use **documents** in the individual's possession or contact the administering agency to **determine** the program under which the assistance is provided.
- **Verify** with agency personnel and/or program descriptions that no

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Federal or private funds are involved and that the program uses income in arriving at eligibility determinations.

- **Retain** the evidence (either written material or oral statements documented).

NOTE: If evidence establishes that the assistance is excludable under this provision, it is not necessary to verify the amount of assistance and when it was received.

- **Document the file** with copies of the original evidence, or mention that a local precedent exists.

D. References Income based on need, S080.170.

S0830.180 OTHER ASSISTANCE INVOLVING GOVERNMENT FUNDS

A. Policy Principle Assistance which is neither IBON nor ABON, but which involves government funds, is subject to the general rules pertaining to income and income exclusions.

NOTE: See section S0830.625, S0830.615 and S0830.405 for examples of this type of assistance.

B. Operating Procedures

1. Determine that the assistance is neither IBON (S0830.170) nor ABON (S0830.175). Remember:

   a. assistance involving Federal funds which are not provided by the Federal government for the purpose of meeting ongoing basic needs is not IBON;

   b. State supplementary payments, including those made to refugees, are always ABON; and

   c. assistance involving funds which have been supplied and directed by the Federal government for use solely in the type of assistance provided is not ABON.

2. Determine the nature of the assistance and apply the appropriate operating instructions pertaining to income and income exclusions. Related sections include:

   S0815.050 (Medical and Social Services)
   S0810.420 ($20 General Income Exclusion)
   S0830.605 (Home Energy Assistance and Support and Maintenance Assistance)

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S0830.185 WORK RELIEF (WORKFARE) PROGRAMS

A. Background

Many governmental assistance programs require that certain recipients work in exchange for the assistance provided. Most often the amount of the assistance payment is divided by the minimum wage and the recipient required to perform some service for the resulting number of hours. Usually a participant in such a work program is given money to cover any expenses incurred (e.g., carfare, special clothing, miscellaneous, etc.). Programs connected with general assistance have various locally established names. Programs connected with AFDC include the Community Work Experience Program (CWEP), and the Work Incentive Program (WIN). Programs are often run as demonstrations or pilot projects.

B. Policy Principle

The fact that an individual is required to work in exchange for an income based on need (S0830.170) or assistance based on need (S0830.175) payment does not change the nature of the payment. For Medicaid purposes, the payment in such situations is an assistance payment and is not earned income.

NOTE: Do not confuse work supplementation programs connected with AFDC with programs which require an individual to work in exchange for income based on need. Work supplementation programs pay wages which are earned income. The family may or may not receive an AFDC payment in addition to the earned income.

C. Operating Procedures

1. Verify the assistance according to the appropriate instructions. Follow the instructions in S0830.170 if IBON is involved; S0830.175 if ABON is involved; S0830.400 if AFDC is involved.

2. Assume that any expense money provided in connection with a governmental work program equals the expenses incurred and does not result in any income. Verify with the paying agency or through documents in the individual's possession that any alleged expense money is provided as such. A precedent may be used. If a precedent has been established, document the file to show this.

MAJOR BENEFIT PROGRAMS

M0830.200 BENEFITS PAID UNDER TITLE XVI OF THE SOCIAL SECURITY ACT

A. Policy Principles

Supplemental Security Income (SSI) payments are monthly unearned income. SSI monthly payments and SSI lump sum payments are totally excluded when determining financial eligibility for Medicaid.

SSI recipients who meet the more restrictive Medicaid resource criteria are eligible for Medicaid as categorically needy.

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S0830.210 BENEFITS PAID UNDER TITLE II OF THE SOCIAL SECURITY ACT

A. Policy Principles

1. Retirement, survivors, and disability insurance (RSDI) monthly benefits are unearned income. Special age 72 payments are also unearned income. (See S0830.545 for treatment of lump-sum death payments.)

2. The amount of premiums deducted for Supplementary Medical Insurance (SMI) under Medicare from RSDI benefits is included in unearned income.

3. Unearned income includes the amount withheld to recover an overpayment (unless the exception in S0830.110 applies).

B. Operating Policies

1. Reductions, Deductions, and Rounding

The amount of Title II after reductions, certain deductions, and dollar rounding, but before the collection of any obligations of the beneficiary (e.g., supplementary medical insurance (SMI) premium, Medicare Part D premium or prior overpayment) is unearned income.

2. *Worker's Compensation Offset*

If a monthly benefit payment has been reduced because of a workers compensation offset, the net amount of the benefit received (plus any SMI/Medicare Part D premium withheld) is unearned income.

3. Prior Overpayment

If all or part of a title II benefit is being withheld to recover an overpayment, count as income the amount of title II before deduction for the overpayment unless the exception in S0830.110 applies. If the exception applies (i.e., the overpayment occurred when the individual was receiving Medicaid and the overpaid amount was included in unearned income at that time), do not include the amount deducted for an overpayment in calculating countable title II income. Also do not count as income monies received as a result of a waiver approval when the money was previously withheld to recover a title II overpayment and was counted as income for Medicaid when originally withheld.

4. SMI Premiums

Do no count refunded SMI premiums as unearned income.

The amount of premiums deducted from RDSI benefits for SMI under Medicare or Medicare Part B is unearned income.

EXAMPLE: An individual's title II benefits for January 1987 through May 1987 are withheld because of expected work and earnings. He reports in June 1987 that he quit working in February 1987. He paid



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SMI premiums for January - March 1987, April - June 1987, and July - September 1987. A Title II check sent in July 1987 includes full benefits for January - June 1987 and refunds SMI premiums for August - September 1987, which will be withheld from future checks. For Medicaid purposes, the part of the check which represents full benefits for January - June 1987 is unearned income in July 1987 and the refunded SMI premiums for August - September 1987 are not income.

4. Retroactive State Buy-In

When a State "buys-in" for Medicare on behalf of an individual, a different amount of Title II income may be posted because of the Title II rounding provisions.

5. Underpay-ments

Title II benefits can be received in regular monthly checks (or by direct deposit) or in retroactive payments. If an individual receives a check because of an underpayment, charge the amount of the check (plus any SMI premiums withheld) as unearned income in the month received; do no look back and allocate an underpayment being made in the current month to prior months. See S0830.010 B. on counting retroactive RSDI benefits for an offset period. See S1120.022 for the treatment of reissued Title II monies in change-of-payee situations.

6. Facility of Payment Provisions

When a Title II auxiliary or survivor beneficiary who is subject to work deductions receives Title II benefits in his name because of the facility (something that makes an operation or action easier) of payment provisions but the benefits are those of other beneficiaries, the amount of Title II benefits of each of the involved beneficiaries must be determined separately. Count the benefits as income to the appropriate beneficiaries.

M0830.211 SPECIAL EXCLUSION OF TITLE II COLA FOR CERTAIN ABD COVERED GROUPS

A. Policy

The cost-of-living adjustment (COLA) in the individual's Social Security Title II benefit is excluded through the month following the month in which the new federal poverty limits (FPLs) are published when determining the income eligibility of an individual in the following ABD covered groups:

- Qualified Medicare Beneficiary (QMB
- Special Low-income Medicare Beneficiary (SLMB),
- Qualified Individuals (QI), and
- ABD with Income ≤ 80% FPL (ABD 80% FPL).

B. Procedure

Exclude the COLA in the individual's SSA Title II benefit until the first day of the second month following the publication month of the new FPL. Local agency staff are notified of the FPL publication *via a broadcast on the VDSS intranet site.*

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C. Example

A QMB-only Medicaid recipient with SSA Title II benefits receives a COLA in the benefit payment for January. The worker does not take any action on this change in income until the FPL broadcast has been posted on *the DSS website.* The FPL change is published on January 31, and LDSS are notified by the FPL broadcast posted on February 3. The worker recalculates the enrollee's income for March 1, based on the recipient's increased Title II benefit and the new QMB income limit which was effective January 31.

Note: COLA exclusion pertains to both ongoing and intake cases.

S0830.215 BLACK LUNG BENEFITS

A. Introduction

1. Types of Black Lung Benefits

Black Lung (BL) benefits are paid to miners and their survivors under the provisions of the Federal Mine Safety and Health Act (FMSHA).

Benefits under **Part B** of the FMSHA are paid by the **Social Security Administration** (SSA) and benefits under **Part C** of the FMSHA are paid by the **Department of Labor** (DOL).

2. Payment Dates

In general, Part B benefits are paid on the third of the month while Part C benefits are paid on the fifteenth of the month.

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3. Reduction of BL Benefits

Both Part B and Part C BL benefits are subject to offsets (e.g., workers' compensation) and can be reduced due to the recovery of an overpayment. In addition, Part C benefits may be reduced because of liens imposed by other Federal agencies (such as the Internal Revenue Service).

B. Policy

1. Unearned Income

BL benefit payments are unearned income.

2. Deductions

The amount deducted from a Part C BL benefit because of garnishment (e.g., liens imposed by other Federal agencies) is unearned income (see S0830.115). (See 0830.110 if an overpayment is involved.)

3. Countable BL Income

The amount of the BL benefit to count as income is the amount paid after application of an offset (i.e., workers compensation offset or work deductions) but before the collection of any obligations of the recipient (unless the exception in S0830.110 applies).

C. Procedure Part B

a. **Verify the receipt of Part B BL benefits**

You may use the individual's award notice or actual check.

b. Use the monthly payment amount **(MPA)** in the PAYMENT section of the Maxium Benefit Rate **(MBR) to calculate BL income**.

NOTE: The MPA is the amount paid to the individual after deduction for an offset or collection of an overpayment.

c. **Document the file** so that it is clear how countable BL income was determined.

D. Procedure Part C

a. **Verify the receipt of Part C BL benefits** with the individual's own records (such as an award notice or check), if available.

b. **Call the appropriate DOL office** if information from the applicant/recipient is unavailable or incomplete. DOL can also resolve questions about overpayments or liens.

c. **Calculate the amount of countable BL income** from the actual payment amount.

d. **Document the file** so that it is clear how countable BL income has been determined.

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S0830.220 OFFICE OF PERSONNEL MANAGEMENT (CIVIL SERVICE AND FEDERAL EMPLOYEE RETIREMENT SYSTEM) PAYMENTS

A. Introduction

1. General

The Office of Personnel Management (OPM) makes U.S. Civil Service and Federal Employee Retirement System (FERS) payments because of disability, retirement, or death.

2. Annuitants Retired Before July 1, 1960

OPM provides annuitants under the Retired Health Benefits (RHB) program free coverage under Part B of Medicare. At the employee's option, the Part B premium may instead be paid to another health insurance plan or paid directly to the annuitant for use in purchasing health insurance coverage privately. All annuitants covered by the RHB program retired before July 1, 1960.

B. Policy

1. General Rule

U.S. Civil Service and FERS payments are **unearned income** to the entitled retiree or individual survivor.

2. Certain Disability Benefits

Certain disability benefits paid within the first 6 months after an employee last worked are earned income.

NOTE: For an explanation of benefits falling under this exception, see S0820.005.

3. Retired Health Benefit (RHB) Payments

RHB payments to annuitants are **not** income.

NOTE: An RHB payment is shown as a **positive** amount on the health benefits line of the OPM notice.

C. Procedure

1. Overpayment Question

Ask if any benefits otherwise due are being withheld to recover an overpayment. If the answer is "yes," see S0830.110.

2. Use Documents Other Than a Check

Use notices or other documents in the individual's possession (other than a check) to verify the **gross amount** of the payment.

3. Do Not Use Check Alone

Do not use a check alone to verify the amount of the payment because a check is not reliable evidence of the gross amount.

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4. Contact with OPM

If the individual has no acceptable documents, write or telephone OPM. Provide the individual's name and civil service annuity claim identification number (a seven-digit number with a "CSA" or "CSF" prefix). If the claim number is not available, provide the individual's date of birth and Social Security number. *You will also be required to provide a written release from the individual to OPM in order for any information to be released.*

The OPM telephone number is (888) 767-6738. Direct written inquiries to:

U.S. Office Personnel Management
Retirement Operations Center
P.O. Box 45
Boyers, PA 16017

S0830.225 RAILROAD RETIREMENT PAYMENTS

A. Introduction

1. Categories of Payment

There are three basic categories of payments made by the Railroad Retirement Board (RRB):

- Life and survivor annuities
- Social Security benefits certified RRB
- Unemployment, sickness, and strike benefits

2. Life and Survivor Annuities

- Life annuities for retirement and disability are paid under the Railroad Retirement (RR) Act to the railroad employee and his/her spouse. Children of a living annuitant are not entitled to benefits.
- Survivor annuities are payable to widows, widowers, children, and dependent parents of railroad employees. A small number of widows receive two annuities, a regular widow's check and a check payable to them as designated survivors of retired railroad employees who elected to receive reduced benefits during their lifetimes.
- RR annuity payments are similar to Title II benefits in that a check for one month is paid the next month. Also, cost of living adjustments (COLA) for RR annuities are effective the same month as Title II COLA's.

3. Social Security Benefits Certified by RRB

SSA may authorize the payment of Social Security benefits for RR employees to RRB instead of directly to Treasury. In these situations, RRB is responsible for certifying Title II benefits to Treasury, but they remain Title II benefits.

RR benefits are not necessarily Title II benefits. Individuals entitled to this type of benefit receive two award notices. The first notice, from SSA, informs the beneficiary that RRB has responsibility for making Social Security payments. The final notice, from RRB, specifies the amount of the first check.

RR annuity payments and Social Security benefits certified by RRB may be paid as a single check. In these cases, RRB may issue an interim notice before the final notice which specifies the amount of the first check.

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4. Unemployment Sickness, and Strike Benefits

Unemployment, sickness, and strike benefits are computed on a daily basis with each check covering a period of up to 2 weeks. These claims are usually filed through the railroad employer or directly with RRB in Chicago.

B. Policy

1. Unearned Income

Payments made by the RRB are unearned income**.**

2. Reduction of RR Benefits

The amount deducted from a RR benefit for supplementary medical insurance (SMI) premiums is unearned income. See S0830.110 if an overpayment is involved.

3. Countable RR Income

The amount of the RR annuity to count as income is the amount before the collection of any obligations of the annuitant (unless the exception in S0830.110 applies).

C. Procedure - Life and Survivor Annuities

1. General Development -- All Cases

a. Be alert to the possibility of the receipt of, or potential entitlement to, RR benefits in every case where:

- the individual's social security number begins with a "7"
- the individual alleges or other evidence indicates railroad employment by the individual or his/her spouse.

b. Verify allegations of receipt of RR annuities by obtaining a copy of the individual's most recent award notice.

c. If the notice is unavailable**,** record in the file the information from the individual's next check.

NOTE: RR checks bear beneficiary symbols that identify the type of RR benefit involved.

D. Procedure for Social Security Benefits Certified By RRB

The applicant should have notices issued by SSA and RRB indicating that the benefit is a Title II benefit. If Title II status cannot be determined from the available documents, verify with the RRB that RR benefits are Title II benefits.

E. Procedure - Unemployment, Sickness, and Strike Benefits

Obtain evidence of unemployment, sickness, and strike benefits from the individual's own records, such as an award letter or actual check. If this evidence is unavailable, contact the RRB headquarters by telephone *toll-free at 1-877-772-5772* or by mail at:

Railroad Retirement Board
844 North Rush Street
Chicago, IL 60611-2092

Local RRB offices do not maintain this information.

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M0830.230 UNEMPLOYMENT COMPENSATION BENEFITS

A. Definition

Unemployment Compensation payments are received under a State or Federal unemployment law and additional amounts paid by unions or employers as unemployment benefits.

B. Procedures

1. General Procedures

Unemployment Compensation benefits are counted as unearned income

2. *Federal Pandemic Unemployment Compensation Program*

Section 2104 of the Coronavirus Aid, Relief, and Economic Security (Cares) Act (Public Law No. 116-136) provides that under the Federal Pandemic Unemployment Compensation Program, eligible individuals who are collecting certain Unemployment Compensation, including regular unemployment compensation, will receive an additional $600 in federal benefits per week for weeks of unemployment ending on or before July 31, 2020.

The $600 weekly Pandemic Unemployment Compensation payments (monthly equivalent of $2,580) are disregarded as income.

S0830.235 WORKERS' COMPENSATION

A. Introduction

Workers' compensation (WC) payments are awarded to an injured employee or his/her survivor(s) under Federal and State WC laws, such as the Longshoremen and Harbor Workers' Compensation Act. The payments may be made by a Federal or State agency, an insurance company, or an employer.

B. Policy

1. Income

a. General

The WC payment less any expenses incurred in getting the payment is unearned income.

b. Amounts Designated for Expenses by Authorizing or Paying Agency

Any portion of a WC award payment **that the authorizing or paying agency designates** for medical expenses or legal or other expenses attributable to obtaining the WC award is not income (S0830.100). The expenses may be **past, current,** or **future**. The WC payments designated for such expenses may be received in a lump sum or as a continuing payment.

c. Other Amounts Claimed for Expenses

If an individual alleges having incurred expenses that exceed amounts designated for expenses as in b. above, or for which no amount was designated, the normal rules pertaining to the expenses of obtaining income apply (see S0830.100).

2. Resources

There is no resource exclusion that applies specifically to WC payments that have been deducted from income under b. or c. above. Normal resource rules apply to WC payments retained after the month of receipt.

C. Procedure

1. Checking for Possible WC Overpayment Withholding

Ask if any WC benefits are being withheld to recover an overpayment. If yes, see S0830.110.

2. Verifying WC Payments

If possible, use an award notice to verify WC payments. If such a notice is not available, obtain information from the Federal or State agency, insurance company, or employer. (The address of the local Federal Employee's Compensation agency or the State Workers' Compensation Office should be in the local phone directory.)

3. Verifying Amounts Designated by Authorizing or Paying Agency

If the WC award notice includes monies designated for expenses listed in B.1.b. above, but does not specify the amount designated, contact the paying agency (i.e., the Federal or State agency, insurance company, or employer) to verify the amount of the WC award that is designated for such expenses.

4. Verifying Other Amounts Claimed for Expenses

Follow the instructions in S0830.100 C. to verify expenses that exceed the designated amounts or for which no amounts are designated.

D. References

- Expenses of obtaining income, S0830.100.
- General resource rules, S1110.001 ff.
- Liquid resources, S1110.300 ff.

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S0830.240 MILITARY PENSIONS

A. Introduction

1. General

The Air Force, Army, Marine Corps, and Navy pay military pensions to military retirees and survivors normally on the first day of the month.

2. Categories of Beneficiaries

There are three categories of beneficiaries who may be entitled to military payments:

- **RETIREE** - A person with 20 years of service who meets the requirement for entitlement;
- **ANNUITANT** - A survivor who is designated by the retiree to receive benefits upon the death of the retiree under the Retired Serviceman's Family Protection Plan **(RSFPP)**, Survivor's Benefit Plan **(SBP)**, or both;
- **ALLOTTEE** - Anyone other than an annuitant of the RSFPP or SBP who is designated to receive money out of the service member's or retiree's check. Entitlement as an allottee terminates upon the death of the retiree. However, an allottee can become an annuitant when the retiree dies.

3. Types of Annuitants

The RSFPP and SBP annuitant programs pay money to surviving spouse(s) and children.

The SBP program also pays:

- "Insurable interest" person: i.e., someone other than a surviving spouse or child that a service member designated to receive survivor benefits based on monies withheld from his or her retirement payment under the provisions of the SBP program; and
- Minimum income level widows (MIW) who are certified by the VA as having low income and are referred by the Department of Defense (DOD).

B. Policy

1. Basic Policy

Military pensions are unearned income.

Payments to MIW's are income based on need not subject to the $20 general income exclusion.

2. Income Exclusion - SBP

Any portion of a retiree's pension that is withheld as a contribution to participate in the SBP is excluded from income. To participate in SBP in conjunction with their retirement, military members must elect to receive reduced retirement pay for their lifetime so that a percentage of their



retirement pay can continue to be paid to their survivors following their death. Once SBP is elected, retirees cannot discontinue the deductions from their pensions.

C. Procedure

1. General

Obtain evidence from the individual's own records, if available. If the individual does not have sufficient evidence, contact the appropriate Military Finance Center as shown in 2. below.

2. Contacting the Military Finance Centers

a. If information must be requested from a Military Finance Center, send a request with the individual's authorization to release the information.

b. Include the following information on the request form:

- The service member's given name, middle initial and surname;
- The service member's service identification number (if available);
- The service member's SSN;
- The annuitant's or allottee's name; and
- The annuitant's or allottee's SSN.

c. **Specify the period** for which payment information is needed and identify the pay plan (e.g., RSFPP, SBP).

d. The following is a listing of the mailing address for each Military Finance Center.

Military Service Branch	Military Finance Center Mailing Addresses
ARMY	USAFAC Director, Retired Operations Indianapolis, IN 46249 ATTN: Management Support Office
NAVY	Defense Finance Accounting Service Code 305 Navy Finance Center Anthony J. Celebrezze Building Cleveland, OH 44199
AIR FORCE	DFAF/DE/CIDM Denver, CO 80279-5000
MARINE CORPS	Marine Corps Finance Center 1500 E. Bannister Street Kansas City, MO 64197

D. References

- Income based on need, S0830.170

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S0830.260 STATE ANNUITIES FOR CERTAIN VETERANS

A. Introduction

On June 17, 2008, President Bush signed into law H.R. 6081, the Heroes Earnings Assistance and Relief Tax Act of 2008 (the HEART Act,) which excludes State annuities for certain veterans from income.

B. Definition of a Veteran

The term "veteran" means a person who served in the active military, naval, or air service, and who was discharged or released under conditions other than dishonorable.

C. Exclusion

Effective benefits payable on or after September 1, 2008, a State annuity paid by a State, to a person, and/or a person's spouse, on the basis of the State's determination that the person is a veteran and is blind, disabled, or aged, is excluded from income in the month of receipt.

NOTE: A State annuity payment is not a benefit issued by the Department of Veterans Affairs, such as VA compensation or VA pension.

D. Procedure – Initial and Post Eligibility

If a veteran or a veteran's spouse, alleges the receipt of a State veteran's annuity as outlined in SI 00830.260C, ask the individual to submit evidence that verifies the source of the State annuity.

Acceptable evidence documents in the individual's possession (i.e. award letter from the State), office precedent, or direct contact with the State.

If evidence verifies that the annuity is paid by the State to a veteran or a veteran's spouse under this provision, but not the amount or date(s) of payment, accept the individual's allegation of amount(s) and date(s) of receipt. Exclude the State veteran's annuity payment from income for the month of receipt and without further development.

NOTE: Interest earned on retained payments is not excluded from income, see Dividends and Interest SI 00830.500.

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DEPARTMENT OF VETERANS AFFAIRS PAYMENTS

S0830.300 DEPARTMENT OF VETERANS AFFAIRS PAYMENTS

The Department of Veterans Affairs (VA) has numerous programs which make payments to Medicaid recipients and their families. For Medicaid purposes, treatment of those VA payments depends on the nature of the payments. The most common types of VA payments are explained in the following sections:

A. Introduction

- PENSION - S0830.302
- COMPENSATION - S0830.304
- EDUCATIONAL ASSISTANCE - S0830.306
- AID AND ATTENDANCE ALLOWANCE - S0830.308
- HOUSEBOUND ALLOWANCE - S0830.308
- CLOTHING ALLOWANCE - S0830.310
- PAYMENT ADJUSTMENT FOR UNUSUAL MEDICAL EXPENSES - S0830.312
- INSURANCE PAYMENTS - S0830.160 (for disability insurance) and S0830.545 (for life insurance).

B. Procedure

Explore the possibility of receipt of, or potential eligibility for, a VA payment, whenever it comes to your attention that an applicant or recipient is:

- a veteran;
- the child or spouse of a disabled or deceased service person or veteran;
- an unmarried widow or widower of a deceased service person or veteran;
- the parent of a service person or veteran who died before January 1, 1957 from a service connected cause.

NOTE: Eligibility for Other Program Benefits: The Social Security Act requires that an applicant or recipient who is potentially eligible for some VA benefits must apply for those benefits.

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S0830.302 VA PENSION PAYMENTS

A. Introduction

1. Basis for Payments

Pension payments are based on a combination of service and a nonservice-connected disability or death. With a few rare exceptions noted below, VA pension payments are also based on need.

2. Payments for Dependents

VA may take dependents' needs into account in determining a pension. However, normally VA will not make a pension payments directly to a dependent during the lifetime of the veteran. Instead, the amount of the veteran's basic pension is increased if the veteran has dependents.

A VA pension payment that has been increased for dependents is an augmented VA payment. A VA pension payment made directly to the dependent of a living veteran is an apportioned payment. (See S0830.314 for a discussion of augmented and apportioned payments.)

3. Frequency

Pension payments are usually paid monthly; however, when the monthly payment due is less than $19, VA will pay quarterly, biannually or annually. VA may also make an extra payment if an underpayment is due.

4. Unusual Medical Expenses

When computing some needs-based pension payments, VA deducts unusual medical expenses from any countable income. This computation may result in an increase in a pension payment or in an extra payment. **An increase or extra payment resulting from this computation is not income**. (See S0830.312 for a discussion of VA payments resulting from unusual medical expenses.)

B. Policy

1. Basic Policy -- Needs - Based

All VA pension payments except those listed in 2. below are federally funded income based on need. As such, these payments are unearned income to which the $20 general income exclusion does not apply.

2. Policy Exceptions

a. Pension Payments Resulting from Aid and Attendance or Housebound Allowances

VA aid and attendance housebound allowances are not income. (See S0830.308.) All or part of a VA pension may be subject to this rule.

b. Pension Payments Resulting from Unusual Medical Expenses

VA payments resulting from unusual medical expenses are not income. (See S0830.312.) All or part of a VA pension payment may be subject to this rule.

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c. Pensions Not Based on Need

Certain pensions paid to veterans or their dependents are not needs based. These pensions are unearned income and the $20 general exclusion (S0810.420) applies. This exception applies to pensions paid on the basis of:

- a Medal of Honor; or
- a special act of Congress.

3. Assumption

Assume that a VA pension is partly or entirely needs based unless there is evidence to the contrary.

C. Procedure

Follow the procedure below for developing and verifying VA pensions.

Step	Action
1	Screen for unusual medical expenses per S0830.312.
2	Develop for augmentation (per S0830.314) if dependents may be involved.
3	Screen for an aid and attendance or housebound allowance per S0830.308.
4	Are unusual medical expenses, augmentation, or an aid and attendance or housebound allowance at issue in the case? • If yes, go to Step 5. • If no, go to Step 6.
5	Verify the gross amount and frequency of payment. STOP.
6	Verify the gross amount and frequency of payment using (in order of priority): • a VA award letter or comparable document in the individual's possession; • a benefit check in combination with a signed statement from the individual that provides the frequency of payment and affirms that VA makes no deductions (such as insurance premiums, loan payments, and overpayment deductions); or • Verification from VA Regional Office (VARO).

D. References

- Applying Income Rules, S0810.030.

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S0830.304 VA COMPENSATION PAYMENTS

A. Introduction

1. Basis for Payments

Compensation payments are based on service-connected disability or death. VA compensation payments may also be based on need.

2. Payments for Dependents

VA may take dependents' needs into account in determining a compensation payment. Compensation payments may be paid directly to dependent parents on the basis of a service-connected death.

A VA compensation payment that has been increased for dependents is an augmented VA payment. A VA compensation payment made directly to the dependent of a living veteran is an apportioned payment. (See S0830.314 for a discussion of augmented and apportioned payments.)

3. Frequency

Compensation payments are paid monthly.

4. Unusual Medical Expenses

For needs-based compensation payments, VA may deduct unusual medical expenses from any countable income. (See S0830.312.)

B. Policy

1. Surviving Parent Compensation

Compensation payments to a surviving parent of a veteran are federally funded income based on need. As such, these payments are unearned income to which the $20 general income exclusion (S0810.420) does not apply.

EXCEPTIONS: Compensation payments resulting from unusual medical expenses, aid and attendance allowances, and housebound allowances are not income (S0830.308 and S0830.312). All or part of a VA compensation payments may be subject to this rule.

2. All Other Compensation

Compensation payments to a veteran, spouse, child, or widow(er) are unearned income subject to the $20 general income exclusion (S0810.420).

EXCEPTION: Any portion of a VA compensation payment that is a VA aid and attendance allowance or housebound allowance is not income. (See S0830.308.)

C. Procedure

- Follow the pension instructions in S0830.302 C.
- Do not screen for unusual medical expenses unless a needs-based payment is involved.

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S0830.306 VA EDUCATIONAL BENEFITS

A. Introduction

VA provides educational assistance under a number of different programs including vocational rehabilitation. The Medicaid income and resource policies that apply depend on the nature of the VA program.

1. General Information

a. **Period of Eligibility**--Generally, veterans have 10 years after leaving the service to complete their education and 12 years after leaving the service to complete a program of vocational rehabilitation.

b. **Frequency of Payment** -- Payments are usually made monthly only for those months the veteran is in school. If school attendance is less than full time, the payments may be made less frequently.

c. **Other Eligibles** -- Dependents and survivors of veterans may also be eligible for educational benefits.

d. **"Contributory" Programs** --Some VA educational benefits are based on contributions by the veteran. That is, the veteran contributed to the educational fund while in the service and VA matches the money when the veteran withdraws it to pursue an education. The veteran also has the right to withdraw, as a lump sum, the funds he/she contributed.

2. Specific Educational Programs

a. **Chapter 30 (Active Duty Educational Assistance Program ("new" GI Bill))** --VA makes payments under this noncontributory program to veterans who:

- entered active service on or after July 1, 1985; or
- meet the qualification in 2 c. below, serve 3 years after June 30, 1985 and have had their military pay reduced for 12 months during their active service due to the individual participating in this program.

Payments under this program are not augmented for dependents if the veteran entered active service after June 30, 1985.

b. **Chapter 31 (Training and Rehabilitation for Veterans with Service Connected Disabilities)** --- VA pays benefits under this noncontributory vocational rehabilitation program to veterans who served in the military after August 1, 1940.

Chapter 31 benefits may be augmented for dependents.

c. **Chapter 32 (Veterans Educational Assistance Program (VEAP))** -- VA pays benefits under this contributory program to veterans who entered active service between January 1, 1977 and June 30, 1985.

The benefits are not augmented for dependents.

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d. **Chapter 35 (Survivors and Dependents Educational Assistance Program)** -- VA makes payments under this noncontributory program to:

- children (between ages 18 and 26) and surviving spouses of veterans who died in the service; or
- children and spouses of living veterans who are 100 percent disabled due to a service-connected injury.

NOTE: Survivors and dependents have 10 years from the date of the veteran's service-connected death or date of 100 percent disability to participate in this program.

e. **Chapter 106 (Selected Reserve Program)**--VA pays benefits under this noncontributory program to reservists who have a 6-year commitment while they are in the reserves. Payments under this program are not augmented for dependents.

B. Policy

1. What is Not Income

a. **Vocational Rehabilitation** -- Payments made as part of a VA program of vocational rehabilitation are not income (S0815.050 C.). This includes any augmentation for dependents.

b. **Withdrawal of Contributions** -- Any portion of a VA educational benefit which is a withdrawal of the veteran's own contribution is conversion of a resource and is not income (S0815.200).

2. What is Income

VA educational benefits other than those in 1.a. and b. above are unearned income. However, any portion of a grant, scholarship, or fellowship used for paying tuition, fees, or other necessary educational expenses is excluded from income (S0830.455).

NOTE: The $20 general exclusion (S0810.420) applies to VA educational assistance and the payments are subject to deeming.

3. Augmented Benefits

The policy for augmented VA benefits as explained in S0830.314 applies to augmented educational benefits.

EXCEPTION: Subsistence allowances received during vocational rehabilitation may be augmented, but the dependent's portion is not income per 1.a. above.

Only that portion of an educational payment which is income to the individual obtaining the education is subject to the exclusion for educational expenses as described in S0830.455. The augmented portion which is income to the dependent is not subject to this exclusion.

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C. Procedure

Accept the following, in the order listed, as documentation of type, amount, and frequency of payments:

1. Acceptable Evidence

a. A VA award letter or comparable document in the individual's possession; or
b. Verification from the VARO.

2. Noncontrib-utory/ Contributory Programs

a. ....**Service Began Prior to January 1, 1977 or After June 30, 1985** -- If there is evidence in file that the veteran's active service began prior to January 1, 1977 or after June 30, 1985, assume that the educational benefits are paid under a noncontributory program. (A signed statement from the veteran or the veteran's surviving spouse or child is sufficient evidence of service dates).

b. **Service Began Between January 1, 1977 and June 30, 1985** -- If there is evidence that the veteran's active duty service began between January 1, 1977 and June 30, 1985, assume that the educational benefits (other than Chapter 31 benefits) paid to a veteran are paid under a **contributory** program. (A signed statement from the veteran or the veteran's surviving spouse or child is sufficient evidence of service dates). Verify the portion of any VA educational benefit that is a withdrawal of the veteran's contributions to the fund.

Verify this information with the VARO and obtain the following information:

- For each periodic payment of educational benefits, provide the dollar amount representing a return of the veteran's own contribution.

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S0830.308 VA AID AND ATTENDANCE AND HOUSEBOUND ALLOWANCES

A. Introduction

VA pays an allowance to veterans, spouses of disabled veterans, and surviving spouses who are in regular need of the aid and attendance of another person or who are housebound. This allowance is combined with the individual's pension or compensation payment.

B. Policy -- Income Treatment

- VA aid and attendance and housebound allowances are not income for Medicaid purposes. (See S0815.050 for rules on medical and social services payments.)

- If the veteran pays his/her own spouse or deemor to provide medical or social services, the payment is not income to the eligible spouse or deemor.

- If a veteran without a spouse or child or a surviving spouse without a child is covered by a Medicaid plan for services furnished him/her by a nursing facility, the maximum pension that can be paid to or for the veteran or surviving spouse for any month after the month of admission to such nursing facility is $90. This reduced pension is an aid and attendance allowance in all cases, and not income.

C. Policy -- Public Income Maintenance (PIM) Payments

A VA payment consisting entirely of an aid and attendance or housebound allowance is not a PIM payment for living arrangement and deeming purposes.

D. Procedure

Contact the VARO for verification of a pension or compensation payment amount whenever the veteran, spouse or a disabled veteran, or surviving spouse;

- alleges an aid and attendance or housebound allowance; or
- is housebound; or
- is blind; or
- is unable to dress or care for him/herself; or
- is a patient in a nursing home; or
- is single and severely and permanently disabled or otherwise appears to require the assistance of someone else on a day-to-day basis.

Do not use a VA check or award letter to verify the amount of income if an aid and attendance or housebound allowance is involved. (When the VARO provides the amount of the pension or compensation payment, they will not include a household or aid and attendance allowance). Do not ask the VARO about the amount of the aid and attendance or housebound allowance because this information is not needed.

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S0830.310 VA CLOTHING ALLOWANCE

A. Introduction

A lump sum clothing allowance is payable in August of each year to a veteran with a service-connected disability for which a prosthetic or orthopedic appliance (including a wheelchair) is used. The allowance is intended to help defray the increased cost of clothing due to wear and tear caused by the use of such appliances.

B. Policy

A VA clothing allowance is not income (S0815.050, Medical and Social Services).

C. Procedure

Accept the individual's allegation concerning a VA clothing allowance. No further development is required

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S0830.312 VA PAYMENT ADJUSTMENT FOR UNUSUAL MEDICAL EXPENSES

A. Introduction

VA considers unusual medical expenses when determining some needs-based pension and compensation payments (S0830.302 and S0830.304). Expenses which exceed 5 percent of the maximum annual VA payment rate are considered unusual. The amount of the unusual medical expenses is deducted from countable income when computing the VA payment. As a result, the veteran, survivor, or dependent may receive a higher monthly VA payment, an extra payment, or an increase in an extra payment.

B. Policy -- Income Treatment

1. Effective July 1, 1994

VA payments resulting from unusual medical expenses are not income.

2. Prior to July 1, 1994

Any VA increase or extra payment resulting from unusual medical expenses was income.

C. Policy -- Public Income Maintenance (PIM) Payments

If a VA payment to an individual is entirely attributable to unusual medical expenses, then it is not a public income maintenance (PIM) payment for living arrangement and deeming purposes.

D. Policy Resources

Any unspent VA payments resulting from unusual medical expenses are resources if retained into the calendar month following the month of receipt.

E. Procedure -- General

1. When to Consider

Consider the issue of unusual medical expenses in all cases involving a VA payment based on need. Develop the issue only if indicated in 2. and 3. below.

2 When Not to Develop

Do not routinely develop the issue of unusual medical expenses for an ineligible spouse or parent (unless you believe the payment may be entirely attributable to such expenses per C. above).

NOTE: If the payment is entirely attributable to unusual medical expenses, other income of an ineligible spouse or parent is subject to deeming.

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3. When to Develop

Develop the issue of unusual medical expenses (unless precluded by 2. above) as indicated in the chart below.

SITUATION	INDIVIDUAL IS...	ACTION NEEDED
Medicaid application filed or VA benefits begin	veteran or widow	Develop per F. below.
	VA dependent	Develop per F. below only if you believe the expenses may affect the dependent's portion per F.7. below.
Redetermination or other income review	veteran or widow	Develop per F.3 below
	VA dependent	Develop per F. below only if you believe the expenses may affect the dependent's portion per F.7. below.

F. Procedure -- Development and Documentation

1. Examine Documents

If documents show that VA considered unusual medical expenses, go to F.3. below. If not, go to F.2. below.

2. Question the Individual

Question the individual following the steps below. You need not document responses.

STEP	ACTION
1	Did the individual or any member of his/her family report any income to VA? • If yes or unknown, go to Step 2. • If no, STOP. No further action is necessary.
2	Did VA ever notify the individual (or the VA claimant) that medical expenses were considered in the VA payment? • If yes, go to F.3. below. • If no, STOP. No further action is necessary. • If unknown, go to Step 3.
3	Has the individual (or the VA claimant) ever reported medical expenses to VA?

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- If yes or unknown, go to F.3. below.
- If no, STOP. No further action is necessary.

3. Contact VA

Contact the VARO:

- See S0830.320 A. for VARO addresses.
- On verification form, complete only the identifying information for the applicant and the veteran unless you are requesting other information.
- Inquire what date payments due to unusual medical expenses began.

4. Unusual Medical Expenses Involved

If VA reports payments due to unusual medical expenses:

- deduct the amount from the total VA payment to determine countable income, and adjudicate the case.

NOTE: If payments due to unusual medical expenses exceed the amount attributable to the veteran/widow(er), see 5. below.

5. Unusual Medical Expenses and Augmentation Involved

If augmentation is involved (S0830.314):

- deduct the payments due to unusual medical expenses first from the veteran/widow(er)'s portion, and
- deduct any remaining amount from the dependent's portion.

NOTE: If more than one dependent is involved, prorate the remaining amount equally among the dependents

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S0830.314 AUGMENTED VA BENEFITS

A. Introduction

The Department of Veterans Affairs (VA) often considers the existence of dependents when determining a veteran's or a veteran's surviving spouse's eligibility for pension, compensation, and educational benefits. If dependents are involved, the amount of the benefit may be larger.

B. Definitions

1. Absent Dependent

An absent dependent is a dependent who does not reside with the veteran or surviving spouse. Residency is determined as of the first moment of the month.

2. Apportionment

Apportionment is direct payment of VA benefits to a dependent. VA decides whether and how much to pay by apportionment on a case-by-case basis. Apportionment reduces the amount of the augmented benefit payable to the veteran or surviving spouse.

3. Augmented Benefit

An augmented benefit is a benefit that is increased, or which has higher income eligibility limits, because of a dependent. An augmented VA benefit, which for Medicaid purposes includes a designated beneficiary's portion and a dependent's portion, usually is issued as a single payment to the veteran or the veteran's surviving spouse.

4. Child

For purposes of this section, a child is a son or daughter (biological, adoptive, or by marriage) who is:

- under age 18, or
- age 18-22 (inclusive) and a student, or
- age 18 or older, and disabled since before age 18.

5. Dependent

For purposes of this section, a dependent is a veteran's child or spouse (other than a surviving spouse) who is or was dependent on the veteran for financial support, as determined by VA.

6. Dependent's Portion

The dependent's portion is that part of an augmented benefit that is attributable to the dependent.

7. Designated Beneficiary

A designated beneficiary is the veteran or surviving spouse who receives an augmented benefit.

8. Designated Beneficiary's Portion

The designated beneficiary's portion is that part of an augmented benefit that is attributable to the veteran or surviving spouse.

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C. Policy

1. Apportioned Benefit

A benefit paid by apportionment (per B.2. above) is VA income to the dependent to who (or for whom) it is paid. It does not constitute a support payment from the designated beneficiary.

2. Designated Beneficiary's Portion

The designated beneficiary's portion is VA income to the designated beneficiary.

3. Dependent's Portion

The dependent's portion is VA income to the dependent, provided the dependent resides with the designated beneficiary. It does not constitute a support payment from the designated beneficiary.

4. Absent Dependent's Portion--Prior to 11/17/94

An absent dependent's portion of augmented benefit received by the designated beneficiary prior to November 17, 1994 was VA income to the absent dependent, unless VA had previously denied an application for apportionment. If apportionment had been denied, the absent dependent's portion, less any amount provided by the designated beneficiary to the absent dependent, was income to the designated beneficiary.

EXAMPLE:
Susan Baker, age 17, is an absent dependent whose application for apportionment has been denied. Her father, Joseph Baker, is also a Medicaid recipient. He receives an augmented monthly VA pension of $450 on the first of each month. He has no other dependents. During 1993, Mr. Baker sends Susan $25 per month. The VA regional office (VARO) verified that Susan's portion of the VA benefit is $50. $25 is child suppoprt payment for Susan ad $425 is income for Mr. Baker.

5. Absent Dependent's Portion--Effective 11/17/94

An absent dependent's portion of an augmented VA benefit, received by the designated beneficiary on or after November 17, 1994, is **not income** to **either** the dependent or the designated beneficiary. This is true even if the designated beneficiary continues to receive the absent dependent's portion. See C.6. below for the policy on payments made to an absent dependent by the designated beneficiary.

6. Other Payments to Absent Dependents--Effective 11/17/94

A payment from a designated beneficiary to an absent dependent on or after November 17, 1994 is not VA income to the absent dependent. It is a gift, a support payment, in-kind support and maintenance, or another kind of income, unless it is not income per SI 00815.001 ff.

EXAMPLE: Robert Jones, age 17, and his father Raymond Jones are both Medicaid recipients who do not reside together. Mr. Jones' VA pension is $450 per month, which includes a portion for Robert as his only dependent. Mr. Jones sends Robert a money order for $25 per month. The $25 is child support for Robert. The EW verified that Mr. Jones' portion of the VA benefit is $400. The $400 is VA pension based on need for Mr. Jones.

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D. Procedure--Initial Application and Posteligibility Development

Use this procedure to determine how to develop for augmentation in initial applications.

Step	Action
1	If the claimant is: • a VA beneficiary (veteran or veteran's surviving spouse), go to step 2. • a VA beneficiary (spouse or child paid by apportionment per B.2. above), go to step 5. • a VA beneficiary 's spouse or child who resides with the beneficiary, go to step 4. • a VA beneficiary's spouse or child who does not reside with the beneficiary, STOP. No income development is required.
2	Ask the applicant whether the benefit includes money for any dependents. If the answer is: • **yes,** go to step 4. • **unknown,** go to step 3. • **no,** go to step 5.
3	Does the applicant have a living spouse or child (including an adult child disabled since childhood)? • If **yes,** go to step 4. • If **no,** go to step 5.
4	Verify the VA income for each month in the period covered by the application.
5	Verify pension or compensation per S0830.302 C. step 6, and educational benefits per S0830.306 C. STOP.

E. References

- Gifts, S0830.520
- Support Payments, M0830.420

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M0830.320 VA REGIONAL OFFICE

A. List of VA Regional Offices This list shows the VARO mailing address for each geographic area:

STATE	ADDRESS
Virginia	210 Franklin Road, SW Roanoke, VA 24011
Washington, D.C. VA-RO (Includes Fairfax County and cities of Alexandria, Fairfax, and Falls Church).	941 North Capitol Street, NE. Washington, DC 20421

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PAYMENTS FOR CHILDREN AND SPOUSES

M0830.400 AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)

A. Definition

Aid to Families with Dependent Children (AFDC) is the program of payments made under Part A of Title IV of the Social Security Act except for section 406(e) of that part. (Payments under section 406(e) are emergency assistance payments and the applicable instructions appear at S0830.405.)

B. Introduction

AFDC makes a payment to a family unit rather than an individual. The payment is frequently referred to as the "grant". An individual who meets the eligibility requirements for both AFDC and SSI may choose the program under which he/she prefers to receive benefits. However, if the individual receives SSI, he/she may no longer be included in the AFDC grant.

S0830.405 EMERGENCY ASSISTANCE UNDER TITLE IV A OF THE SOCIAL SECURITY ACT

A. Background

Emergency Assistance under title IV A is provided for children, including families with children, by States and localities. Their expenditures are matched by the Federal government. Although Emergency Assistance is authorized by title IV A of the Social Security Act ("Aid to Families with Dependent Children"), it is a program separate from the income maintenance program commonly known as AFDC (S0830.400).

The Emergency Assistance Program is optional to the State. The assistance may be provided in cash or in kind and may be a loan. The assistance may include support and maintenance, social services or medical services. The program's purpose is to meet emergency or crisis needs, not ongoing basic needs, and assistance is limited to payments which are authorized during a period of 30 consecutive days in any 12-month period. Although there is an immediately available resource test for eligibility, an Emergency Assistance Program is not required to have an income test.

B. Policy Principle

Emergency Assistance is subject to the general rules pertaining to income and income exclusions. Emergency Assistance is neither IBON (S0830.170) nor ABON (S0830.175).

C. Operating Procedures

Determine the nature of the assistance and apply the appropriate operating instructions pertaining to income and income exclusions. Related sections include:

S0815.050 Medical and Social Services
S0815.350 and S1120.220. Loans
S0810.420 $20 General Income Exclusion
S1110.600.B.4. Replacement of a Resource

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M0830.410 FOSTER CARE

A. Definitions

1. Foster Care

An individual is considered to be in foster care when:

- a public or private nonprofit agency places the individual under a specific placement program; and
- the placement is in a home or facility which is licensed or otherwise approved by the State to provide care; and
- the placing agency retains responsibility for continuing supervision of the need for such placement and the care provided.

NOTE: When determining the eligibility of a child in foster care refer to the Family & Children's Policy. This section (S0830.410) is to be used only when evaluating the eligibility of a provider of foster care when the provider is the applicant.

2. Foster Care Payment

For Medicaid purposes, a foster care payment is a payment made to the provider for the purpose of meeting the needs of the individual in foster care.

NOTE: An agency may make an additional payment to the foster care provider for his or her own use (e.g., an incentive or service payment not intended to support the child). While these two payments may be combined and termed the "foster care payment" by the issuing agency, only the part which is provided to meet the needs of the individual in care is the foster care payment for Medicaid purposes. *This could include payment(s) such as KinGap, the kinship care program, would provide.*

B. Policy

a. Foster Care Provider

- Foster care payments (as defined in A.2. above) are not income to the provider.
- Amounts paid to a provider of foster care in addition to the foster care payment are income to the provider.

C. Procedure

1. Foster Care Payments to Providers of Foster Care

a. **Assume that the payment made to the provider is a foster care payment** (i.e., is to meet the needs of the individual in care) and is not income to the provider, unless there is evidence to the contrary.

b. **If the provider is a Medicaid recipient or deemor and evidence indicates a payment includes additional monies above the foster care payment,** verify the purpose(s) of the payment and the amounts involved using documents in the individual's possession, or regional

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precedents, or contact with the agency. Consider any payment in excess of the amount paid to meet the needs of the individual to be income to the care provider.

NOTE: This income is usually unearned income but may be earned income.

If the care provider is not self-employed and evidence indicates a payment was made for a specific service (e.g., $20 for shopping assistance), accept the care provider's signed allegation of any cost of providing the service (e.g., $5 automobile expense). Deduct the cost from the payment and consider the remainder to be unearned income.

E. References

- Forms and amounts of income, S0810.020.
- $20 general income exclusion, S0810.420.
- Medical and social services, S0815.050.
- Assistance based on need, S0830.175.
- Foster care payments made by the Bureau of Indian Affairs, S0830.810

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S0830.415 ADOPTION ASSISTANCE

A. General

Adoption assistance programs provide payments and/or services for children for whom unassisted adoption is unlikely because of age, ethnic background, physical, mental or emotional disability, etc. The income of either the adopting parent, the adopted child, or both may have been considered in determining the payment. Usually, adoption assistance will be formalized in a written agreement between the adopting parents and the agency involved. Adoption assistance may be provided by public or private agencies and may be based on financial need.

Adoption assistance is provided by States under title IV-E of the Social Security Act involves Federal funds and is needs-based. Under IV-E, there is no income test for the adopting parents but the children must be those who are, or could be, eligible for AFDC or SSI prior to adoption. Therefore, there is an income test for the children who receive IV-E adoption assistance.

B. Policy Principles

1. Adoption Assistance Under Title IV-E

These individuals are eligible for Medicaid as Mandatory Categorically Needy. No further development is necessary. These individuals are automatically eligible. Refer to Family & Children's Policy.

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M0830.420 SUPPORT PAYMENTS (CHILD SUPPORT, SPOUSAL SUPPORT, ALIMONY) --GENERAL

A. Policy

1. Definitions

Alimony and support payments are cash. In-kind contributions for food, clothing or shelter are not income. Support payments may be made voluntarily or because of a court order. Alimony (sometimes called "maintenance") is an allowance made by a court from the funds of one spouse to the other spouse in connection with a suit for separation or divorce.

2. Alimony, Spousal, and Other Adult Support

Alimony, spousal, and other adult support payments are unearned income.

3. Child Support Exclusion

Child support payments are unearned income *to the child. O*ne-third of the amount of a payment made to or for an eligible child by an absent parent *is excluded*. (See B. below for definition of an absent parent for purposes of this exclusion.)

4. Child Support on Behalf of an Adult Child

a. Current Child Support Received on Behalf of an Adult Child

Child support payments (excluding arrearages) received for an adult child by a parent after an adult child stops meeting the definition of a child are income to the adult child. The support payments are income to the adult child whether or not the adult child lives with the parent or receives any of the child support payment from the parent. Such support payments are not subject to the one-third exclusion.

b. Child Support Arrearages Received on Behalf of an Adult Child

When a parent receives a child support arrearage payment on behalf of an adult child:

- *Any amount of that payment that the parent receives and does not give to the adult child is income to the parent. The portion of the arrearage payment retained by the parent is not income to the adult child and does not affect the adult child's Medicaid eligibility.*
- *Any amount of that payment that the parent gives to the adult child is income to the adult child in the month given, not income to the parent.*
- *The one-third child support exclusion does not apply.*
- *When an adult child receives a child support arrearage payment directly from the absent parent, the arrearage payment is income to the adult child.*

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B. Definition--Absent Parent

1. General

A parent is considered absent if the parent and the child do not reside in the same household. **NOTE:** There is no connection between the terms used in this subsection and the concept of "temporary absence" for deeming purposes.

a. If the periods of living together are brief and the child remains independent or under the care and control of another person, agency, institution, or is living in the home of another, the parent is usually considered absent unless he/she retains **parental responsibility and control.**

b. A parent is not considered absent if he is away due to **employment** (except for military service), intends to resume living with the child, and retains parental control and responsibility.

c. A child (or parent) who is a **boarding student** in an educational facility is not considered absent.

C. Procedure

1. Verification of Amount and Frequency

To verify the amount and frequency of support payments use:

court records;
records of an agency through which the payments are made;
documents in the individual's possession; or
contact with the source of the payment.

If this is not successful, accept the individual's notarized statement.

2. Relationship

Accept the individual's allegation of relationship of the payer to the payee unless you doubt the allegation.

3. One Payment for Two or More Individuals

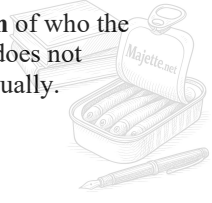
In the case of one payment for two or more individuals:

a. To determine one individual's share of a support payment made for more than one person, **look first to the legal document** setting the payments.

b. **If the legal document** addresses each person's share, divide the payment according to the terms of the document. If the payment does not equal the established support amount, contact the source of the payment to establish intent and divide the payment according to that intent. If this is unsuccessful, divide the payment proportionately.

c. If **no legal document** exists or the document does not address shares, contact the source of the payment to establish intent and allocate the support according to that intent.

d. If this is not successful, accept the individual's **signed allegation** of who the support is for and how the support is divided. If the individual does not know how the support should be divided, divide the payment equally.



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D. References Estimating income, S0810.600-.610

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EDUCATIONAL ASSISTANCE

S0830.450 GENERAL

A. Introduction

Educational assistance is provided in many forms. For Medicaid purposes, treatment will vary depending on the nature and sometimes the use of the assistance. Educational assistance may be earned or unearned income and may be counted or excluded, B. below provides a guide to specific educational assistance instructions and related sections.

B. References

1. Specific Instructions

The following sections address specific types of educational assistance:

- Department of Education or Bureau of Indian Affairs Involved S0830.460
- Tuition, Fees, and Other Expense Amount of Grants, Scholarships & Fellowships S0830.455
- VA Educational Benefits S0830.306

2. Related Instructions

The following sections contain related instructions:

- Student Child Earned Income Exclusion S0820.510
- Plan for Achieving Self-Support *S0810.430*
- Proceeds of a Loan S0815.350
- Earned Income S0820.001

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S0830.455 TUITION, FEES AND OTHER EXPENSE AMOUNTS OF GRANTS, SCHOLARSHIPS, AND FELLOWSHIPS

A. Definition

1. Grant, Scholarship, or Fellowship

Grants, scholarships, and fellowships are amounts paid by private nonprofit agencies, the U.S. Government, instrumentalities or agencies of the U.S., State and local governments, foreign governments, and private concerns to enable qualified individuals to further their education and training by scholastic or research work, etc.

2. Not a Grant, Scholarship, or Fellowship

a. Any amount provided by an individual to aid a relative, friend, or other individual in pursuing his studies where the grantor is motivated by family or philanthropic considerations is a **gift** and is not a grant, scholarship, or fellowship for purposes of this section.

b. Any amount which is **earned income** is not a grant, scholarship, or fellowship.

B. Policy

1. Exclusion

Any portion of a grant, scholarship, or fellowship used for paying tuition, fees, or other necessary educational expenses is excluded from income. This exclusion does not apply to any portion set aside or actually used for food, clothing, or shelter. (See S0830.460 if the Department of Education or BIA is involved.)

2. Allowable Expenses

It is expected that **expenses will include** carfare, stationery supplies, and impairment-related expenses necessary to attend school or perform schoolwork (e.g., special transportation to and from classes, special prosthetic devices necessary to operate school machines or equipment etc.).

3. Allowable Fees

Allowable fees will include laboratory fees, student activity fees, etc.

C. Procedure

1. Verify Nature of Assistance

Use documents in the individual's possession, contact with the institution or provider, or a precedent to verify the nature of the assistance (e.g., scholarship, grant, etc.) and then, if not totally excluded under another provision, the amount, date(s) of payment, payee, etc. (See S0830.460 if the Department of Education or the Bureau of Indian Affairs is involved.)

2. Allowable Expenses

In determining allowable expenses:

a. Use your **judgement** to determine whether payment of an expense was a necessary part of obtaining an education.
b. Use any **reasonable method** for deducting educational expenses from income.

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3. Verify Expense Use receipts, bills with cancelled checks, contact with the provider, etc., to verify expenses paid. If an expense is verified as incurred but not paid, assume the individual will pay the expense unless you have reason to question the situation. No followup is required if the assumption is applied.

4. Tolerance - Miscellaneous Expenses A signed allegation is acceptable evidence of expenses when it is unreasonable to obtain other evidence (e.g., daily busfare, small expendable items, etc.). Do not apply this tolerance to major expenses such as tuition, fees, and books.

D. References Department of Education or the Bureau of Indian Affairs involved, S0830.460
Veteran Administration educational benefits, S0830.306

S0830.460 DEPARTMENT OF EDUCATION OR THE BUREAU OF INDIAN AFFAIRS INVOLVED

A. Background Federal funds or insurance are provided for a number of educational programs at middle school, secondary school, undergraduate and graduate levels under title IV of the Higher Education Act of 1965 and student assistance programs of the Bureau of Indian Affairs (BIA). Included are work-study programs, upward bound and talent search programs, as well as grants-in-aid and loans for college study.

B. Policy

1. Undergraduate College Study--Grants/Loans Any grant, scholarship, or loan to an undergraduate student for educational purposes made or insured under any program administered by the U.S. Commissioner of Education is excluded from income and resources.

2. Financial Assistance Any portion of student financial assistance for attendance costs received from a program funded in whole or in part under title IV of the Higher Education Act of 1965 or under BIA Student Assistance Programs is excluded from income and resources. Attendance costs are:

- tuition and fees normally assessed a student carrying the same academic workload (as determined by the institution), including costs for rental or purchase of any equipment, materials, or supplies required of all students in the same course of study; or

- allowances for books, supplies, transportation, and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution.

NOTE: This exclusion applies to the common programs of Federal financial aid for college students; e.g., Supplemental Education Opportunity Grants (SEOG), National Defense Student Loans (NDSL), Pell Grants, and State Student Incentive Grants (SSIG)

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C. Procedure

1. Determine Funding

Determine whether Federal funds under a Department of Education (DE) or BIA program are involved in any educational assistance (e.g., loan, scholarship, stipend, employment under a work-study program, etc.). Use documents in the individual's possession, printed material, precedents, contact with the school or provider, etc. If such Federal funds are not involved, follow the instructions in S0830.455.

2. Undergraduate Study With DE Involvement

If Federal funds under a DE program are involved and the individual has received a grant, scholarship, or loan for **undergraduate** college study, use documents in the individual's possession, contact with the school or provider and/or precedents to verify the DE involvement and the purpose of the assistance. Totally exclude all the assistance from both income and resources. No further development is necessary.

3. Other Study With DE Involvement

In all other situations involving Federal funds under a DE program, determine if any of the funds are provided under title IV of the Higher Education Act of 1965. If not provided under title IV, follow the instructions in S0830.455. Otherwise, see 4. below.

4. BIA or Title IV Involvement

If educational assistance is provided under title IV of the Higher Education Act of 1965 or a BIA Student Assistance program:

a. **Verify** the amount of the assistance and the portion which has been provided for tuition, fees, equipment, books, supplies, transportation, and/or miscellaneous personal expenses. Also, if a portion of the assistance is provided as an allowance for books, supplies, transportation and/or miscellaneous expenses, **verify** that the student is attending the institution on at least a half-time basis. Use **documents** in the individual's possession, or **contact** with the institution.

b. **Exclude** from income and resources any verified assistance made available for tuition, fees, equipment and supplies and, the case of a student attending school on at least a half-time basis, as an allowance for books, supplies, transportation and miscellaneous personal expenses.

c. Consider any student assistance in excess of the amount made available for the purposes in 4.b. above as income and resources. For example, $400 of $500 in work-study earnings may be excluded from income and resources if a college indicates that $400 from work-study was provided for tuition, books, supplies, transportation and miscellaneous personal expenses. The remaining $100 is considered as earned income.

However, excess income may be excludable under the instructions in S0830.455 or under a plan for achieving self-support (S0870.001).

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MISCELLANEOUS UNEARNED INCOME

M0830.500 DIVIDENDS AND INTEREST

A. Definition

Dividends and interest are returns on capital investments such as stocks, bonds, or savings accounts.

B. Policy-- Month Dividends/Interest are Unearned Income

Dividends and interest are unearned income at the earlier of the following:

- the month they are credited to an individual's account and are available for use;
- the month they are set aside for the individual's use; or
- the month they are received by the individual.

NOTE: Account service fees or penalties for early withdrawal do not reduce the amount of interest or dividend income.

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C. Policy - Income Treatment

The following describes when dividends or interest are considered unearned income.

When the source of dividends or interest is a	**and it ...**	**then ...**
financial institution	credits income to a customer account,	the interest is income.
	computes or com-pounds interest or up-dates its own records **but** does not report income to a customer account,	the interest is not income.
series E/EE U.S. savings bond	was purchased by the owner; or was a gift to the owner **prior** to the expiration of the minimum retention period,	the interest is not income upon receipt or upon expiration of the minimum retention period. **Rationale:** When series E/EE bonds are redeemed, the interest is an income in the value of a resource; it is **not** income.
	was a gift to the owner **after** expiration of the minimum retention period	the bond produces income equal to the purchase price plus accrued interest through the month the individual receives it.
series H/HH U.S. savings bonds	makes a semi-annual interest payment,	the interest is income when available to the individual.
	was a gift to the owner **after** expiration of the minimum retention period,	the bond produces income equal to the purchase price plus accrued interest through the month the individual receives it.

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C. Policy - Income Treatment (Cont'd)

The following describes when dividends or interest are considered unearned income.

When the source of dividends or interest is a	**and it ...**	**then ...**
life insurance policy	pay dividends;	the dividends are not income.
life insurance policy	pays interest on dividend,	the interest is income (this is the case even when the policy is not a resource; i.e., face value is under $1,500).
promissory note or other loan agreement	pays interest; or pays principal and interest in the same payment,	the interest **only** is income. **Rationale**: the principal amount represents conversion of a resource.

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D. Procedure - Verification and Documentation

1. Development for Dividends and Interest

If you must develop dividends or interest, use the chart below to verify and document frequency and amount.

If the payer is a ...	**and the owner ...**	**then....**
financial institution that pays interest	has countable resources within the applicable resource limit (S1110.003),	Verify: • type of account • whether it pays interest; and if so, • the frequency and amount.
financial institution that pays interest	has countable resources in excess of the resource limit,	accept the allegations as to the three points listed above and stop development. The individual is not eligible.
	alleges joint ownership of all interest-bearing account,	see S0810.130.
promissory note or other loan agreement	alleges interest income,	verify amount and frequency of interest income with a check or notice issued by the source or an amortiza-tion table. If one of these is not available, see S0830.005 on developing unearned income. **NOTE:** If interest income is excludable because it is received infrequently or irregularly, see S0810.410.

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D. Procedure - Verification and Documentation (Cont'd)

1. Development for Dividends and Interest (Cont'd)

If you must develop dividends or interest, use the chart below to verify and document frequency and amount.

If the payer is a ...	**and the owner ...**	**then....**
promissory note or other loan agreement	does not know whether interest income is received or due, or does not know the amount of interest income,	• inspect the loan agreement for the needed information; or • if necessary, consult an amortization schedule.
	has countable resources in excess of resource limit,	verify resources.
source of interest different from above	has a check or award notice from the payer,	document the file with a copy of the check or award notice.
	does not have a check or award notice.	see S0830.005 on developing unearned income.
source of dividends	has a check or dividend notice from the payer,	use the check or dividend notice from the source as verification; or if necessary, see S0830.005 on developing unearned income.
	receives payment in a form other than cash (e.g., shares of stock),	determine the value as income under instructions specific to that item.

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E. Procedure - Resolving Discrepancies

Use the following procedure to resolve discrepancies when an individual disagrees with the amount and/or frequency of interest or dividend payments as shown on account records.

is...	**and ...**	**then...**
totally excludable	_____	no resolution is necessary
not totally excludable	the individual has a reasonable explanation for the discrepancy	accept his/her allegation; and document the file
	the individual does not have a reasonable explanation for the discrepancy	use account records as as verification.

F. Procedure -- Projecting Future Interest/Dividend

Unless there is evidence to the contrary, **assume** that interest or dividend payments will continue at the current amount and frequency.

G. References

These are **some** (not all) of the exclusions that may apply to dividend or interest income:

- Infrequent or irregular income, S0810.410;
- Interest on and appreciation in value of excluded burial funds, S0830.501;
- Interest on disaster assistance funds, S0830.620 B.3.;
- Interest on funds to replace certain excluded resources, S1130.620-.630;
- *German Reparations Payments, S0830.710;*
- *Austrian Social Insurance Payments, S0830.715;*
- *Japanese-American and Aleutian Restitution Payments, S0830.720;*
- *Netherlands WUV Payments to Victims of Persecution, S0830.725;*
- *Agent Orange Settlement Payments, S0830.730;*
- *Radiation Exposure Compensation Trust Fund (RECTF) Payments, S0830.740; and*
- *Walker v. Bayer Settlement Payments, M0830.760.*

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S0830.501 INTEREST AND APPRECIATION IN VALUE OF EXCLUDED BURIAL FUNDS AND BURIAL SPACE PURCHASE AGREEMENTS

A. Policy--Exclusion of Interest and Appreciation

1. The Exclusion

a. Interest earned on the value of excluded burial funds is excluded from income (and resources), if left to accumulate.

b. Interest earned on agreements representing the purchase of an **excluded burial space** is excluded from income (and resources), if left to accumulate.

2. When Exclusion Applies

This income exclusion applies only if the burial fund or space purchase agreement is excluded at the time the interest is paid.

3. Interest and Appreciation Must Be Left to Accumulate

Appreciation in value and interest must be left to accumulate to be excluded from income. If not left to accumulate (e.g., paid directly to the individual, spouse, or parent), the receipt may result in countable income.

B. Policy--Related Burial Issues

1. Nonexcluded Funds

If interest is paid on a burial fund or space purchase agreement and the fund or agreement is not excluded at the time the interest is paid, the interest is treated under interest income rules. See S0830.500.

2. Commingled Funds

When excluded funds or spaces are commingled with nonexcluded funds or spaces, only the interest on the excluded portion is excluded. See M1130.410C.

3. Irregular or Infrequent Exclusion

Effective April 1, 1990, it is not necessary to apply the irregular or infrequent income exclusion to interest earned on excluded burial funds or burial space purchase agreements.

- You must apply the irregular or infrequent exclusion to income other than that earned on excluded burial funds or burial space purchase agreements. See S0810.410.
- You should apply the specific burial funds or burial space interest exclusion as discussed in this section.

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C. Procedure -- Development and Documentation of Interest Earned on Burial Funds

1. Consider Type of Contract

If funds and space items are held together in the same purchase agreement or contract, first determine which portions are funds and which are space items. See M1130.420.

2. Entire Burial Fund is Excluded

Do not document interest if entire burial fund is excluded.

3. Only a Portion of the Burial Fund is Excluded

a. Use the following procedure to determine countable interest to be counted:

STEP	ACTION
1	**Determine** total interest paid on the commingled account following development guidelines in S0830.500.
2	**Determine** the ratio of the nonexcluded portion of the fund to the excluded portion by dividing the value of the nonexcluded portion of the fund by the total value of the fund. Carry the quotient to 3 decimal places.
3	**Multiply** the decimal obtained in step 2 representing the nonexcluded portion by the total amount of interest earned on the fund. The result is the amount of interest paid on the nonexcluded portion of the fund for the period in question.

NOTE: The same action (in step 2) may be used every month as long as there are no deposits to or withdrawals from the total fund.

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b. **EXAMPLE** - Computation When Only a Portion of the Burial Fund is Excluded.

Mr. Sam Rogers filed for Medicaid on January 8, 1990. His assets as of January 1, 1990 included the following:

• Savings account ($1,000 resources) ($50 interest income posted 1/1/90)	$1,050
• Irrevocable burial contract	$1,200
• Nonhome real property	$ 500
• Checking account	$ 474
	$1,974

Mr. Rogers designated $500 of his savings account for burial. His available burial fund exclusion is $1,300. ($2,500* - $1,200 irrevocable burial contract.)

Computation of countable interest using steps above:

- $500 = nonexcluded portion of funds
- Divided by $1,000 (total resources in savings account for January)
- Percentage of nonexcluded funds = 50 percent
- Total interest paid = $50
- Percentage of countable interest = 50 percent x $50 = $25 countable income for January.

4. Burial Fund Exclusion No Longer Applies

If you determine that application of the burial funds exclusion ceased during a past period, the interest paid on the burial funds in the months the burial funds are not excluded may result in countable income the month of receipt and countable resource following the month of receipt. Follow interest income development for each month that the burial funds exclusion does not apply.

D. Procedure -- Interest Earned On Burial Space Purchase Agreements

a. **Consider Type of Contract** - See C.1. above.

b. **Entire Burial Space Purchase Agreement is Excluded**
Do not document interest if entire burial fund is excluded.

c. **Only a Portion of Burial Space Purchase Agreement is Excluded**
Follow the interest computation procedures explained in C.3. above when excluded and nonexcluded burial space items are held in the same purchase agreement or contract.

*Virginia Medicaid policy allows a $3,500 maximum burial fund exclusion

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M0830.505 RENTAL INCOME

A. Policy

1. Definitions

a. **Rent** is a payment which an individual receives for the use of real or personal property, such as land, housing or machinery.

b. **Net rental income** is gross rent less the ordinary and necessary expenses paid in the same taxable year.

c. **Ordinary and necessary expenses** are those necessary for the production or collection of rental income. In general, these expenses include:

- interest on debts;
- State and local taxes on real and personal property and on motor fuel;
- general sales taxes; and
- expenses of managing or maintaining property.
  See A.10. below a for more specific list.

2. Depreciation Not Deductible

Depreciation or depletion of property is not a deductible expense.

3. When to Deduct Expenses

We deduct expenses when paid, not when incurred.

4. Earned or Unearned Income

Net rental income is unearned income unless it is earned income from self-employment (e.g., someone who is in the business of renting properties).

5. Rental Deposits

Rental deposits are not income to the landlord while subject to return to the tenant. Rental deposits used to pay rental expenses become income to the landlord at the point of use.

6. Rent/Expenses Prior to Eligibility

In determining net rental income, we do not consider rents received or expenses paid in months prior to Medicaid eligibility.

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7. Multiple Family Residence

In multiple family residence:

- If the units in the building are of approximately **equal size**, we prorate allowable expenses based on the number of units designated for rent compared to the total number of units.

- If the units are **not** of approximately **equal size**, we prorate allowable expenses based on the number of rooms in the rental units compared to the total number of rooms in the building. (The rooms do not have to be occupied.)

NOTE: Any expenses strictly related to a particular rental unit are deducted in total from the rent for that unit. Such expenses are not prorated

8. Rooms in Single Residence

For rooms in a single residence:

a. We prorate allowable expenses based on the **number of rooms** designated for rent compared to the number of rooms in the house.

b. We do not count **bathrooms** as rooms in the house.

c. We count **basements** and **attics** only if they have been converted to living spaces (e.g., recreation rooms).

NOTE: Any expenses strictly related to a particular rental room are deducted in total from the rent for that room. Such expenses are not prorated.

9. Land

We prorate expenses based on the percentage of total acres that is for rent.

10. Deductible Expenses

Example of deductible expenses:

- Interest and escrow portions of a mortgage payment (at the point the payment is made to the mortgageholder);

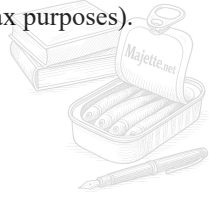
- real estate insurance;
- repairs (i.e., minor correction to an existing structure);
- property taxes;
- lawn care;
- snow removal; and
- advertising for tenants.

11. Nondeductible Expenses

Examples of nondeductible expenses:

- principle portion of a mortgage payment; and

- capital expenditures (i.e., an expense for an addition or increase in the value of property which is subject to depreciation for income tax purposes).



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B. Procedures

1. Evidence

a. **Use documents** in the individual's possession (e.g., 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 will be helpful in identifying past expenses and in estimating future rental income.

b. **If no documents are available**, obtain a signed statement explaining why no documents are available and providing an allegation of the gross rent and expenses paid for the period involved. **Do not** contact the tenants to verify the allegation.

c. If you are **uncertain** whether an expense is allowable (e.g., whether it is an incidental repair or a capital expenditure), contact the local Internal Revenue Service (IRS) or refer to IRS Publication 527. Document the file with the information obtained from IRS.

2. Computation

a. **Determine** gross rent received and deductible expenses month-by-month.

b. **Subtract** deductible expenses paid in a month from gross rent received in the same month.

c. If deductible expenses exceed gross rent in a month, subtract the **excess expenses** from the next month's gross rent and continue doing this as necessary until the end of the tax year in which the expense is paid.

d. If these are **still excess expenses** after applying b. above, subtract them from the gross rent received in the month prior to the month the expenses were paid and continue doing this as necessary to the beginning of the tax year involved.

NOTE: Do not carry excess expenses over to other tax years nor use them to offset other income.

3. Documenting Calculations

Document the proration of allowable expenses and the calculation of net rental income.

4. Joint Owners

Absent evidence to the contrary, apportion net rental income equally among owners. (A signed statement can be acceptable evidence if it reasonably explains why apportionment is not equal.)

If the gross rent is split between two joint owners before expenses are paid, deduct expenses paid by the Medicaid recipient from his/her portion of the gross rent.

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5. Future Rental Income

a. Use evidence from the retroactive period to estimate net rental income for the next 12 months; however, deduct only **predictable expenses**, (e.g., utilities, interest payments, taxes, etc.).

b. If an **unpredictable expense** is reported at a later date (e.g., a repair), deduct it in the month paid. If the expense exceeds the rent for that month, recalculate the rest of the estimated period as necessary (see 2.b. above).

6. Interest

a. Use the individual's **amortization schedule** to determine interest expense.

b. If a **schedule is not available**, divide the yearly interest by twelve to determine monthly interest.

7. Refunds on Paid Expenses

If the Medicaid recipient receives a refund for an expense already paid (e.g., a property tax refund), recalculate his/her future net rental income for the remainder of the eligibility period.

C. Examples

1. Proration of Room Rental Expenses

Mr. Joshua Steele, a Medicaid recipient, rents out a room in his house to a cousin. The house has six rooms excluding the bathroom. Since Mr. Steele's expenses (interest on a mortgage, utilities, etc.) are for the whole house, only one-sixth of the expenses is deducted from the gross rent.

2. Rental Income Interrupted

Mrs. Anna Minnick, an Medicaid recipient, owns a multiple family residence and rents out half of it. In 9/89, her tenants leave and she receives no gross rent until 11/89 when new tenants move in. Mrs. Minnick continues to pay the mortgage and utilities on the residence during 9/89 and 10/89. The EW determines that Mrs. Minnick has excess expenses and no rental income for 9/89 and 10/89 because she received no gross rent for those months. The excess expenses are carried over into the calculation of net rental income for 11/89.

3. Gross Rent - Two Owners But Only One Owner Pays Expenses

Mrs. Kate Henning, an Medicaid recipient, owns her home jointly with her son, John. Mrs. Henning rents out a couple of rooms in her house for $350/month and gives her son half of it ($175/month). Mrs. Henning pays all the rental expenses herself. To calculate Mrs. Henning's net rental income, deduct the allowable expenses she pays (prorated, if necessary) from $175 (her portion of the gross rent).

D. References

Property essential to self-support, S1130.500.
Net earnings from self-employment, S0820.200.

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E. Exhibit -Rental Income Worksheet

RENTAL INCOME WORKSHEET												
Expenses	Jan/July*		Feb/August *		March/Sept *		April/Oct *		May/Nov *		June/Dec *	
	Gross	Prorated	Gross	Prorated	Gross	Prorated	Gross	Prorated	Gross	Prorated	Gross	Prorated
Rent/Mtg Ins												
Property Ins												
Insurance												
Gas/Oil												
Electricity												
Water/Sewage												
Repairs												
Other												
Other												
Other												
Total Expenses (Prorated)												
Gross Rent												
Monthly Exp (from above)	(-)		(-)		(-)		(-)		(-)		(-)	
Prior Month Excess Exp	(-)		(-)		(-)		(-)		(-)		(-)	
Subtotal												
Excess Exp From End of Tax Year	(-)		(-)		(-)		(-)		(-)		(-)	
Net Rental Income												

*NOTE: Be sure to circle the applicable month

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S0830.510 ROYALTIES

A. Policy

1. Definition

Royalties include compensation paid to the owner for the use of property, usually copyrighted material (e.g., books, music, or art) or natural resources (e.g., minerals, oil, gravel or timber). Royalty compensation may be expressed as a percentage of receipts from using the property or as an amount per unit produced.

To be considered royalties, payments for the use of natural resources also must be received:

- under a formal or informal agreement whereby the owner authorizes another individual to manage and extract a product (e.g., timber or oil), and
- in an amount that is dependent on the amount of the product actually extracted.

2. Sale of Natural Resources

An outright sale of natural resources by the owner of the land or by the owner of rights to use of the land constitutes the conversion of a resource. Proceeds from the conversion of a resource are not income.

3. Earned vs. Unearned Income

Royalties are unearned income unless they are:

- received as part of a trade or business (see S0820.200. for NESE), **or**
- received by and individual in connection with any publication of his/her work. Royalties earned by an individual in connection with any publication of his/her work are earned income (e.g., publication of a manuscript, magazine article, or artwork) (S0820.450).

4. Income or Windfall Profits Tax

Some documents concerning royalty payments will provide both a gross and a net payment amount. When the difference between the gross and the net figures is due to income taxes withheld or windfall profit tax deductions, we use the gross figure when determining income for Medicaid purposes.

5. Production or Severance Tax

When the difference between the gross and net figures represents a production or severance tax (e.g., most oil royalties will be reduced by this tax), we use the net figure when determining income for Medicaid purposes. The production or severance tax is a cost of producing the income and, therefore, is deducted from the gross income.

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B. Procedure

1. Verification

a. Verify that payments received meet the definition of royalty (A.1. above) by examining the agreement between the parties involved. If the agreement is unclear, unavailable, or informal, contact the company or source of the payment.

b. Verify the amounts of royalty payments by examining documents in the individual's possession. If documents are unclear or unavailable, contact the company or source of the royalty.

c. If verification cannot be obtained by the above means, see S0830.005 A.5. - A.6. for additional verification procedures.

2. Documentation

Document the file by including copies of documents or indicating in the file information provided by the payment source concerning the nature, amount(s), month(s) of receipt, and, if appropriate, frequency of payments.

C. References

- Mineral rights, S1140.110.
- Timber rights, S1140.110.
- Definition of nonbusiness income-producing property, S1130.502.
- Conversion of a resource, S0815.200 and S1110.600 B.4.

S0830.515 AWARDS

A. Policy

1. Definition

An award is usually something received as the result of a decision by a court, board of arbitration, or the like.

2. Award As Income

An award is unearned income subject to the general rules pertaining to income and income exclusions.

B. Procedure

1. Verification

Use documents in the individual's possession or contact with the court, board, source, etc; to verify:

- the amount of the award;
- the payment date; and
- if needed, the purpose(s) of the payment (e.g., part of the payment is reimbursement for medical expenses).

2. Apply Appropriate Rules

Determine the nature of the award and apply the appropriate rules pertaining to income and income exclusions.

C. References

Expenses of obtaining income, S0830.100

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M0830.520 GIFTS

A. Policy

1. Definition

- A gift is something a person receives which is **not repayment** for goods or services the person provided and is **not** given because of a **legal obligation** on the givers' part.
- To be a gift, something must be given **irrevocably** (i.e., the donor relinquishes all control).
- **"Donations,** and **"contributions"** (*including income from crowdsourcing or crowdfunding)* may meet the definition of a gift.

NOTE: A gift received as the result of a death is a death benefit. See S0830.545.

2. Gift as Income

A gift is unearned income subject to the general rules pertaining to income and income exclusions.

3. Gifts Used to Pay Tuition, Fees, or Other Necessary Educational Expenses

Gifts (or a portion of a gift) used to pay for tuition, fees, or other necessary educational expenses at any educational institution, including vocational and technical education, are excluded from income.

B. Procedure

1. Apply Appropriate Rules

Determine the nature of the gift and apply the appropriate operating instructions pertaining to income and income exclusions (see C. below).

C. References

- Cash income, S0810.020
- Bills paid by a third party, S0815.400
- Home energy assistance and support and maintenance assistance, S0830.605
- Infrequent or irregular income exclusion, S0810.410
- $20 general income exclusion S0810.420
- Trusts, M1120.200
- Uniform gifts to minors, S1120.205
- Gifts of domestic travel tickets, S0830.521

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S0830.521 GIFTS OF DOMESTIC TRAVEL TICKETS

A. Definition

Domestic travel is travel in or between the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

B. Policy

1. Gift of Ticket Not Converted To Cash

The value of a ticket for domestic travel received by an individual, or his her spouse, or parent whose income is subject to deeming is excluded from income if:

- the ticket is received as a gift (S0830.520); and
- the ticket is not converted to cash (e.g., cashed in, sold, etc.).

2. Gift of Ticket Converted to Cash

A ticket received as a gift is treated as unearned income in the month the ticket was converted to cash.

C. Procedure

1. Obtain a Statement

Obtain the individual's signed statement as to whether the ticket has been retained, used, or converted to cash. If the ticket has been converted to cash, specify in the statement the amount of cash received. In the absence of evidence to the contrary, accept the statement as fact.

2. Ticket Used or Still Retained

Exclude from income.

3. Ticket Converted to Cash

Treat as unearned income in the month the ticket was converted to cash.

D. Reference

Gifts, S0830.520
Treatment of domestic travel tickets for resource purposes, S1120.150

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S0830.522 GIFT CARDS and GIFT CERTIFICATES

A. Definition

Absent evidence to the contrary, presume a gift card/certificate can be resold. For example, evidence to the contrary may include a legally enforceable prohibition on resale or transfer of the card imposed by the card issuer/merchant printed on the card.

B. Policy

Gift Cards/Gift Certificates as Income

The value of a gift card/gift certificate is income in the month it is received if the gift card/certificate:

- *Can be used to purchase food or shelter;* ***or***
- *Can be resold.*

The value of the gift card/certificate is subject to the general rules pertaining to income and income exclusions. See S0810.410 for the infrequent or irregular income exclusion policy.

Any unspent balance remaining on a gift card/certificate is a resource beginning the month following the month the gift card/certificate was received. If personal property is obtained with the gift card/certificate, it must be evaluated under the resources policy

NOTE: *A gift card/certificate that is restricted on its use,* ***and*** *is legally prohibited from resale, must be evaluated (case by case) based on the restrictions and or prohibitions for determining as income.*

Gift Cards/Gift Certificates Not Income

The value of a gift card/gift certificate is not income in the month it is received if the gift card/certificate:

- *Cannot be used to purchase food or shelter;* ***and***
- *Cannot be resold.*

In addition, if the individual does not have the right, authority, or power to convert or sell the gift card/certificate for cash, and it cannot be used to purchase food or shelter, then the gift card/certificate would not meet the definition of a resource in M1110.100

The restriction on use of a gift card/certificate can be legal, (imposed by the card issuer), or practical, (the store where the card must be redeemed does not sell food or shelter items).

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S0830.525 PRIZES

A. Policy

1. Definition

A prize is generally something won in a contest, lottery or game of chance.

2. Prize As Income

A prize is unearned income subject to the general rules pertaining to income and income exclusions.

NOTE: We do not subtract gambling losses from gambling winnings in determining an individual's countable income.

3. Choice Between Cash and In-Kind Item

If an individual is offered a choice between an in-kind prize and cash, the cash offered is counted as unearned income. This is true even if the individual chooses the in-kind item and regardless of the value, if any, of the in-kind item.

B. Procedure

1. Signed Statement

When an individual reports receipt of a prize, obtain the individual's signed statement of the following:

- date the prize was received;
- type or prize received;
- individual's estimate of the value of the prize if not cash;
- amount of income tax withheld, if any; and
- source of the prize

2. Tolerance for Valuing

Accept an individual's signed estimate of the value of the prize (or actual value if cash or cash offer) unless you have reason to doubt the estimate. If you doubt the estimate, determine the item's current market value with an independent source.

3. Apply Appropriate Rules

Determine the nature of the prize and apply the appropriate operating instructions pertaining to income and income exclusions (see C. below).

C. References

- Cash income, S0810.020 A.2.a.
- Infrequent or irregular income exclusion, S0810.410
- $20 general income exclusion, S0810.420

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S0830.530 WORK RELATED UNEARNED INCOME

A. Policy Principle Unearned income is all income that is not earned income.

B. Related Policies

1. Earned Income For policies on earned income, see S0820.000.

2. Title II Wage Exclusions For title II wage exclusions as they related to the Medicaid program, see S0815.600.

3. Sick Pay For treatment of sick pay, see S0830.543 and S0820.005.

C. Operating Policy The following work related payments are unearned income:

Money paid to a resident of a public institution when no employer/employee relationship exists.

Tips under $20 per month.

Jury fees (i.e., fees paid for services, not expense money; see S0830.100 if expense money is provided).

Cash allowances for food, clothing and shelter provided to members of the Uniformed Services and their families, all types of special and incentive pay. (See S0830.540 for a description of and instructions on all aspects of compensation in the form of unearned income in the Uniformed Services.)

D. Development and Documentation

1. Individual Has Evidence Verify the amounts of work-related payments, if possible, using papers in the individual's possession, and document the file with photocopies or document contact certifying the contents.

2. Individual Does Not have Evidence If the individual cannot provide the required evidence:

Verify jury fees by contacting the court clerk or jury commissioner. Document the file.

Verify other work-related payments by contacting the source of payment. Document the file.

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M0830.535 *WORKFORCE INNOVATION AND OPPORTUNITY ACT (FORMERLY WORKFORCE INVESTMENT ACT)*

A. Introduction

The purpose of the *Workforce Innovation and Opportunity Act (WIOA,* formerly the *Workforce Investments Act – WIA*) is to prepare individuals for entry into the labor force. *WIOA* funding is much like a block grant and programs will vary among areas within the State. *WIOA* payments may be called "needs-based" for *WIOA* purposes but are not "income based on need" or "assistance based on need" for Medicaid purposes. *WIOA* payments may be in cash or in kind, and participants in *WIOA* may receive supportive services in cash or in kind. Usually, adult participants receive **only** supportive services.

B. Policy

WIOA payments are **subject to the general rules** pertaining the income and income exclusions.

C. Procedure

1. Allegations

Accept an individual's allegation of participation in *WIOA* and receipt of supportive services unless there is reason to question the information.

2. Assumption

- **Assume** that supportive services such as child care, transportation, medical care, meals and other reasonable expenses, provided in cash or in kind, are **social services** and **not income**.
- Disregard the supportive services without further development or documentation.

NOTE: However, items such as salaries, stipends, incentive payments, etc., must be evaluated under the general rules of unearned and earned income. Any payments made directly to vendors by *WIOA* are not income.

D. References

Medical and Social Services S0815.050
Earned income, S0820.001.
Blind Work Expenses, S0820.535
IRW E, S0820.540
PASS, S0870.001.

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M0830.540 UNIFORMED SERVICES -- PAY AND ALLOWANCES

A. Introduction

Compensation to most members of the Uniformed Services takes the form of b earned and unearned income, and often of both cash and in-kind income.

All branches of the Uniformed Services adhere to a single pay system, but that system is complex and varies significantly from branch to branch. Proper and efficient handling of cases require an understanding of:

- how the pay system works;
- what the key terms mean; and
- how Medicaid policies and procedures apply to different forms of compensation.

The policy and procedures in this section are effective September 1, 2008 and are based on the Heroes Earnings Assistance and Relief Tax Act of 2008 (the Heart Act) that changed how we treat certain cash payments to members of the Uniformed Services. Such cash payments are considered earned income

B. Definitions

1. Uniformed Services

The Uniformed Services are defined by law and include the:

- Army;
- Navy;
- Air Force;
- Marine Corps;
- Coast Guard;
- Reserve and National Guard components of the above;
- Public Health Service commissioned officer corps; and
- National Oceanic and Atmospheric Administration commissioned
- officer corps.

2. Entitlements

Entitlements are pay, allowances, and other **cash** benefits due a service member. Entitlements can include basic pay, special and incentive pay, allowances, advance pay, and reimbursements for certain work-related expenses.

3. Basic Pay

Basic (or base) pay is the service member's wage. It is based solely on the member's pay grade and length of service.

Basic pay is subject to FICA taxes as well as income tax.

4. Allowances

Allowances are **cash** benefits that compensate the service member, at least in part, for the expenses of housing, food, clothing, and special situations during periods of active duty service. Allowances are not paid for weekend drills of Reserve and National Guard components.

Allowances are not subject to FICA tax and usually are not subject to income taxes.



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Often, for accounting purposes, a service branch changes a subcategory of allowance retroactively (e.g., from one type of subsistence allowance to another). The change is explained on the pay slip by showing, as an **entitlement**, the full amount due for the earlier month under the correct subcategory (e.g., leave rations). The full amount previously paid as the entitlement for the earlier month under the incorrect subcategory is shown as a **deduction** (e.g., separate rations). The amounts may be identical or different. (See D.7. for the policy governing these retroactive adjustments.)

5. Subsistence

Subsistence means food and is also referred to as rations. Service members usually receive either free rations from a service facility or an allowance for rations. (The value of free rations does not appear on pay records.)

Effective in 2002, subsistence is paid at a fixed monthly rate for both officers and enlisted persons which applies to all branches of military service.

6. Basic Allowance for Housing (BAH)

The basic allowance for housing (BAH) is an amount of money that a service member receives to pay for housing not provided by the Government. It is a combination of the old basic allowance for quarters (BAQ) and the variable housing allowance (VHA). The BAH was designed to make housing allowances more equitable throughout the services and the ranks, and more in line with civilian cost of living in the areas surrounding military installations.

In some cases, the service branch may pay a BAH to a service member living in free on-base housing, but then deduct the allowance (rather than rent) in the same month. This transaction is merely for accounting purposes and results in a zero-payment transaction. What is actually received is rent-free shelter. The BAH is based on the service person's rank, and has nothing to do with the current market value (CMRV) of the shelter. The CMRV of the shelter must be obtained, for presumed maximum value rebuttal purposes, by determining what the shelter would rent for in the community (i.e., off the military installation).

7. Basic Discount Meal Rate

The Basic Discount Meal Rate (BAS DISC MEAL RATE) is the amount deducted from the service member's pay for subsistence (rations) when a meal card is issued for purchasing food at an on-base dining hall. The meal card is based on a standard daily rate.

8. Continental United States Cost of Living Allowance (CONUS COLA)

The CONUS COLA is paid to members of the Uniformed Services as compensation for a portion of excess costs for non-housing expenses incurred based on the geographical duty location. CONUS COLA is a monthly entitlement based on a 30-day month, the same as BAH. Private sector pay scales tend to reflect local living costs in United States locations, but military pay tables do not. The purpose of the CONUS COLA is to provide compensation for variations in non-housing costs in the continental United States. The CONUS COLA is considered a COLA (wages). It is not considered a special pay, additional pay, or an incremental increase.

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7. Clothing Issuances and Allowances

Clothing issuances consist of uniforms, boots, and other clothing items service members need when they enter on active duty. Whatever is received in cash is countable income. If uniform, insignia, boots, are provided, it is in-kind and not counted.

Clothing allowances are payments provided for the purchase and care of uniforms and, in some cases, civilian clothes.

a. **Officers**
Officers receive an allowance for uniforms and insignia after being commissioned and may receive periodic allowances thereafter.

b. **Enlisted Persons**
Enlisted persons receive in kind the uniforms, boots, and other clothing they need when they enter active duty. (The value of such clothing issued in kind does not appear on pay records.)

Generally, every 12 months thereafter, they receive an allowance for the care and replacement of those uniforms. The rates vary by branch of service, length of service, and sex, and they usually increase each year.

c. Special Clothing Allowances
Special clothing allowances are also paid when assignments require members to wear civilian clothes.

8. Special and Incentive Pay

Special and incentive pay is compensation to specific groups of uniformed people for inconveniences or hazards, or provides incentives for those with skills in high demand to joining or remain in the service. Special pay includes;

- enlistment and reenlistment bonuses;
- combat pay;
- flight pay;
- sea pay; and
- more than 30 additional types of pay.

Special and incentive pay is usually subject to income taxes but is not subject to FICA tax.

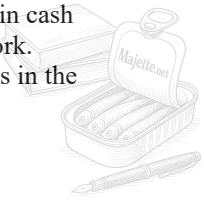
9. Hostile Fire Pay

Hostile fire pay is a type of special pay to a service member who is:

- subject to hostile fire or explosion of hostile mines; or
- on duty in an area in which he/she is in imminent danger of being exposed to hostile fire or explosion of hostile mines, **and**
  while on duty in that area, other service members in the same area are subject to hostile fire or explosion of hostile mines; or
- killed, injured, or wounded by hostile fire, explosion of a hostile mine, or any other hostile action.

10. Advance Pay

In the Uniformed Services, advance pay is a **cash loan** to be repaid in cash installments, usually by payroll deductions, rather than by future work. Advance pay is not taxed. (See S0815.350 for the treatment of loans in the Medicaid program.)



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11. Allotments

Allotments are deductions, usually voluntary, from a service member's paycheck for special purposes. Allotments are often requested for purposes such as:

- payments to dependents;
- deposits to a savings account;
- charitable contributions; and
- purchasing savings bonds.

12. Pay Grade

The pay grade is an alphanumeric code designating the rank of a service member. It also indicates whether that service member is:

- an enlisted member (pay grades E-1 through E-9);
- a warrant officer (W-1 through W-4); or
- a commissioned officer (0-1 through 0-10).

Within a pay grade, pay levels vary according to the number of years of service.

13. Leave and Earnings Statement (LES)

The LES is the monthly pay slip issued to service members. Each service branch has its own version. G. below lists common abbreviations used on LES's.

14. *Additional Pay*

Additional pay in any extra increment in pay, other than an increase in basic pay (e.g. COLAs, promotions). Increase in basic pay includes items such as cost-of living adjustment (COLA) and promotions.

C. Process--How the Pay System Works

1. Forms of Compensation

Compensation to members of the Uniformed Services take several forms, chiefly:

- basic (or base) pay;
- special and incentive pay; and
- cash allowances for, and in-kind provision of, subsistence (rations), clothing, and quarters.

2. Amount of Compensation

The amount of compensation, depending on the form it takes, can vary with rank, length of service, location of duty station, family size, and other factors.

3. Paydays

a. First-of-Month Payday
All branches of the Uniformed Services pay full-time service members on the first day of the month for work performed in the previous calendar month.

b. **Mid-Month Payday**
All service branches (other than the Public Health Service) offer full-time members a mid-month payment as partial payment of the net amount due for the full calendar month. The mid-month payment is optional or standard, depending on the service branch:

- Army and Air Force -- Optional
  Navy, Marine Corps, Coast Guard, and National Oceanic and Atmospheric Administration (NOAA) – Standard

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c. **Casual Pay**
While away from base, a service member can receive payment of pay and allowances due for the current month. This casual pay is issued at odd times of the month. Casual pay is not an entitlement. It is a manner of paying compensation that is already due.

d. **Reserve and National Guard Paydays**
Part-time service members are paid at different times depending on their periods of service.

4. Apportionment Between Paydays

a. **First-of-Month Payday**

...The first-of-month payment represents all net compensation due for the work month less the amount paid earlier in the pay period.

b. **Mid-Month Payday**
..The amount paid mid-month (if any) varies according to the rules of the service branch and rank of the service member, as illustrated in the following chart:

SERVICE BRANCH	**AMOUNT PAID MID-MONTH**	
	BASIC PAY, SPECIAL PAY AND ALLOWANCES (EXCEPT SUBSISTENCE)	**SUBSISTENCE ALLOWANCE**
Air Force Navy Marine Corps Coast Guard NOAA	One-half of net amount due for work month.	*Effective 2002, subsistence is paid at a fixed monthly rate for both officers and enlisted persons which applies to all branches of military service.*
Army	Optional percentage (up to 50%) of net amount paid for the month **before** the work month	

5. Pay Slips

The service branches issue a **single** pay slip each month on or after the first-of-month payday. That pay slip shows the gross amount due for the full calendar month and the net amount issued on each payday of the month.

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D. Policy

1. Basic Pay

Only basic pay constitutes wages.

2. Special Pay and Allowances

All special pay and allowances, except hostile fire pay, are countable unearned income to the service member.

3. Hostile Fire Pay

Hostile fire pay is excluded from income. Any unspent hostile fire pay becomes a resource if retained into the following month and not otherwise excluded. See B.9. above for the definition of hostile fire pay.

4. Quarters Allowances

A quarters allowance is not income if:

- the service member lives in free on-base housing, **and**
- the allowance is paid and deducted in the same pay period. (See B.6. above and D.5. below.)

5. Overpayments

a. Basic Pay

An overpayment of basic pay (wages) is income when received. Any amount deducted to recover a wage overpayment is not wages, regardless of when the overpayment occurred.

See B.10. for a discussion of advance pay.

b. Allowances and Special Pay

An overpayment of an allowance or special pay, other than hostile fire pay, is countable income when received. Any amount deducted to recover an overpayment of an allowance or special pay is also income, unless double counting would result (the allowance or special pay has been previously counted AND Medicaid eligibility established). Apply the policy in S0830.110 (regarding overpayments from other benefit programs) to amounts deducted to recover overpayments of allowances and special pay.

See 6. below for the policy on retroactive adjustments of allowances and special pay, which are not considered overpayments.

See B.10. for a discussion of advance pay.

6. Retroactive Adjustments

A retroactive adjustment in the **type** of pay or allowance, even if the change affects the amount due, is not an overpayment. Such retroactive adjustments are usually made in full in a single month. (B.4. above describes how these adjustments appear on the pay slips.) Only the **net** amount paid for a month in a category of allowance or special pay (e.g., all subsistence **entitlements** less all subsistence **deductions**) is income for the month.

See 5. above for the policy on overpayments.

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E. Procedure

1. General

a. Request LES's from the applicant or service member. If LES's are unavailable, make oral or written contact with the employer, per 5. and 6. below. If all else fails, take the service member's signed allegation, and proceed as explained in 7. below.

Except as provided in 7. below, you need not document the reason for using one verification method rather than another.

b. Ask the service member to estimate the amount and expected payment date of future clothing allowances.

NOTE: Clothing allowances usually are paid annually.

c. Keep in mind the need to consider retroactive adjustments of pay and ..... allowances per D.6. above when determining countable income.

2. Pay Slips—General

Whenever possible, use the individual's copy of an LES to verify the gross pay for a work month, including both earned and unearned income.

NOTE: In most cases, two checks are issued to pay the amounts due for the month, and these checks are issued in different months, as explained in C.3. above.

Determine how much earned and unearned income is countable for each payday. Use the charts in 3. and 4. below unless evidence indicates another method would be more appropriate. If you use another method, document the reason in file. Carry all calculations three digits to the right of the decimal point.

See 4. below for an example of the use of an LES in dividing gross pay between paydays. See 0830.541D. for an example of the use of a worksheet to perform these calculations.

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3. Pay Slips—Army and Officers

Use this chart to determine how much earned and unearned income from Army or officer pay is countable for each payday.

STEP	ACTION
1	Divide the mid-month payment by the total net pay for the work month to calculate the fraction of pay and allowances paid mid-month.
2	Multiply the result of step 1 by the basic pay for the ..... work month to calculate wages paid mid-month.
3	Subtract the result of step 2 from the basic pay for the work month to calculate wages paid the first of the next month.
4	Add up all other pay and allowances for the work month.
5	Multiply the result of step 1 by the result of step 4 to calculate the amount of unearned income paid mid-month.
6	Subtract the result of step 5 from the result of step 4 to calculate the amount of unearned income paid the first of the next month.

4. Pay Slips--Non-Army, Non-Officer—Example

Use this chart to determine how much earned and unearned income from non-Army and non-officer is countable for each payday.

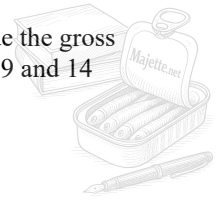
To see the procedure illustrated, refer to the example in the right column of the chart below (and in the completed worksheet in S0830.541D.), which is based on the following case facts:

- Karen Dean is an Medicaid recipient married to Ken Dean, an enlisted person in the Air Force.
- The couple lives in off-base housing.
- Mr. Dean is paid twice a month. Mr. Dean's LES for October 1992 shows the following (gross) entitlements:

  base pay -- $808.80
  quarters -- $253.20
  rations -- $166.47
  variable housing allowance (VHA) --$34.14

- The LES shows a mid-month (October 15) net payment of $564.02 and a first-of-month (November 1) net payment of $569.39.

NOTE: In the example, the results of steps 8 and 13 below provide the gross wages and unearned income paid October 15. The results of steps 9 and 14 provide the gross wages and unearned income paid November 1.



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E. Procedure—

4. Pay Slips-- Non-Army, Non-Officer -- Example (cont.)

STEP	ACTION	EXAMPLE
1	Divide the total subsistence (i.e., rations) allowance for the work month by the number of days in the calendar month of work to calculate the daily subsistence rate.	$ 166.470 ÷ 31 $ 5.370
2	Multiply the result of step 1 by 15 days (regardless of the number of days in the work month) to calculate the subsistence allowance paid mid-month.	$ 5.370 x 15 $ 80.550
3	Subtract the result of step 2 from the total subsistence allowance for the work month to calculate the subsistence allowance paid the first of the next month.	$ 166.470 - 80.550 $ 85.920
4	Subtract the result of step 2 from the net amount paid mid-month to calculate the total nonsubsistence pay (i.e., special pay and allowances for quarters and clothing) issued mid-month.	$ 564.020 - 80.550 $ 483.470
5	Subtract the result of step 3 from the net amount paid first-of-month to calculate the total nonsubsistence pay for the work month.	$ 569.390 - 85.920 $ 483.470
6	Add the result of steps 4 and 5 to calculate the total net nonsubsistence pay for the work month.	$ 483.470 + 483.470 $ 966.940
7	Divide the result of step 4 by the result of step 6. The result is the fraction of basic pay, special pay, and nonsubsistence allowances paid mid-month.	$ 483.470 ÷ 966.940 $ .500
8	Multiply the result of step 7 by the basic pay for the work month to calculate wages paid mid-month.	$ 808.800 x .500 $ 404.400
9	Subtract the result of step 8 from the basic pay for the work month to calculate wages paid the first of the next month.	$ 808.800 ÷ 404.400 $ 404.400
10	Add up all other pay and allowances for work month, except for subsistence.	Quarters Allowance: $ 253.200 VHA: + 34.140 $ 287.340
11	Multiply the result of step 7 by the result of step 10 to calculate the nonsubsistence unearned income paid mid-month.	$ 287.340 ÷ .500 $ 143.670

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E. Procedure Pay Slips—Non-Army, Non-Officer -- Example (cont.)

12	Subtract the result of step 11 from the result of step 10 to calculate the nonsubsistence unearned income paid the first of the next month.	$ 287.340 - 143.670 $ 143.670
13	Add the results of steps 2 and 11 to calculate the total unearned income paid mid-month.	$ 80.550 + 143.670 $ 224.220
14	Add the result of steps 3 and 12 to calculate the total unearned income paid the first of the next month.	$ 85.920 + 143.670 $ 229.590

5. Oral Statement of Employer

If LES's are not available, verify, if possible, the amounts of pay and allowances by telephone contact with the service member's Pay and Finance Office. Document the information.

6. Written Information from Employer

If LES's are not available and telephone contact with the employer is not productive, request pay information in writing as follows:

a. Request Information From Military Installation
- Request information from the Pay and Finance Office of the service installation to which the service member is attached.
- Ask the installation for copies of LES's for needed months in the period under review.
- Provide the installation with the beginning and ending dates of service if the member is no longer on active duty.
- Determine monthly income per 2.-4. above.

b. Member's Installation Will Not Provide Information
- Request the information from the national Pay and Finance Center for the member's branch of service.(Reserve components, other than the National Guard, are part of their service branches.)

NOTE: Since responses from the national centers often take 30-45 days, make requests to them only when the service member's base will not cooperate.

7. Signed Allegation

If other methods (2., 5., and 6. above) of verifying basic pay, special pay, and allowances are unproductive, document the file accordingly. Take the service member's signed allegation of the amounts along with any available supporting evidence.

F. References

- Advance dated paychecks, S0810.030.
- Allotments sent to dependents, S0810.120.
- Estimating future pay and allowances, S0810.600.-620.
- Evidence not readily available, S0830.005A.6.
- Uniformed services monthly Income Worksheet, S0830.541.

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G. List of Common Abbreviations On LES's

CATEGORY	ABBREVIATIONS	MEANING
Clothing	BCRA CLOTHING ALW CMA CRA FCRA SCRA UNIF	clothing allowances
Quarters	ASHA AVHA BAQ FSBAQ INADQTR OHA RENT COL SHA TLA VHA	advance housing allowances basic allowance for quarters family separation BAQ inadequate quarters allowance overseas housing allowance payroll deduction for rent station housing allowance temporary lodging allowance variable housing allowance
Special Pay	DIVE EB FDP HDIP HFP HSTL PROPAY SRB VRB	special pay for diving enlistment bonus foreign duty pay hazardous duty pay hostile fire pay superior performance pay reenlistment bonuses

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G. List of Common Abbreviations On LES's (cont.)

CATEGORY	ABBREVIATIONS	MEANING
Subsistence	BAS	basic allowance for subsistence
	EMR FLD RAT FLDRE LR LV RATS RATS-LV RATS-SEP SEP RATS SR	rations allowances
Miscellaneous	ACLVN	accrued leave (unearned income)
	ACLVT	accrued leave (basic pay)
	AP (APA)	advance pay (and allowances)
	BP	basic pay
	DLA	dislocation allowance
	EOM	end-of-month payment (actually paid on the first day of the next month)
	FSA	family separation allowance
	MALT	monetary allowance in lieu of transport
	MM MID-MO PMT	mid-month payment
	SGLI	Servicemen's Group Life Insurance
	USSH	U.S. Soldiers' Home (charitable deduction)

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H. List of National Pay and Finance Centers

SERVICE BRANCH	FACILITY ADDRESS
Air Force	Documentation Branch Directorate of Resource Management Building 444 HQ Air Force Accounting Finance Denver, CO 80279
Air National Guard	The Adjutant General, VA Attn: Executive Support Staff Officer for Air 401 E. Main Street Richmond, VA 23219
Army	USAFAC, CMDR Social Security Sections Centralized Pay Operations Fort Benjamin Harrison Indianapolis, IN 46249-0865
Army National Guard	The Adjutant General, VA 401 E. Main Street Richmond, VA 23219
Coast Guard	Commandant U.S. Coast Guard Washington, DC 20593
Marine Corps	Centralized Pay Division Marine Corps Finance Center 1500 East Bannister Road Kansas City, MO 64197
National Oceanic and Atmospheric Administration	Commissioned Personnel Division NCI Rockwall Building, Room 115 Department of Commerce, NOAA Rockville, MD 20852
Navy	Navy Finance Center Anthony J. Celebrezze Building Cleveland, OH 44199
Public Health Service	U.S. Public Health Service Employment Operations Branch Commissioned Personnel Division Park Lawn Building, Room 4-35 5600 Fishers Lane Rockville, MD 20852

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S0830.541 UNIFORMED SERVICES -- WORKSHEETS

A. Introduction

Form SSA-3991 and form SSA-3992 guide the user through the calculation of monthly earned and unearned income using a leave and earnings statement (LES), as explained in S0830.540E. Use of these worksheets is optional.

B. Procedure

1. Heading

Enter the names, Social Security number, and page number at the top of the form.

Then **enter the consecutive LES work months** (i.e., the calendar months and years of work).

2. Section I

Enter the verified amounts of pay from the LES for each work month requested. If using the SSA-3992, also enter the number of days in each calendar month of work.

NOTE: The "Net Pay First-of-Month" entry refers to the **second** regular payment for the work month, usually issued on the first day of the following month.

3. Section II

Perform the calculations (described in the first column) within each of the columns headed by a work month. Carry each result to 3 decimal places, dropping the fourth digit, if any.

4. Section III

a. **Enter the same months** at the top of the "Received in" columns as were entered in the "LES Work Month" columns.

b. **Enter the amounts from the requested cells in Section II (and from the previous worksheet used, if any).**

NOTE: In Section III, all cell names in column 1 that begin with "4" are carry-over amounts from the last column of a previous worksheet.

c. **Total the entries** to obtain countable earned and unearned income for each month.

C. Exhibits

If you choose to use either the SSA-3991 or the SSA-3992, you must reproduce the appropriate exhibit below; the forms will not be available by order.

The completed example below illustrates use of the SSA-3992 in the situation described in S0830.540. E.4.

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C. Exhibits (Cont.)

UNIFORMED SERVICES MONTHLY INCOME WORKSHEET (All Army and Officers)				
Applicant/Recipient A/N				
Service Member Page _____ Of _____				
	LES Work Month 1 _____/_____	LES Work Month 2 _____/_____	LES Work Month 3 _____/_____	LES Work Month 4 _____/_____
Section I: Pay Amounts from the LES				
Basic Pay	1A	2A	3A	4A
Total Allowances and Special Pay	1B	2B	3B	4B
Net Pay Midmonth	1C	2C	3C	4C
Net Pay First-of-Month	1D	2D	3D	4D
Section II: Calculations (Carry to 3 decimal places.)				
C + d	1E	2E	3E	4E
C ÷ E	1F	2F	3F	4F
A x F	1G	2G	3G	4G
A - G	1H	2H	3H	4H
B x F	1J	2J	3J	4J
B - J	1K	2K	3K	4K

Section III: Countable Income by Month of Receipt

Received in Month 1 _____/_____	Received in Month 2 _____/_____	Received in Month 3 _____/_____	Received in Month 4 _____/_____
EARNED INCOME 4H*: ± 1G : Total:	EARNED INCOME 1H: ± 2G: Total:	EARNED INCOME 2H: ± 3G: Total:	EARNED INCOME 3H: ± 4G: Total:
UNEARNED INCOME 4K*: ± 1J : Total:	UNEARNED INCOME 1K: ± 2J: Total:	UNEARNED INCOME 2K: ± 3J: Total:	UNEARNED INCOME 3K: ± 4J: Total:
*Carried over from column 4 of prior worksheet.			

Form SSA-3991

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C. Exhibits (Cont.)

UNIFORMED SERVICES MONTHLY INCOME WORKSHEET (Non-Army, Non-officers)

Applicant/Recipient A/N

Service Member Page _____ Of _____

	LES Work Mth 1 _____/_____	LES Work Mth 2 _____/_____	LES Work Mth 3 _____/__	LES Work Mth 4 _____/__
Section I: Pay Amounts from the LES				
Basic Pay	**1A**	**2A**	**3A**	**4A**
Total Subsistance	**1B**	**2B**	**3B**	**4B**
Total Nonsubsistance Allowance & Special Pay	**1C**	**2C**	**3C**	**4C**
Net Pay Midmonth	**1D**	**2D**	**3D**	**4D**
Net Pay First-of-Month	**1E**	**2E**	**3E**	**4E**
Number of Days in Month	**1F**	**2F**	**3F**	**4F**
Section II: Calculations (Carry to 3 decimal places.)				
B ÷ F	**1G**	**2G**	**3G**	**4G**
G x 15	**1H**	**2H**	**3H**	**4H**
B - H	**1J**	**2J**	**3J**	**4J**
D - H	**1K**	**2K**	**3K**	**4K**
E - J	**1L**	**2L**	**3L**	**4L**
K + L	**1M**	**2M**	**3M**	**4M**
K ÷ M	**1N**	**2N**	**3N**	**4N**
A x N	**1P**	**2P**	**3P**	**4P**
A - P	**1Q**	**2Q**	**3Q**	**4Q**
C x N	**1R**	**2R**	**3R**	**4R**
C - R	**1S**	**2S**	**3S**	**4S**

Section III: Countable Income by Month of Receipt

Received in Month 1 /	Received in Month 2 /	Received in Month 3 /	Received in Month 4 /
EARNED INCOME	**EARNED INCOME**	**EARNED INCOME**	**EARNED INCOME**
4Q*:	**1Q:**	**2Q*:**	**3Q:**
+ 1P :	**+ 2P:**	**+ 3P:**	**+ 4P:**
Total:	**Total:**	**Total:**	**Total:**
UNEARNED INCOME	**UNEARNED INCOME**	**UNEARNED INCOME**	**UNEARNED INCOME**
4J*:	**1J:**	**2J:**	**3J:**
+ 4S*:	**+ 1S:**	**+ 2S:**	**+ 3S:**
+ 1H :	**+ 2H:**	**+ 3H:**	**+ 4H:**
+ 1R :	**+ 2R:**	**+ 3R:**	**+ 4R:**
Total:	**Total:**	**Total:**	**Total:**

***Carried over from column 4 of prior worksheet.**

Form SSA-3992

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C. Exhibits (Cont.)

UNIFORMED SERVICES MONTHLY INCOME WORKSHEET (Non-Army, Non-officers)

Applicant/Recipient Karen Dean A/N

Service Member Ken Dean Page _____ Of _____

	LES Work Mth 1 10 /93	LES Work Mth 2 _____/_____	LES Work Mth 3 _____/_____	LES Work Mth 4 _____/_____
Section I: Pay Amounts from the LES				
Basic Pay	**1A 808.80**	**2A**	**3A**	**4A**
Total Subsistance	**1B 166.47**	**2B**	**3B**	**4B**
Total Nonsubsistance Allowance & Special Pay	**1C 287.34**	**2C**	**3C**	**4C**
Net Pay Midmonth	**1D 564.02**	**2D**	**3D**	**4D**
Net Pay First-of-Month	**1E 569.39**	**2E**	**3E**	**4E**
Number of Days in Month	**1F 31**	**2F**	**3F**	**4F**
Section II: Calculations (Carry to 3 decimal places.)				
B ÷ F (166.47 ÷ 31)	**1G 5.370**	**2G**	**3G**	**4G**
G x 15 (5.370 x 15)	**1H 80.550**	**2H**	**3H**	**4H**
B - H (166.47 - 80.550)	**1J 85.920**	**2J**	**3J**	**4J**
D - H (564.02 - 80.550)	**1K 483.470**	**2K**	**3K**	**4K**
E - J (569.39 - 85.920)	**1L 483.470**	**2L**	**3L**	**4L**
K + L (483.470 ÷ 483.70)	**1M 966.940**	**2M**	**3M**	**4M**
K ÷ M (483.470 ÷ 966.940)	**1N 0.500**	**2N**	**3N**	**4N**
A x N (808.80 x 0.500)	**1P 404.400**	**2P**	**3P**	**4P**
A - P (808.80 - 404.400)	**1Q 404.400**	**2Q**	**3Q**	**4Q**
C x N (287.34 x (0.500)	**1R 143.670**	**2R**	**3R**	**4R**
C - R (287.34 - 143.670)	**1S 143.670**	**2S**	**3S**	**4S**

Section III: Countable Income by Month of Receipt

Received in Month 1 10/93	Received in Month 2 11/93	Received in Month 3 /	Received in Month 4 /
EARNED INCOME	**EARNED INCOME**	**EARNED INCOME**	**EARNED INCOME**
4Q*: --	**1Q : 404.400**	**2Q*:**	**3Q:**
+ 1P: 404.400	**+ 2P: --**	**+ 3P:**	**+ 4P:**
Total: 404.400	**Total: 404.400**	**Total:**	**Total:**
UNEARNED INCOME	**UNEARNED INCOME**	**UNEARNED INCOME**	**UNEARNED INCOME**
4J*: --	**1J: 85.920**	**2J:**	**3J:**
+ 4S*: --	**+ 1S: 143.670**	**+ 2S:**	**+ 3S:**
+ 1H: 80.550	**+ 2H: --**	**+ 3H:**	**+ 4H:**
+ 1R: 143.670	**+ 2R: --**	**+ 1R:**	**+ 4R:**
Total: 224.220	**Total: 229.590**	**Total:**	**Total:**

***Carried over from column 4 of prior worksheet.**

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S0830.543 SICK PAY AS UNEARNED INCOME

A. Policy Any payments on account of sickness and accident disability paid more than 6 months after work stopped because of that sickness or disability are unearned income.

B. References

1. Earned or Unearned? For detailed guidelines for determining whether sick pay is earned or unearned income, see S0820.005.

2. Amount of Income For instructions on the amount of unearned income sick pay that is countable to the individual, see S0830.100.

M0830.545 DEATH BENEFITS

A. Definitions A death benefit is something received as the result of another's death. Examples of death benefits include:

- proceeds of life insurance policies received due to the death of the .. insured;
- lump sum death benefits from SSA;
- RR burial benefits;
- VA burial benefits;
- inheritances in cash or non cash;
- cash given by relatives, friends, or a community group to "help out" with expenses related to the death.

NOTE: Recurring survivor benefits such as those under title II, private pension programs, etc. are not death benefits.

B. Policy Principle-- Death benefits provided to an individual are income to such 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.

C. Operating Policy—Life Insurance Proceeds A life insurance policy may have been a resource in the past (i.e., the cash surrender value was a resource), at the time of the insured's death that particular resource ceases to exist. The insurance proceeds received as a result of the death are not a converted resource (i.e., the proceeds represent the death benefit payable not a return of the cash surrender value).

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D. Operating Procedure

1. Identifying Death Benefits

The Medicaid application and redetermination forms do not ask specifically about death benefits. Be alert for situations where further questioning about death benefits is advisable.

2. Verifying Expenses

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 your 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.

3. Amount of Death Benefits

Accept the individual's signed allegation of the amount of death benefits and when received unless you have reason to doubt the allegation.

4. Income From Death Benefits Benefits

To determine the income derived from death benefits, subtract the total expenses from the total death benefits. Count the income in the month the death benefit(s) is received. If death benefits are received in more than one month, assume that the funds first received are the first spent. For example, if the death benefits are $1,000 received in January and $1,000 in February and the allowable expenses are $1,500, count the remaining $500 as income in February.

M0830.550 INHERITANCES

A. Policy

1. Definitions

An **inheritance** is cash, a right, or a noncash item(s) received as the result of someone's death.

2. Inheritance as Income

An inheritance is a **death benefit**. See S0830.545.

NOTE: Until an item or right has a value (i.e., can be used to meet the heir's need for food, clothing, or shelter), it is neither income nor a resource. The inheritance is income in the first month it has a value and can be used, if it meets the definition of income. (See S0810.005 A.)

3. Inheritance Already a Resource

An inheritance is not income to an individual if the inheritance is something which was considered that individual's resource (either as a member of an eligible couple or through deeming of resources) immediately before the death.

NOTE: The proceeds of a life insurance policy were **not** a resource before the death. (See S0830.545 D.)



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B. Procedure

1. General

Follow the instructions at S0830.545 pertaining to death benefits.

2. Establishing Date of Receipt

Individual State laws establish when an inheritance is received.

If it is not specified in state law when an inheritance is "received", assume the individual derives no income until the earliest of:

- the date the individual alleges receiving the inheritances (using a signed statement from the individual or documents in the individual's possession); or
- the date the estate is closed (which may be determined by contacting the court or an attorney involved in the closing of the estate).

3. Amount Received

a. Verify the amount or value of the inheritance using:

- **documents** in the individual's possession;
- a **court order** closing the estate;
- a copy of the **will**; or
- an **estimate** from a knowledgeable source, if real property involved.

b. Based on what the inheritance is, apply the appropriate instructions for valuing what was received. Depending upon what has been received, some instructions will be found in S0800.001. (Income) and some in S1120.001. (Resources). See C. below.

C. References

Receipt of certain noncash items, S0815.550

Trusts, M1120.200

Types of liquid resources, S1110.305

Inheritance and unprobated estates, M1120.215

Real property, M1130.100.

Personal property--household goods and personal effects, M1130.430

Personal property--automobile, M1130.200

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EXCLUSIONS INVOLVING ASSISTANCE PROGRAMS

S0830.600 LOW INCOME ENERGY ASSISTANCE

A. Introduction

Through a block grant, the Federal Government provides funds to States for energy assistance (including weatherization) to low income households. This assistance may be provided by a variety of agencies (e.g., state or local welfare offices, community action agencies, special energy agencies, etc.) and known by a variety of names (e.g., HEAP, Project Safe, etc.) It is most often provided in a medium other than cash (e.g., voucher, two-party check, direct payment to vendor, etc.) but may be in cash.

B. Policy

Home energy assistance payments or allowances provided under subchapter II of chapter 94, title 42 of the U.S. Code (Low-Income Energy Assistance) are excluded from income and resources.

C. Procedure

Use documents in the individual's possession, contact with the provider or agency involved, or a precedent to verify that assistance from a particular program is provided under the Federal Low-Income Home Energy Assistance Program or "LIHEAP". Once this is verified, no further development or documentation is necessary.

D. References

Home energy assistance and support and maintenance assistance, S0830.605.

S0830.605 HOME ENERGY ASSISTANCE AND SUPPORT AND MAINTENANCE ASSISTANCE (HEA/SMA)

A. Background

The legislative intent of this exclusion was to address charitable efforts by the community to help Medicaid recipients.

NOTE: See S0830.600 for instructions pertaining to energy assistance provided under Federal programs.

B. Policy — Definitions

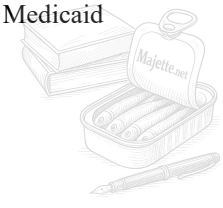
1. Appropriate State Agency

The **appropriate State agency** is the agency designated by the chief executive officer of the State to handle the State responsibilities with regard to the home energy assistance and support and maintenance (HEA/SMA) exclusion. In Virginia it is the Department of Social Services.

2. Based on Need

For purposes of this exclusion, **based on need** means that the provider of the assistance:

- does not have an express obligation to provide the assistance ;
- states the aid is given for the purpose of support and maintenance assistance or for home energy assistance (e.g., vouchers for heating/cooling bills, storm door); and
- provides the aid for an Medicaid applicant/recipient, a member of the household in which a Medicaid applicant/recipient lives, or a Medicaid applicant/recipient ineligible spouse, or parent.



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3. Private Nonprofit

A private nonprofit agency is a religious, charitable, educational, or other organization **such as** described in section 501(c) of the Internal Revenue Code of 1954. (Actual tax exempt certification by IRS is not necessary.)

4. Rate-of-Return Entity

A rate-of-return entity is an entity (generally a utility company) whose revenues are primarily received from the entity's charges to the public for goods or services and such charges are based on rates regulated by a State or Federal governmental body.

5. Support and Maintenance Assistance (SMA)

Support and maintenance assistance (SMA) is in-kind support and maintenance, or cash provided for the purpose of meeting food, clothing, or shelter needs. It includes home energy assistance.

NOTE: Remuneration for work is not assistance.

6. Home Energy Assistance (HEA)

Home energy assistance is any assistance related to meeting the costs of heating or cooling a home. It includes such items as payments for utility service or bulk fuels, assistance in kind such as portable heaters, fans, blankets, storm doors, or other items which help reduce the costs of heating and cooling such as conservation or weatherization materials and services.

C. Policy Exclusion

1. Certification

a. General

Home energy or support and maintenance assistance is excluded from income if it is certified in writing by the appropriate State agency to be both based on need and:

- provided **in kind** by a private nonprofit agency; or
- provided **in cash or in kind** by a supplier of home heating oil or gas, a rate-of-return entity providing home energy, or a municipal utility providing home energy.

b. State Certification: Individual or Blanket

State certification may be in the form of an individual certification of a particular case, or a **"blanket"** certification of a program or organization. A blanket certification serves as a precedent for assistance from the certified agency or program.

2. Recipient of Assistance

The exclusion applies to such assistance provided for:

- Medicaid applicant/recipient;
- a member of the household in which Medicaid applicant/recipient lives; or
- Medicaid applicant's/recipient's spouse, or parent(s).

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D. Procedure

1. General

At times, the interaction of the private and public sectors and various funding sources may make it difficult to determine whether income received may be excluded under these instructions. Exclude assistance on the basis of the individual's allegation and a State certification precedent without further development unless you have reason to question the situation.

2. Statement Required-Income

Obtain a signed statement which identifies:

- the HEA or SMA received;
- when the HEA or SMA was received;
- who received the HEA or SMA; and
- the source of the HEA or SMA.

3. Certification Before Assistance

- Certification may be made before any assistance is actually provided.
- Exclude assistance which might meet the requirements for State certification pending certification.
-

4. Certification Precedent Established

If a precedent has been established, document the file to state that a precedent exists unless the certification is listed in regional instructions. Exclude the income on the basis of the claimant's/recipient's allegation. (See D.2. above for documentation of the allegation.)

5. Certification Precedent not Established

a. **Exclude** any HEA/SMA assistance which might meet the requirements for State certification.

b. **Contact** the RO unless instructed to do otherwise by regional instructions.

c. **Provide** the name of the individual who allegedly received the assistance, and the alleged amount and/or form, date and/or frequency and source of the assistance.

d. **Do not** contact the State agency directly unless you have been instructed to do so by the RO

E. References

S0830.625, Federal Emergency Management Agency (FEMA) emergency food distribution and shelter programs.

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S0830.610 ACTION PROGRAMS/DOMESTIC VOLUNTEER SERVICES

A. Introduction

The Federal government through the ACTION, the Federal domestic volunteer agency, is involved in a number of volunteer service programs including:

- Volunteers in Service to America (VISTA);
- University Year for ACTION (UYA);
- Special and Demonstration Volunteer Programs;
- Retired Senior Volunteer Program (RSVP);
- Foster Grandparent Program;
- Senior Companion Program.

B. Policy

1. General Exclusion

Payments to volunteers under chapter 66 of title 42 of the U.S. Code Domestic Volunteer Services (ACTION programs) are excluded from income and resources.

2. Exception

Payments are not excluded if the Director of the ACTION agency determines that their value, adjusted to reflect the hours served, is equivalent to or greater than the minimum wage in effect under the Fair Labor Standards Act of 1938 or the minimum wage under the applicable State law, whichever is greater.

NOTE: See assumption in C.3. below. To date, the Director of Action has not made the above determination and the ACTION agency does not foresee that such a determination will ever be made.

C. Procedure

1. Assume Excluded

Assume that all payments made by ACTION programs are excludable.

2. Verify Program

Use documents in the individual's possession, contact with the program or agency involved or a precedent to verify that a program is one of those listed in A. above or is otherwise funded by or according to agreement with the Federal government under an ACTION program.

3. Accept Allegation

Accept an individual's allegation of participation in an ACTION program and exclude any payments from income and resources without further development or documentation.

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S0830.615 COMMUNITY SERVICE BLOCK GRANTS

A. Background The Department of Health and Human Services makes community service block grants to States to provide a broad range of services and activities to assist low-income individuals and alleviate the causes of poverty in a community. States may subsequently make grants or enter into contracts with private nonprofit organizations or political subdivisions.

B. Policy--Principle Assistance involving community service block grants is subject to the general rules pertaining to income. It is neither IBON (S0830.170) nor ABON (S0830.175).

C. Operating Procedures Determine the nature of the assistance and apply the appropriate operating instructions pertaining to income and income exclusions. Related sections include:

S0815.050, Medical and Social Services
S0830.605, Home energy Assistance and Support and Maintenance Assistance
S0810.420, $20 General Income Exclusion

M0830.620 DISASTER ASSISTANCE--PRESIDENTIALLY-DECLARED DISASTER

A. Background

1. General This section addresses presidentially-declared disasters. There are no specific instructions or exclusions addressing other disasters.

2. Declaration At the request of a State governor, the President may declare a major disaster when the disaster is of such severity and magnitude that effective response is beyond the capabilities of the State and local governments, and Federal assistance is needed. Disasters include such things as hurricanes, tornadoes, floods, earthquakes, volcano eruptions, landslides, snowstorms, drought, etc.

3. Source Assistance provided to victims of a presidentially-declared disaster includes assistance from:

- Federal programs and agencies;
- joint Federal and State programs;
- State or local government programs;
- private organizations (e.g., the Red Cross).

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B. Policy

1. Support and Maintenance Other Than Repair or Replacement of Property

The value of support and maintenance in cash or in kind is excluded from countable income if:

a. the individual lived in a household which he or she (or he/she and another person) maintained as his/her or their home at the time a catastrophe occurred in the area; and

b. the President declared the catastrophe a major disaster for purposes of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (formerly the Disaster Relief Act of 1974); and

c. the individual stopped living in his/her home because of the catastrophe and began to receive support and maintenance within 30 days after the catastrophe; and

d. the individual receives support and maintenance while living in a residential facility maintained by another person. A residential facility is to be interpreted broadly, including a private household, a shelter, or any other temporary housing arrangement resorted to because of the disaster.

2. Other Disaster Assistance

Assistance (other than support and maintenance described in B.1. above) received under the Robert T. Stafford Disaster Relief and Emergency Assistance Act or any other Federal statute because of a catastrophe which the President declares to be a major disaster, is excluded from countable income. This includes assistance to repair or replace the individual's own home or other property, and disaster unemployment assistance.

3. Interest Earned

Any interest earned on assistance described in B.2. above is excluded from countable income.

C. Process--Verification of Presidential Declaration

A declaration by the President of a major disaster will be public information, i.e., newspaper, television, radio, and printing in the Federal Register. The Office of the ARC, Programs for the area is responsible for confirming a presidential declaration of a major disaster and the geographic area involved and communicating this information.

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D. Procedure

1. Presidential Declaration - Documentation

When a residentially-declared disaster has been verified, document the following:

a. that it is declared to be a major disaster by the President in accordance with the Robert T. Stafford Disaster Relief and Emergency Assistance Act;

b. the geographic areas included in the declared disaster area;

c. the fact that the Medicaid applicant/recipient lived in the declared disaster area and was affected by the disaster; and

d. the exact date(s) on which the disaster occurred.

NOTE: If a precedent has been established, only document the fact that the Medicaid applicant/recipient lived in the disaster area and was affected by the disaster.

2. Support and Maintenance

a. Absent evidence to the contrary:

- **Accept** an individual's allegation that he was affected by the disaster and that he is receiving support and maintenance on a temporary basis as a result.
- **Assume** that a living arrangement change due to a disaster is temporary.

b. **Be alert** to situations where an individual reports a change in circumstances (living arrangements, receipt of household items, cash receipts, etc.) which has been brought about by a disaster, but the individual has not reported involvement in the disaster.

3. Verification of Assistance Other Than Support and Maintenance

Use documents in the individual's possession, or contact with the source to verify that assistance, other than support and maintenance subject to the exclusion in B.1. above, is provided under a Federal statute and because of the disaster.

E. Reference

Disaster assistance (exclusion from resources), S1130.620.

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S0830.625 FEDERAL EMERGENCY MANAGEMENT AGENCY (FEMA) EMERGENCY FOOD DISTRIBUTION AND SHELTER PROGRAMS

A. Background

Through a national board chaired by the Federal Emergency Management Agency (FEMA) and local boards, funds are provided to private nonprofit organizations and State and local governmental entities for the purpose of providing emergency food and shelter to needy individuals. The entity receiving these funds decides how they will be best used (e.g., to buy beds and blankets, to stock a soup kitchen or to pay an individual's rent). The Federal funds are not provided to meet ongoing basic needs.

B. Policy Principle

Assistance involving FEMA funds is subject to the general rules pertaining to income and income exclusions. It is neither IBON (S0830.170) nor ABON (S0830.175).

C. Operating Procedures

Determine the nature of the assistance and apply the appropriate operating instructions pertaining to income and income exclusions. Related sections include:

S0815.050 (Medical and Social Services)
S0830.605 (Home Energy Assistance and Support and Maintenance Assistance)
S0810.420 ($20 General Income Exclusion)

NOTE: Assistance involving FEMA funds is most often provided in kind by private nonprofit organizations and with State certification will qualify for exclusion as HEA/SMA (see S0830.605).

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S0830.630 FEDERAL HOUSING ASSISTANCE

A. Introduction

The Federal Government through the Office of Housing and Urban Development (HUD) and the Farmers Home Administration (FMHA) provides many forms of housing assistance including:

- Subsidized housing (e.g., public housing, reduced rent, cash towards utilities, etc.);
- loans for renovations;
- loans for construction, improvement, or replacement of farm homes and other buildings;
- mortgage or investment insurances;
- guaranteed loans and mortgages.

This assistance may be provided directly by the Federal Government or through other entities such as local housing authorities, nonprofit organizations, etc.

B. Policy

1. Exclusion

The value of any assistance paid with respect to a dwelling unit is excluded from income and resources if paid under:

- the United States Housing Act of 1937 (section 1437 et seq. of 42 U.S.C.)
- the National Housing Act (section 1701 et seq. of 12 U.S.C.)
- section 101 of the Housing and Urban Development Act of 1965 (section 1701s of 12 U.S.C., section 1451 of 42 U.S.C.);
- title V of the Housing Act of 1949 (section 1471 et seq. of 42 U.S.C.); or
- section 202(h) of the Housing Act of 1959.

C. Procedure

1. Assumption

Assume that any housing assistance in which HUD or FMHA is involved is subject to the exclusion in B. above.

NOTE: "Section 8" housing is HUD housing assistance.

2. Allegation Acceptable

Accept an individual's allegation about receipt of housing assistance with HUD or FMHA involvement.

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3. HUD or FMHA Involvement Unknown

If an individual alleges receipt of housing assistance and it is not known whether HUD or FMHA is involved, use documents in the individual's possession, contact with the appropriate housing authority, or a precedent (see Note below) to verify whether HUD or FMHA is involved.

NOTE: A precedent may be used to establish HUD or FMHA involvement when it has been verified that a project provides only HUD or FMHA assistance.

4. State, Local or Indian Assistance

In some cases, States, Indian tribes, or local housing authorities may control public housing and provide assistance without Federal involvement. See the instructions listed below for pertinent instructions for this and other non-Federal housing assistance.

D. References

Assistance programs with governmental involvement--general S0830.165
Home energy assistance and support and maintenance assistance, S0830.605

S0830.635 FOOD PROGRAMS WITH FEDERAL INVOLVEMENT

A. Policy

1. SNAP

The value of the food under the Supplemental Nutrition Assistance Program (SNAP--formerly Food Stamps) to any household is excluded from income and resources.

2. School Lunch Programs

The value of any assistance to children under chapter 13 of title 42 of the U.S. Code, School Lunch Programs, is excluded from income and resources.

3. Child Nutrition Programs

The value of any assistance to children (e.g., school breakfasts, WIC Program, Milk Programs) under chapter 13A of title 42 of the U.S. Code, Child Nutrition, is excluded from income and resources.

4. Nutrition Programs for Older Americans

The value of any assistance (other than a wage or salary) provided by any project under chapter 35 of title 42 of the U.S. Code, Programs for Older Americans, is excluded from income.

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S0830.640 PROGRAMS FOR OLDER AMERICANS

A. Introduction

The Federal Government through the Administration on Aging is involved in a variety of programs for older Americans. The programs may be operated by State or local governments or community organizations. Some types of programs are:

- health services;
- nutrition services (see S0830.635);
- legal assistance; and
- community service employment.

B. Policy

1. Wage or Salary

A wage or salary paid under Chapter 35 *of* Title 42 of the U.S. Code, Programs for Older Americans, is earned income subject to the general Medicaid policies on earned income.

2. Not a Wage or Salary

Anything provided under Chapter 35 of Title 42 of the U.S. Code, Programs for Older Americans, other than a wage or salary is excluded from income.

C. Procedure

1. Verify Program

Use documents in the individual's possession, contact with the provider or a local council on aging, or a precedent to verify that the program is funded by the Federal Government under chapter 35 of "The Older Americans Act" and whether a wage or salary is paid.

2. Wage or Salary

See S0820.100.

3. Not a Wage or Salary-Accept Allegation

Accept the individual's allegation of receipt of anything other than a wage or salary and exclude it without further development unless you have reason to question the allegation.

D. References

ACTION programs (e.g., foster grandparents, retired senior volunteer program, senior companion program), S0830.610

Food programs with Federal involvement, S0830.635

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S0830.645 REFUGEE CASH ASSISTANCE, CUBAN AND HAITIAN ENTRANT CASH ASSISTANCE, AND FEDERALLY REIMBURSED GENERAL ASSISTANCE PAYMENTS TO REFUGEES

A. Background

Refugee Cash Assistance and Cuban Haitian Entrant Cash Assistance and federally funded programs which make ongoing needs-based payments to refugees during their first *4* months in the United States.

B. Policy Principles

1. Refugee Cash Assistance, Cuban and Haitian Entrant Cash Assistance and federally reimbursed general assistance payments to refugees are federally funded income based on need and, unless excluded under a PASS (S0810.430) are counted as income. The $20 general income exclusion (S0810.420) does not apply to this income.

2. A payment under one of these programs is always considered to be a cash payment.

C. Operating Procedures

If a payment is made under one of these programs to a family unit or a group of people, the amount of the grant attributable to one individual in the family is determined by the incremental method (i.e., the income is the difference between the amount paid and the amount which would have been paid had the individual not been included).

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S0830.650 REFUGEE RECEPTION AND PLACEMENT GRANTS AND REFUGEE MATCHING GRANTS

A. Background

Federal funds are provided to national voluntary refugee resettlement agencies such as Catholic Charities or the Hebrew Immigrant Aid Society, which provides services (including food, clothing and shelter) related to initial resettlement of new refugees. Assistance involving these funds will usually be received during the first 30 days after the refugee arrives in this country.

Refugee reception and placement grants are provided by the Department of State. Refugee matching grants are provided by the Department of Health and Human Services.

B. Policy Principle

Assistance involving a refugee reception and placement grant or a refugee matching grant is subject to the general rules pertaining to income and income exclusions.

NOTE: Assistance involving a refugee reception and placement grant or a refugee matching grant is not federally funded income based on need (S0830.170). However, do not confuse this assistance with Refugee Cash Assistance, Cuban and Haitian Entrant Cash Assistance, and federally reimbursed general assistance. The latter three types of assistance are provided by governmental entities rather than the voluntary agencies and pertinent instructions are found in S0830.645.

C. Operating Procedures

Consider the assistance to be provided and funded by the voluntary agency. Determine the nature of the assistance and apply the appropriate operating instructions pertaining to income and income exclusions. Related instructions include:

S0815.050 (Medical and Social Services)
S0830.605 (Home Energy Assistance and Support Maintenance Assistance)
S0810.420 ($20 General Income Exclusion)

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S0830.655 RELOCATION ASSISTANCE

A. Kinds of Relocation Assistance

Relocation assistance is provided to persons displaced by projects which acquire real property. The following types of reimbursement, allowances, and help are provided:

- moving expenses;
- reimbursement for losses of tangible property;
- expenses of looking for a business or farm;
- displacement allowances;
- amounts required to replace a dwelling which exceed the agency's acquisition cost for the prior dwelling;
- compensation for increased interest costs and other debt service costs of replacement dwelling (if it is encumbered by a mortgage);
- expenses for closing costs (but not prepaid expenses) on replacement dwelling (if it encumbered by a mortgage);
- rental expenses for displaced tenants;
- amounts for downpayments on replacement housing for tenants who decide to buy;
- mortgage insurance through Federal programs with waiver of requirements of age, physical condition, personal characteristics, etc., which borrowers must usually meet; and
- direct provision of replacement housing (as a last resort).

B. Policy - Federal or Federally Assisted Project

1. Exclusion

Relocation assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 (subchapter II, chapter 61, title 42 of the U.S. Code) is excluded from income.

2. Applicability

This exclusion applies to relocation assistance provided to persons displaced by any Federal or federally-assisted project. Any Federal assistance is sufficient to bring into play the Federal statutes controlling acquisition of real property, requiring that relocation assistance be available and excluded from income.

3. Exception: Revenue Sharing

If the only Federal assistance is revenue sharing, this exclusion does not apply, since such funds are considered to belong to the governmental unit which received them from the Federal Government. However, the exclusion in C. below may apply.

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C. Policy - State, Local, or State - Assisted/Locally Assisted Project

1. Exclusion Relocation assistance provided by a State or local government or through a State-assisted or locally-assisted project, which is the same type of assistance described in A. above (i.e., comparable to relocation assistance provided under the statute shown in B.1. above) is excluded from income.

2. Applicability This exclusion applies to relocation assistance provided by persons displaced by any State, local, or State-assisted/locally-assisted project.

D. Procedure Verify that the project which displaces the individual has governmental involvement. This can be done by using documents in the individual's possession, contacting the provider or entity involved in the project, or using a precedent. Once verified, accept the individual's signed statement of the assistance without further development or documentation.
NOTE: If the individual retains relocation assistance beyond the month of receipt, see S1130.670B.

E. References

- Treatment of resources excluded by other Federal statutes, S1130.640.
- Treatment of resources excluded as relocation assistance, S1130.670.

S0830.660 VICTIMS COMPENSATION PAYMENTS

A. Policy Any payment received from a fund established by a State to aid victims of crime is excluded from income.

B. Procedure

1. Verification Verify that the compensation came from a State-established fund to aid victims of crime. This can be done by using documents in the individual's possession, contacting the provider or using a precedent. Once verified, accept the individual's allegation of amounts and date of receipt and exclude the payment without further development.

NOTE: If the individual retains compensation payments beyond the month of receipt, see S1130.665 for additional verification requirements.

C. References

- Exclusion from resources of crime victim's compensation payments, S1130.665.

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Manual Title	Chapter	Page Revision Date
Virginia Medical Assistance Eligibility	**M08**	**November 1995**
Subchapter Subject	Page ending with	Page
M0830 UNEARNED INCOME	**S0830.700**	**118**

OTHER UNEARNED INCOME EXCLUSIONS

S0830.700 HOME PRODUCE FOR PERSONAL CONSUMPTION

A. Definition Home produce is food which a person catches in the wild or raises.

B. Policy

1. Home Produce Which is Consumed Home produce is excluded from income if it is consumed by the individual or his or her household.

2. Home Produce Which is Sold The proceeds from the sale of home produce are earned or unearned income according to the chart below:

If the activity is	and the individual is	and the income was derived from land the income from which is...	then the value received is.....
not a trade or business	N/A	N/A	unearned income
A trade or business	not an Indian	N/A	net earnings from self-employment (NESE)
	an Indian	exempt from income tax by reason of a Federal statute or treaty	unearned income
		not exempt from income tax by reason of a Federal statute or treaty	NESE

C. Procedure

1. Assumption About Use Assume that any home produce which an individual alleges will be used for personal or household consumption will be so used.

2. Amount of Home Produce Traded or Sold is Small If the produce is basically raised for home consumption rather than as a business and the amount of produce traded or sold is small (e.g., extra eggs, home-canned beans, etc.), assume that the production costs equaled the value of what was received. No income is derived from such a trade or sale.

3. Accept Allegation Accept an individual's allegations concerning the raising, catching, and consuming of home produce unless you have reason to question the allegation.

4. Documentation If you apply an assumption from 1. or 2. above, document the allegation only. No further development or documentation is needed.



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Manual Title	Chapter	Page Revision Date	
Virginia Medical Assistance Eligibility	**M08**	**January 2010**	
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M0830 UNEARNED INCOME	**S0830.710**		**119**

S0830.705 REFUNDS OF TAXES PAID ON REAL PROPERTY OR FOOD

A. Policy Any amount received from any public agency as a return or refund of taxes paid on real property or on food purchased is excluded from income.

B. Procedure Accept an allegation that a refund of this nature has been received and exclude the income without further development unless you have reason to question the allegation (e.g., the program making the refunds is unknown, the amount of the refund appears inordinate, etc.).

C. Reference Income tax refunds, S0815.270.

S0830.710 GERMAN REPARATIONS PAYMENTS

A. Introduction German reparations payments are made under the Republic of Germany's Federal Law for Compensation of Nationalist Socialist Persecution ("German Restitution Act") to certain survivors of the Holocaust. The payments may be made periodically or as a lump sum.

B. Policy

1. Income Rule Reparations payments received from the Federal Republic of Germany are excluded from income. These payments are excluded prior to application of the $20 general income exclusion.

2. Interest Income *Interest earned on German Reparations payments received on or after July 1, 2004 is excluded from income.*

C. Procedure If an individual reports receiving German reparations payments, accept a signed allegation of the amount(s) involved and the date(s) these payments were received. No further development or documentation is needed.

D. Reference Exclusion of German reparations payments from resources, S1130.610.

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Manual Title	Chapter	Page Revision Date	
Virginia Medical Assistance Eligibility	**M08**	**January 2010**	
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M0830 UNEARNED INCOME	**S0830.715**		**120**

S0830.715 AUSTRIAN SOCIAL INSURANCE PAYMENTS

A. Background

The nationwide class action lawsuit, Bondy v. Sullivan, involved Austrian social insurance payments which were based, in whole or in part, on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act (GSIA). These paragraphs grant credits to individuals who suffered a loss (i.e., were imprisoned, unemployed, or forced to flee Austria) during the period from March 1933 to May 1945 for political, religious, or ethnic reasons. (The GSIA does not specify what entity, e.g., the government or an employer, must be responsible for the loss in order for the credits to be granted.) Not all Austrian social insurance payments are based on Paragraphs 500-506.

B. Policy

1. Income Rule

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 are not counted as income. Austrian social insurance payments not based, in whole or in part, on wage credits granted under Paragraphs 500-506 are counted as income for Medicaid purposes.

2. Interest Income

Interest earned on Austrian social insurance payments received on or after July 1, 2004 is excluded from income.

C. Description of Award Notices

Austrian pension insurance agencies issue many types of award notices. Some notices contain information about wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act. The notices are written in German, and anywhere in the notice, the following language may appear:

DIE BEGUENSTIGUNGSVORSCHRIFTEN FUER GESCHAEDIGTE AUS POLITISCHEN ODER RELIGIOESEN GRUENDEN ODER AUS GRUENDEN DER ABSTAMMUNG WURDEN ANGEWENDET (§500FF ASVG);

TRANSLATION: "The regulations which give preferential treatment for persons who suffered because of political or religious reasons or reasons of origin were applied (§500ff ASVG)."

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Virginia Medical Assistance Eligibility	**M08**	**November 1995**
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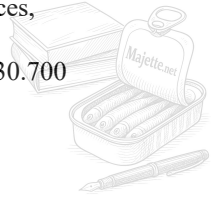
D. Procedure

Use this chart to determine whether or not to count Austrian social insurance payments as income.

STEP	ACTION
1	Does the individual have an award notice from an Austrian pension insurance agency? If yes, go to step 2. If no, go to step 4.
2	Does the notice include the German phrase from C. above? If yes, retain a copy of the notice for the file. Go to step 3. If no, retain a copy of the notice for the file. Go to step 4.
3	• Do **not** count the payment as income. • STOP.
4	Does the individual allege that the payment is based, in whole or in part, on wage credits under Paragraph 500-506 of the Austrian General Social Insurance Act? If **yes,** document the allegation. Go back to step 3. If **no**, document the allegation. Go to step 6. If **unknown**, go to step 5.
5	Does the individual allege being imprisoned, unemployed or forced to flee Austria during the period 1933 - 1945 because of political or religious reasons? **NOTE:** The individual need not specify which entity caused the loss. If **yes**, document the allegation. Go back to step 3. If **no**, document the allegation. Go to step 6.
6	• Count the payment as unearned income. • Follow verification requirements in S0830.005 and S0830.105. If verification is not readily available, accept the individual's signed statement as to the amount, source, and frequency of the payment. • STOP.

E. References

- General rules for developing unearned income, S0830.005
- Payments in foreign currency, S0830.105
- Dividends and interest, S0830.500
- German reparations payments, S0830.710
- Treatment of Austrian social insurance payments as resources, S1130.615
- Excluded funds commingled with nonexcluded funds, S1130.700



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Manual Title	Chapter	Page Revision Date	
Virginia Medical Assistance Eligibility	**M08**	**January 2010**	
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M0830 UNEARNED INCOME	**S0830.725**		**122**

S0830.720 JAPANESE-AMERICAN AND ALEUTIAN RESTITUTION PAYMENTS

A. Policy

Restitution payments made by the U.S. Government to individual Japanese-Americans or the spouse or parent of an individual of Japanese ancestry (or, if deceased, to their survivors) and Aleuts who were interned or relocated during World War II are excluded from income and resources. Also, restitution payments from the Canadian Government to individual Japanese-Canadians who were interned or relocated during World War II are excluded from income and resources.

Interest earned on Japanese-American and Aleutian Restitution payments received on or after July 1, 2004 is excluded from income.

B. Procedure

Use documents in the individual's possession to verify the nature of these payments. Accept the individual's signed allegation of the amount and date of receipt if this is not evident from the documents.

If the individual alleges receiving restitution payments from the U.S. Government but has no documents which verify this, obtain verification from the:

Office of Redress Administration
U.S. Department of Justice
P. O. Box 66260
Washington, DC 20035-6260

Provide the individual's name, address, date of birth and Social Security number in the request accompanied by signed authorization from the individual for release of information.

If the individual alleges receiving restitution payments from the Canadian Government but has not documents which verify this, ask if the individual was imprisoned, relocated, deported, or deprived of other rights in Canada during the period December 1941 to March 1949 because of their Japanese ancestry.

If the answer is "yes," exclude the payment. If the answer is "no," count the payment as income.

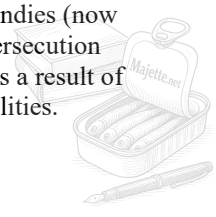
C. Reference

Funds commingled, S1130.700

S0830.725 NETHERLANDS WUV PAYMENTS TO VICTIMS OF PERSECUTION

A. Background

The Dutch government, under the Netherlands' Act on Benefits for Victims of Persecution 1940-1945 (Dutch acronym, WUV), makes payments to both Dutch and non-Dutch individuals who, during the German and Japanese occupation of the Netherlands and Netherlands East Indies (now the Republic of Indonesia) in World War II, were victims of persecution because of their race, religion, beliefs, or homosexuality and, as a result of that persecution are presently suffering from illnesses or disabilities.



Payments under this Act began January 1, 1973 and include four categories of benefits: periodic income payments, compensation for non-definable disability expenses (Dutch acronym, NMIK), reimbursement of persecution related disability expenses, and partial compensation for persecution related disability expenses.

B. Policy

1. Income Rule WUV payments are excluded from income.

2. Interest Income Interest earned on WUV payments received on or after July 1, 2004 is excluded from income.

C. Procedure Use documents in the individual's possession to verify that the payment is a Netherlands WUV payment. If the individual has no documentation or there is reason to question the source of the payments, obtain verification from:

Consulate General of the Netherlands
Attn: WUV Department
Suite 509
3460 Wilshire Blvd.
Los Angeles, CA 90010-2270
(213) 480-1471 (9:00 - 12:30 Pacific Time)

If you will also be developing a resource exclusion for retained WUV payments, see S1130.605 for instructions on verifying dates and amounts of payments.

D. References Exclusion of Netherlands WUV Payments From Resources, S1130.605.

S0830.730 AGENT ORANGE SETTLEMENT PAYMENTS

A. Background Agent Orange settlement payments made in connection with the case of **In re Agent Orange Product Liability Litigation** come from a fund created by manufacturers of Agent Orange who agreed to pay into a settlement fund. Payments began in March 1989. Qualifying veterans will receive at least one payment a year for the life of the program. Qualifying survivors of deceased veterans will receive a single lump sum payment.

Interest earned on Agent Orange settlement payments received on or after July 1, 2004 is excluded from income.

B. Policy Effective January 1, 1989, payments made from the Agent Orange settlement fund or any other fund established pursuant to the settlement in the Agent Orange product liability litigation are excluded from income and resources.

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Virginia Medical Assistance Eligibility	**M08**	**July 2023**
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M0830 UNEARNED INCOME	**S0830.735**	**123a**

S0830.735 PAYMENT FOR CLINICAL TRIAL PARTICIPANTS

A. Background

On October 5, 2010, the President signed into law the "Improving Access to Clinical Trials Act." This Act provides for the income and resource exclusion of compensation received for participating in clinical trials researching and testing treatment of rare diseases or conditions as defined in Section 5(b)(2) of the "Orphan Drug Act". The income exclusion applies to the first $2,000 per calendar year received by an SSI beneficiary, spouse, or deemor as compensation for participation in clinical trials that meet the criteria detailed in this section.

B. Glossary of Terms

The following provides an understanding of terms used:

a. Clinical Trial – A research study designed to answer specific questions about vaccines or new therapies or new ways of using known treatments. Clinical trials (also called medical research or research studies) serve to determine whether new drugs or treatments are both safe and effective.

b. Informed consent form - The document that describes the rights of the clinical trial participants and includes key information about the study, including but not limited to: purpose, duration, required procedures, reasonably foreseeable risks, reasonably expected benefits, contacts, and any compensation or reimbursement information. Department of Health and Human Services (HHS) regulations at 45 C.F.R. 46.116 generally requires the administrators of clinical trials involving human subjects to obtain the participants' signed informed consent.

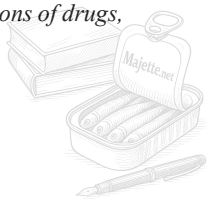
c. Institutional review board (IRB) is a a committee of physicians, statisticians, researchers, community advocates, and others responsible for ensuring that a clinical trial is ethical and protects the participants. In the United States, an IRB must approve the clinical trial before the trial begins.

d. The "Orphan Drug Act", Public Law 97-414, promotes the development of drugs for rare diseases and conditions.

e. Rare disease or condition, also known as an "orphan" disease, is generally any disease or condition that affects less than 200,000 people in the United States. Certain conditions that affect more than 200,000 people may be considered orphan diseases if they meet other criteria in the "Orphan Drug Act".

f. Types of Clinical Trials – There are five types of trials.

- *Diagnostic trials look for better tests or procedures for diagnosing a particular disease or condition;*
- *Quality of Life trials (or Supportive Care trials) explore ways to improve comfort and the quality of life for individuals with a chronic illness;*
- *Prevention trials look for better ways to prevent disease in people who have never had the disease or to prevent a disease from returning. These approaches may include medicines, vaccines, vitamins, minerals, or lifestyle changes;*
- *Screening trials test the best way to detect certain diseases or health conditions; and*
- *Treatment trials test experimental treatments, new combinations of drugs, or new approaches to surgery or radiation therapy.*



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C. Income Exclusion Policy

Effective April 3, 2011, exclude from income the first $2,000 paid during a calendar year to a member, spouse, or deemor as compensation for participation in a clinical trial. but only if the clinical trial meets the following requirements:

- *must be reviewed and approved by an IRB;*
- *must involve research and testing of medical treatments; and*
- *must target a rare disease or condition.*

a. *Do not exclude from income any compensation received prior to April 3, 2011, for participation in clinical trials that meet the criteria in SI 00830.735C.1. Apply regular income counting rules to those payments.*

b. *Payments as reimbursement for expenses incurred while participating in a clinical trial: The income exclusion for clinical trial compensation does not apply to payments received as reimbursement for expenses incurred while participating in a clinical trial.*

c. *Payments to reimburse clinical trial participants for expenses incurred while participating in the trial do not reduce the $2,000 calendar year maximum.*

d. *Exclude reimbursement payments following the instructions in SI 00815.250, Rebates and Refunds. Some examples of reimbursable expenses are travel to and from research location, meals, etc.*

e. *Request the "informed consent form" from the clinical trial participant. The informed consent form provides most of the required information.*

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Manual Title	Chapter	Page Revision Date
Virginia Medical Assistance Eligibility	**M08**	**January 2010**
Subchapter Subject	Page ending with	Page
M0830 UNEARNED INCOME	**S0830.740**	**124**

S0830.740 RADIATION EXPOSURE COMPENSATION TRUST FUND (RECTF) PAYMENTS

A. Background

Fallout emitted during the U.S. Government's atmosphere nuclear testing in Nevada during the 1950's and during a brief period in 1962 exposed some individuals to doses of radiation that put their health at risk. In addition, some individuals employed in uranium mines during the period January 1, 1947 to December 31, 1971 were exposed to large doses of radiation Public Law Fund 101-426 created the Radiation Exposure Trust Fund (RECTF) and authorizes the Department of Justice (DOJ) to make compensation payments to individuals (or their survivors) who were found to have contracted certain diseases after the exposure. The payments will be made as one-time lump sum. Generally, the exposure occurred in parts of Arizona, Colorado, Nevada, New Mexico, Utah, and Wyoming.

B. Policy

1. RECTF Payments

Payments from RECTF are excluded from income.

2. Interest on Unspent RECTF Funds

Interest earned on unspent RECTF payments received on or after July 1, 2004 is excluded from income.

C. Procedure

Use documents in the individual's possession to verify that the payment is from the RECTF. Accept the individual's signed allegation of the amount and date of receipt if it is not evident from the documents.

If the individual has no documents or there is reason to question the source of the payments, obtain verification from:

The Radiation Exposure Compensation Program
U.S. Department of Justice
P. O. Box 146
Benjamin Franklin Station
Washington, DC 20044-0146

Use the individual's name and Social Security number (SSN) as identifying information when writing to the DOJ. When writing on behalf of a survivor, also include the survivor's name and SSN. Include an authorization from the individual for release of the information.

D. Reference

Exclusion of Radiation Exposure Compensation Trust Fund payments from resources, S1130.680.

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Virginia Medical Assistance Eligibility	**M08**	**April 2023**
Subchapter Subject	Page ending with	Page
M0830 UNEARNED INCOME	**S0830.741**	**124a**

S0830.741 ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PLAN (EEOICP)

A. Background

The EEOICP was established to pay claims for benefits under the Energy Employees Occupational Illness Compensation Program Act of 2000 (the EEOICP Act). The EEOICP Act authorizes lump sum payments and the reimbursement of medical expenses to employees of the Department of Energy (DOE) or of private companies under contract with DOE, who suffer from specified diseases as a result of their work in the nuclear weapons industry. The EEOICP Act also authorizes compensation to the survivors of these employees under certain circumstances. The Department of Labor (DOL) is responsible for the administration, adjudication and payment of claims under the EEOICP. DOL makes payments from the Energy Employees Occupational Illness Compensation Fund. Part B and Part E of the EEOICP have different effective dates, illness criteria and medical/compensation allowances.

B. Policy

Lump sum payments made under the EEOICP, including reimbursement for medical expenses, are excluded from income for Medicaid purposes.

1. EEOICP Payments

NOTE: Individuals who are eligible under Section 5 of the Radiation Exposure Compensation Program (RECP) may also be eligible for compensation and paid medical expenses under the EEOICP.

2. Interest on EEOICP Payments

Effective July 1, 2004, interest earned on unspent EEOICP payments is excluded from income for SSI purposes.

C. Procedure

Use documents the applicant provides to verify the payment is from EEOICP. Accept the individual's signed allegation of the amount and date of receipt if it is not evident from the documents.

If the individual has not documentation or there is reason to question the source of the payments, contact the Department of Labor (DOL). A list of the DOL district offices and telephone numbers can be found on the DOL website at: http://www.dol.gov/esa/regs/compliance/owcp/eeoicp/main.htm

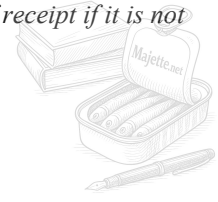
M0830.745 EUGENICS STERILIZATION COMPENSATION (VESC)

C. Background

In 2015, the legislature authorized compensation of up to $25,000 per claim to provide compensation for individuals sterilized "pursuant to the Virginia Eugenical Sterilization Act and who were living as of February 1, 2015." If the person died on or after February 1, 2015, a claim may be submitted by the estate or personal representative of the person who died. Federal law provides that payments made under a state eugenics compensation program shall not be considered as income or resources for purposes of determining the eligibility of a recipient of such compensation for, or the amount of, any federal public benefit.

D. Policy

Use documents the applicant provides to verify the payment is from this source. Accept the individual's signed allegation of the amount and date of receipt if it is not evident from the documents.



Manual Title	Chapter	Page Revision Date
Virginia Medical Assistance Eligibility	**M08**	**July 2023**
Subchapter Subject	Page ending with	Page
M0830 UNEARNED INCOME	**S0830.750**	**124b**

S0830.750 GIFTS to CHILDREN with LIFE-THREATENING CONDITIONS

A. Introduction

This section provides policy and procedures applicable when a tax-exempt organization gives a gift to a disabled child with a life-threatening condition; specifically when to count or exclude such gifts as income. For information regarding gifts from non-organizational donors, see SI 00830.520.

B. Definitions

Definitions pertinent to this exclusion

- *Child - Apply the exclusion only to a child who has not attained age 18 and who has a life-threatening condition.*
- *In-kind gift- An in-kind gift is any food, shelter, or other item donated to the child or another individual on the child's behalf. An in-kind gift cannot be cash itself.*
- *Benefit of the child - A gift is for the benefit of the child if the giver intends the gift for the use, welfare, or enjoyment of the child. However, the gift still meets the benefit of the child criteria if it benefits more people than just the disabled child; for example, shared electronics like a computer or television or a family trip. Interpret this definition broadly.*
- *501(c) (3) tax-exempt organization – review the Internal Revenue Code, as it pertains to a 501(c) (3) tax-exempt organization to see if organization qualifies when used for this exemption.*

C. Policy regarding gifts

Eligibility for the exclusion depends on both the giver of the gift and the recipient.

1. *The recipient of the gift must be under age 18 and have a life-threatening condition. The donor must be an organization described in Section 501(c) (3) of the Internal Revenue Code of 1986, which is exempt from taxation under Section 501(a). For more information regarding section 501(c) (3) organizations, see SI 00830.750D.3, in this section.*

2. *Gifts to exclude from income the following gifts or for the benefit of the child:*
   - *Any in-kind gift, not converted to cash; and Cash gifts to the extent that the total cash we exclude under this provision does not exceed $2,000 in any calendar year.*
   - *Cash the individual receives in excess of $2,000 in a calendar year is subject to regular income counting rules. For example, we exclude $2,000 of a $2,500 cash gift and count the remaining $500 as income.*
   - *For instructions regarding how to determine whether to consider a gift card cash or an in-kind gift, see SI 00830.522.*

3. *Gifts to count as income - converted into cash. When an individual converts an in-kind gift to cash, determine whether to count the cash as income in the month of receipt of the converted funds based on whether the gift met the criteria to exclude it under a different resource provision. If the gift would not meet the criteria to exclude it under a different resource provision, count the cash as income in the month of receipt of the converted funds. Consider as a countable resource any funds retained into the month following the month of receipt. Do not apply the $2000 income exclusion to the converted funds.*

   Exception : Apply the income exclusion to the profits from the conver from the conversion if other resource exclusions (i.e., auto exclusion, household goods, and personal effects) would have applied to the gift that the individual converted to cash.

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S0830.755 RICKY RAY HEMOPHILIA RELIEF FUND PAYMENTS

A. Background

On November 12, 1998, the President signed into law the Ricky Ray Hemophilia Relief Fund Act of 1998, P.L. 105-369.

This Act provides for a single payment of $100,000 from the Ricky Ray Hemophilia Relief Fund to:

- Certain individuals with a blood-clotting disorder who may have contracted an HIV infection from a blood transfusion, and
- Certain current and former spouses of these individuals who also contracted an HIV infection, and
- Certain children of these individuals who also contracted an HIV infection, and
- Certain surviving spouses, children, and parents of the above persons.

B. Policy

The Act provides for exclusion of payments from the Ricky Ray Hemophilia Relief Fund for Medicaid purposes.

C. Procedure

If verification of the payment is available from the individual:

- For private payments, contact Metropolitan Life at 1-800-638-8787 for verification of the type and amount of the private payment. Document the case record with the type and amount of the payment.

- For payments from the Ricky Ray Hemophilia Relief Fund, contact the Ricky Ray Program Office at 1-888-496-0338 for verification of the type and amount of the payment. Document the case record with the type and amount of the payment.

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Virginia Medical Assistance Eligibility	**M08**	**January 2010**
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M0830 UNEARNED INCOME	**S0830.800**	**125**

M0830.760 WALKER V. BAYER SETTLEMENT PAYMENTS

A. Policy

Section 4735 of the Balanced Budget Act of 1997 (P.L. 105-33) states that payments described in this subsection from the settlement of the Susan Walker v. Bayer Corp., et.al., class action lawsuit are NOT counted as income in determining eligibility for Medicaid. Payments described in this subsection are:

a. payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corp., et. al., 96-C-5024 (N.D.III.); and

b. payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement of Susan Walker v. Bayer Corp., et. al., and that is signed by all affected parties on or before the later of

- December 31, 1997, or
- the date that is 270 days after the date on which such release is first sent to the persons to whom the payment is to be made.

Interest earned on retained funds from payments made pursuant to a class settlement in the case of Susan Walker v. Bayer Corp, et. al. on or after July 1, 2004 is excluded from income.

B. Procedure

Information received by claimants in this lawsuit shows that claimants can choose to receive the payment in one of three ways - in a lump sum, a structured settlement, or a special needs trust. Regardless of which form the individual chooses, the payment(s) are excluded if the above requirements are met.

Verify the source of the funds from a letter from the individual's attorney or a copy of the check which identifies the payer as a Walker v. Bayer settlement account.

SPECIAL CONSIDERATIONS FOR NATIVE AMERICANS

S0830.800 BUREAU OF INDIAN AFFAIRS GENERAL ASSISTANCE

A. Definition

Bureau of Indian Affairs General Assistance (BIA GA) is a federally funded program administered by the Bureau of Indian Affairs (BIA) through its local agency or a tribe. The program makes periodic payments to needy Indians.

B. Policy

BIA GA payments are federally funded income based on need and, therefore, count as income. The $20 per month general income exclusion does not apply.

C. Procedure

Develop BIA GA payments using the instructions and development guidelines for AFDC payments in S0830.400 D. except contact the local agency administering the BIA GA program.

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M0830 UNEARNED INCOME	**S0830.820**		**126**

S0830.810 BUREAU OF INDIAN AFFAIRS ADULT CUSTODIAL CARE AND CHILD WELFARE ASSISTANCE PAYMENTS

A. Introduction

Bureau of Indian Affairs (BIA) Adult Custodial Care (ACC) and Child Welfare Assistance (CWA) payments are made on behalf of both institutionalized and noninstitutionalized recipients. BIA foster care payments are made under the ACC and CWA programs.

B. Policy

1. Noninstitutionalized Recipients

BIA ACC and CWA payments (other than foster care assistance) made to noninstitutionalized individuals are federally funded income based on need and, therefore, count as income.

2. Foster Care

BIA foster care assistance is considered a social service and, therefore, is not income for Medicaid purposes.

C. References

- Definition of foster care, S0830.410
- Income Based on need, S0830.170
- Social Services, S0815.050

S0830.820 INDIVIDUAL INDIAN MONEY ACCOUNTS

A. Introduction

No special policy applies to Individual Indian Money (IIM) accounts. Regular income and resources rules concerning restricted and unrestricted accounts apply. The following material is provided for informational purposes only.

IIM accounts are similar to regular bank accounts. Funds retained in an IIM account may earn interest. The BIA area office or agency on the reservation administers these accounts which are either restricted or unrestricted. A restricted account may be converted to an unrestricted account or vice versa, but only with BIA approval.

B. Definitions

A restricted IIM account requires BIA authorization for the individual to make a withdrawal.

1. Restricted IIM Account

2. Unrestricted IIM Account

An unrestricted account does not require BIA authorization for the individual to make a withdrawal.

C. List of IIM Deposit Sources

The following are typical sources of deposits to IIM accounts. The following list is not all-inclusive:

- Money distributed from tribal funds;
- Proceeds from trust sources;
- Proceeds from the sale or conversion of trust capital assets;
- Proceeds from an inheritance interest in trust lands;
- Per capita payments from judgments of the Indian Claim

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Commission;
- Proceeds from the sale of crops, livestock, or other personal property held in trust;
- Restricted funds pursuant to a specific plan approved by the Federal Government;
- Benefits from Federal agencies due minors and incompetents who have neither guardians nor payees;
- Lease income.

D. Procedures

Use the following guidelines, when necessary, to develop IIM accounts.

REMINDER: Regular income and resources rules apply to the development of IIM accounts.

As necessary, use information in the recipient's possession, or determine through contact with BIA.

If an account has been converted from restricted to unrestricted or vice versa, note the beginning and ending dates for each period.

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E. Examples

These examples show how regular income and resources rules apply to IIM accounts.

Example 1 - Restricted Account

In March, Mr. Strong's $2,200 annual individual Indian trust income payment is deposited, as required by BIA, into the restricted IIM account. The same month, his title II check of $250 is also directly deposited into that account. Because Mr. Strong's title II check was available to him in March (though he opted to have it deposited into his restricted account), regular income rules require treating the $250 as unearned income for that month. If retained in the restricted account, the title II benefits are not a resource.

Under P.L. 103-66, $2,000 of lease income would be excluded per S0830.850. However, per S1140.200, none of the lease income is income when deposited or a resource when retained in the IIM account since Mr. Strong does not have direct control of the funds.

In April, the BIA releases $200 to Mr. Strong. Per S0810.030 A., $200 is counted as unearned income for the month of April since the nonexcludable $200 of the $2,200 lease income was then available to him. Per S1130.700 B.2., the EW assumes that the nonexcludable lease income funds are withdrawn first, leaving as much of the excludable funds in the account as possible.

Example 2 - Unrestricted Account

In May, a $150 per capita payment from locally managed tribal funds is deposited into Mr. Thornton's unrestricted IIM account. Development reveals that these funds were not held in trust by the Secretary of the Interior and, therefore, are not excluded from income and resources. The $150 counts as income to Mr. Thornton in May, per S0810.030 A., and counts as a resource, to the extent retained, in June per S1120.005 B.2. In June, Mr. Thornton withdraws the money from his account. The $150 is a conversion of a resource in June per S0815.200, and is therefore not counted as income for that month.

F. References

- When income is counted, S0810.030
- What is income, S0810.005
- What is not income, S0815.001
- Conversion of a resource, S0815.200
- Definition of resources, S1110.100
- Checking and savings accounts, S1140.200
- Comingled funds, S1130.700

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S0830.830 INDIAN-RELATED EXCLUSIONS ACCOUNTS

A. Introduction

For Medicaid purposes, many Federal statutes provide for the exclusion from income and resources of certain payments made to members of Indian tribes and groups. Some statutes pertain to specific tribes or Indian groups while others apply to certain types of payments. Some statutes that predate the SSI program provide that some payments made under those acts shall not be considered as income or resources when determining eligibility for assistance under the Social Security Act.

B. Definition Per Capita Payments

Per capita payments are payments that are made according to the number of individual in a specific group and in which each individual shares equally.

C. Policy - Type of Payment

The following statutes provide that certain **types of payments** made to members of Indian tribes are excluded from income **and** resources (1.-4., below), or **only** from income (5., below).

1. Indian Judgment Funds Distribution Act—Public Law (P.L.) 93-134

Effective October 19, 1973, per capita distribution payments to members of Indian tribes who are due judgment funds, according to a plan of the Secretary of the Interior (or legislation, when a plan cannot be prepared or is not approved by the Congress) are excluded from income and resources. This does not include payments of funds distributed or held in trust (i.e., in the possession or care of a trustee) according to public laws enacted before October 19, 1973.

2. Distribution of Indian Judgment Funds—P.L. 97-458

Effective January 12, 1983, Indian judgment funds held in trust (i.e., in the possession or care of a trustee) or distributed per capita, pursuant to an approved plan, or their availability, are excluded from income and resources Indian judgment funds include interest and investment income accrued while the funds are held in trust. Initial purchases made with distributed judgment funds are excluded from resources.

3. Per Capita Act — P.L. 98-64

Effective August 2, 1983, per capita distributions of all funds held in trust by the Secretary of the Interior to members of Indian tribe are excluded from income and resources.

NOTE: Any local tribal funds that a tribe distributes to individuals on a per capita basis, but which have not been held in trust by the Secretary of the Interior (e.g., tribally managed gaming revenues) are **not** excluded from income and resources under this provision.

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4. Alaska Native Claims Settlement Act (ANCSA) — P.L. 100-241

Effective February 3, 1988, the following items received from a native corporation are excluded from income and resources:

- cash received from a native corporation (including cash dividends on stock received from a native corporation) to the extent it does not exceed $2,000 per individual per year;
- stock (including stock issued or distributed by a native corporation as a dividend or distribution on stock);
- a partnership interest;
- land or an interest in land (including land or an interest in land received from a native corporation as a dividend or distribution on stock);
- an interest in a settlement trust.

The ANCSA also provides that up to $2,000 in retained distribution from a native corporation may be excluded from resources for each year beginning with 1988.

5. Payments From Individual Interests in Trust or Restricted Lands — P.L. 103-66

Effective January 1, 1994, up to $2,000 per year received by Indians that is derived from individual interests in trust or restricted lands is excluded from income. (See S0830.850.)

NOTE: Interests of individual Indians in trust or restricted lands are excluded from resources (S1130.150.)

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D. Policy — Payments to Specific Indian Tribes and Groups

The following statutes provide that certain payments made to members of **specific Indian tribes and groups** and excluded from income and resources.

1. Distribution of Per Capita Funds — P.L. 85-794

Effective August 28, 1958, per capita payments to members of the **Red Lake Band of Chippewa Indians** from the proceeds of the sale of timber and lumber on the Red Lake Reservation are excluded from income and resources.

2. Distribution of Judgment Funds — P.L. 92-254

Effective March 18, 1972, per capita distribution payments by the **Blackfeet and Gros Ventre** tribal governments to members, which resulted from judgment funds to the tribes, are excluded from income and resources.

3. Distribution of Claims Settlement Funds — P.L. 96-531 and 96-305

Effective December 22, 1974, settlement fund payments to members of the **Hopi and Navajo Tribes,** and the availability of such funds, are excluded from income and resources.

4. Receipts from Lands Held in Trust for Indian Tribes — P.L. 94-114

Effective October 17, 1975, receipts derived from the following trust lands and distributed to members of designed Indian tribes are excluded from income and resources.

The first four Indian groups had lands conveyed with mineral rights prior to P.L. 94-114; that law conveyed the rest of the lands to the remaining Indian groups.

Indian Group	Conveyance Statue	State
Seminole Indians	P.L. 84-736 (70 Stat 581) (July 20, 1956)	Florida
Pueblos of Zia and Jemez	P.L. 84-926 (70 Stat 941) (August 2, 1956)	New Mexico
Stockbridge Munsee Indian Community	P.L. 92- 480 (86 Stat 795) (October 9, 1972)	Wisconsin
Burns Indian Colony	P.L. 92-488 (86 Stat 806) (October 13, 1972)	Oregon

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Indian Group	Lands Conveyed Reservation	Lands Conveyed By P.L. 94-114	State
Assiniboine and Sioux Tribe	Fort Peck	LI-MT 6 Fort Peck	Montana
Bad Rive Band of the Lake Superior Tribe of Chippewa Indians	Bad River	LI-WI 8 Bad River	Wisconsin
Blackfeet Tribe of Montana	Blackfeet	LI-MT 9 Blackfeet	Montana
Cherokee Nation of Oklahoma	None	LI-OK 4 Delaware LI-OK 5 Adair	Oklahoma
Cheyenne River Sioux Tribe	Cheyenne River	LI-SD 13 Cheyenne Indian	South Dakota
Crow Creek Sioux Tribe	Crow Creek	LI-SD 10 Crow Creek	South Dakota
Devil's Lake Sioux Tribe	Fort Totten	LI-ND 11 Fort Totten	North Dakota
Fort Belknap Indian Community	Fort Belknap	LI-MT 8 Fort Belknap	Montana
Keweenaw Bay Indian Community	L' Anse	LI-MI 8 L' Anse	Michigan
Lac Courte Oreilles Band of Lake Superior Chippewa Indians	Lac Courte Oreilles	LI-WI 9 Lac Courte	Wisconsin
Lower Brule Sioux Tribe	Lower Brule	LI-SD 10 Lowers Brule	South Dakota
Minnesota Chippewa Tribe	White Earth	LI-MN 6 Twin Lakes LI-MN 15 Flat Lake	Minnesota
Navajo Tribe	Navajo	LI-NM 18 Gallup Two Wells	New Mexico
Oglala Sioux Tribe	Pine Ridge	LI-SD 7 Pine Ridge	South Dakota
Rosebud Sioux Tribe	Rosebud	LI-SD 8 Cutmeat LI-SD 9 Antelope	South Dakota
Shoshone-Bannock Tribe	Fort Hall	LI-ID 2 Fort Hall	Idaho
Standing Rock Sioux Tribe	Standing Rock	LI-ND 10 Standing Rock LI-SD 10 Standing Rock	North Dakota South Dakota

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5. Distribution of Judgment Funds — P.L. 94-189	Effective December 31, 1975, judgment fund distributed per capita to, or held in trust for, members of the **Sac and Fox Indian Nation,** and the availability of such funds, are excluded from income and resources.
6. Distribution of Judgement Funds — P.L. 94-540	Effective October 18, 1976, judgment funds distributed per capita to, or held in trust for, members of the **Grand River Band of Ottawa Indians,** and the availability of such funds, are excluded from income and resources.
7. Distribution of Judgment Funds — P.L. 95-433	Effective October 10, 1978, any judgment funds distributed per capita to members of the **Confederated Tribes and Bands of the Yakima Indian Nation** or the **Apache Tribe of the Mescalero Reservation** are excluded from income and resources.
8. Receipts from Lands Held in Trust — P.L. 95-498	Effective October 21, 1978, receipts derived from trust lands awarded to the **Pueblo of Santa Ana** and distributed to members of that tribe are excluded from income and resources.
9. Receipts from Lands Held in Trust — P.L. 95-499	Effective October 21, 1978, receipts derived from trust lands awarded to the **Pueblo of Zia** and distributed to members of that tribe are excluded from income and resources.
10. Distribution of Judgment Funds — P.L. 96-318	Effective August 1, 1980, any judgment funds distributed per capita or made available for programs for members of the **Delaware Tribe of Indians** and the absentee **Delaware Tribe of Western Oklahoma** are excluded from income and resources.
11. Maine Indian Claims Settlement Act — P.L. 96-420	Effective October 10, 1980, all funds and distributions to members of the **Passasmaquoddy Tribe, the Penobscot Nation, and the Houlton Band of Maliseet Indians** under the Maine Indian Claims Settlement Act, and the availability of such funds, are excluded from income and resources.
12. Distribution of Judgment Funds — P.L. 97-95	Effective December 17, 1981, any distributions of judgment funds to members of the **San Carlos Tribe of Arizona** are excluded from income and resources.
13. Distribution of Judgment Funds — P.L. 97-371	Effective December 20, 1982, any distributions of judgment funds to members of the **Wyandot Tribe of Indians of Oklahoma** are excluded from income and resources.
14. Distribution of Judgment Funds — P.L. 97-372	Effective December 20, 1982, distributions of judgment funds to members of the **Shawnee Tribe of Indians (Absentee Shawnee Tribe of Oklahoma, the Eastern Shawnee Tribe of Oklahoma, and the Cherokee Band of Shawnee descendants)** are excluded from income and resources.
15. Distribution of Judgment Funds — P.L. 97-376	Effective December 21, 1982, judgment funds distributed per capita or made available for programs for members of the **Miami Tribe of Oklahoma** and **the Miami Indians of Indiana** are excluded from income and resources.

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16. **Distribution of Judgment Funds — P.L. 97-402** — Effective December 31, 1982, distributions of judgment funds to members of the **Clallam Tribe of Indians of the State of Washington (Port Gamble Indian Community, Lower Elwha Tribal Community, and the Jamestown Band of Clallam Indians)** are excluded from income and resources.

17. **Distribution of Judgment Funds — P.L. 97-403** — Effective December 31, 1982, judgment funds distributed per capita or made available for programs for members of the **Pembina Chippewa Indians (Turtle Mountain Band, Chippewa Cree Tribe, Minnesota Chippewa Tribe, and Little Shell Band of Chippewa Indians of Montana)** are excluded from income and resources.

18. **Distribution of Judgment Funds — P.L. 97-408** — Effective January 8, 1983, per capita distributions of judgment funds to members of the **Gros Ventre and Assiniboine Tribes of Fort Belknap Indian Community, and the Papago Tribe of Arizona,** are excluded from income and resources.

19. **Distribution of Judgment Funds — P.L. 97-436** — Effective January 8, 1983, up to $2,000 of per capita distributions of judgment funds to members of the **Conferated Tribes of the Warm Springs Reservation** are excluded from income and resources.

20. **Distribution of Judgment Funds — P.L. 98-123** — Effective October 13, 1983, judgment funds distributed to the **Red Lake Band of Chippewa Indians** are excluded from income and resources.

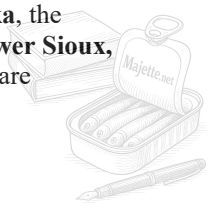
21. **Distribution of Claims Settlement Funds — P.L. 98-124** — Effective October 13, 1983, funds distributed per capita or family interest payments for members of the **Assiniboine Tribe of the Fort Belknap Indian Community of Montana and the Assiniboine Tribe of the Fort Peck Indian Reservation of Montana** are excluded from income and resources.

22. **Distribution of Claims Settlement Funds — P.L. 98-432** — Effective September 28, 1984, judgment funds and income therefrom distributed to members of the **Shoalwate Bay Indian Tribe** are excluded from income and resources.

23. **Distribution of Claims Settlement Funds — P.L. 98-500** — Effective October 19, 1984, all distributions to heirs of certain deceased Indians under the Old Age Assistance Claims Settlement Act are excluded from income and resources.

24. **Distribution of Judgment Funds — P.L. 98-602** — Effective October 30, 1984, judgment funds distributed per capita or made available for any tribal program, for members of the **Wyandotte Tribe of Oklahoma** and the **Absentee Wyandottes,** are excluded from income and resources.

25. **Distribution of Judgment Funds — P.L. 99-130** — Effective October 28, 1985, per capita and dividend payment distributions of judgment funds to members of the **Santee Sioux Tribe of Nebraska**, the **Flandreau Santee Sioux Tribe,** and the **Prairie Island Sioux, Lower Sioux,** and **Shakopee Mdewakanton Sioux Communities of Minnesota** are excluded from income and resources.



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26. Distribution of Judgment Funds — P.L. 99-146	Effective November 11, 1985, funds distributed per capita or held in trust for members of the **Chippewas of Lake Superior** and the **Chippewas of the Mississippi** are excluded from income and resources.
27. Distribution of Claims Settlement Funds — P.L. 99-264	Effective March 24, 1986, distributed of claims settlement funds to members of the **White Earth Band of Chippewa Indians** as allottees, or their heirs, are excluded from income and resources.
28. Distribution of Judgment Funds — P.L. 99-346	Effective June 30, 1986, payments or distributions of judgment funds, and the availability of any amount for such payments or distributions, to members of the **Saginaw Chippewa Indian Tribe of Michigan** are excluded from income and resources.
29. Distribution of Judgment Funds — P.L. 99-377	Effective August 8, 1986, judgment funds distributed per capita or held in trust for members of the **Chippewas of Lake Superior and the Chippewas of the Mississippi** are excluded from income and resources.
30. Distribution of Judgment Funds — P.L. 100-139	Effective October 26, 1987, judgment funds distributed to members of the **Cow Creek Band of Umpqua Tribe of Indians** are excluded from income and resources
31. Aleutian and Pribilof Islands Restitution Act — P.L. 100-383	Effective August 10, 1988, per capita restitution payments made to eligible **Aleuts** who were relocated or interned during World War II are excluded from income and resources. See S080.720.
32. Distribution of Claims Settlement Funds — P.L. 199-411	Effective August 22, 1988, per capita payments of claims settlement funds to members of the **Coushatta Tribe of Louisiana** are excluded from income and resources.
33. Hoopa-Yurok Settlement Act —P.L. 100-580	Effective October 31, 1988, funds distributed per capita for members of the **Hoopa Valley Indian Tribe and the Yurok Indian Tribe** are excluded from income and resources.
34. Distribution of Judgment Funds — P.L. 100-581	Effective November 1, 1988, judgment funds held in trust by the United States, including interest and investment income accruing on such funds, and judgment funds made available for programs or distributed to members of the **Wisconsin Band of Potawatomi (Hannahaville Indian Community and Forest County Potawatomi)** are excluded fro income and resources.
35. Distribution of Money and Land — P.L. 101-41	Effective June 21, 1989, all funds assets, and income from the trust fund transferred to the member of the **Puyallup Tribe** under the Puyallup Tribe of Indians Settlement Act of 1989 are excluded from income and resources.



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36. Distribution of judgment Funds — P.L. 101-277

Effective April 30, 1990, judgment funds distributed per capita, or held in trust, or made available for programs, for members of the **Seminole Nation of Oklahoma, the Seminole Tribe of Florida,** and **Miccosukee Tribe of Indians of Florida,** (plus any interest and investment income accruing on the funds held in trust), and the availability of those funds, are excluded from income and resources.

37. Distribution of Settlement Funds — P.L. 101-503

Effective November 3, 1990, payments, funds, distributions, or income derived from them under the **Seneca Nation** Settlement Act of 1990 ar excluded from income and resources.

38. Distribution of Settlement Funds — P.L. 101-618

Effective November 16, 1990, per capita distributions of settlement funds under the **Fallon Paiute Shoshone Indian Tribes** Water Rights Settlement Act of 1990 are excluded from income and resources.

E. Procedure

If there is an allegation or other indication that an individual received excluded judgment funds or settlement fund distributions, per capita payments, land, or receipts from land, follow these procedures.

1. Verification of Tribe Member-ship

As necessary, verify that the individual is a member of the relevant tribe by contact with BIA or tribal authorities.

2. Payment/ Distribution Development

Develop the identity and amount of excludable payment or distribution by contact with BIA or tribal authorities or use of a precedent file. Trust Property Income (TPI) reports may also be available form BIA, which list to whom restricted individual Indian property is assigned, and show if lease or grazing rights payments are not paid through BIA or the tribe. If land is distributed, identify the location of the land as recorded by deed or other legal conveyance. (Additional contacts with the Bureau of Land Management may be necessary to develop land information.)

3. Documentation

Document the file using the method(s) below as needed:

- Document case record for verifications made over the phone with the tribal authorities or the BIA area office.
- Income report or comparable document from the BIA, the tribe's governing body, or its official financial representatives.
- Signed statement from the tribal authorities, the BIA area offices, or Bureau of Land Management.

F. References

- Aleutian restitution payment, S0830.720
- BIA student assistance program, S0830.460
- Certain stock in Alaska regional or village corporations, S1120.105
- Commingled funds S1130.700
- Indian trust or restricted funds, S1130.150

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S0830.840 ALASKA NATIVE CLAIMS SETTLEMENT ACT EXCLUSIONS

A. Policy

1. Current Exclusions--Effective February 3, 1988

P.L. 100-241 provided Medicaid income and resource exclusions to Alaska Natives and their descendants. The following items received from a Native Corporation, are excluded from income and resources for Medicaid purposes:

- cash received from a native corporation (including cash dividends on stock received from a native corporation) to the extent it does not exceed $2,000 per individual per year;
- stock (including stock issued or distributed by a native corporation as a dividend or distribution on stock);
- a partnership interest;
- land or an interest in land (including land or an interest in land received from a native corporation as a dividend or distribution on stock);
- an interest in a settlement trust.

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S0830.850 EXCLUSION OF INCOME FROM INDIVIDUAL INTERESTS IN INDIAN TRUST OR RESTRICTED LANDS

A. Introduction

Native American income derived from tribal trust lands is excluded by federal statutes (see S0830.830 B). Individual interests of Native Americans in trust or restricted lands are excluded from resources (see S1130.150). The Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66), enacted August 10, 1993, further provides for an exclusion of income derived from those individual interests in Indian trust or restricted lands for purposes of determining Medicaid eligibility.

This income (often called individual Indian trust or lease income) generally comes from interests in lands that were allotted to individual Indians many years ago. The income generated by those interests may be quite small since many of the original interests in allotted lands have fractionated over time, e.g., due to inheritance by multiple heirs over several generations.

B. Policy

Up to $2,000 per year in payments derived from individual interests in Indian trust or restricted lands is excluded from income. Such payments include any interest which accrues on funds while held by B/A and before being distributed or credited to an individual's account.

This exclusion applies to the income of an ineligible spouse or ineligible parent(s) in the deeming process.

For purposes of applying the $2,000 annual exclusion, for both eligibles and deemors, only payments received in months of the Medicaid individual's eligibility count toward the $2,000 annual exclusion.

C. Procedure--Development and Documentation

Verify and document income derived from individual interests in trust or restricted lands per S0830.820 E.

If that income exceeds $2,000 per calendar year, determine the month that the $2,000 annual exclusion was exceeded, and count the excess as unearned income in the months received.

EXAMPLE: During a redetermination interview, Mr. Elwell, a member of the Yakima Indian Tribe, reports receiving accumulated lease payments of $2,800 in 1994 from his individual interests in allotted Indian grazing lands. He alleges receiving $1,000 in March, $700 in June and $ 1,100 in October. Review of case records shows that the payments for March and June were reported timely, but Mr. Elwell was ineligible for Medicaid in June due to receipt of earned income. The eligibility worker (EW) excludes the payment received in March and $1,000 of the payment received in October, and does not consider the $700 received in June. The EW determines unearned income of $100 for October, the month the $2,000 annual exclusion was exceeded.

D. References

- Other Indian related exclusion, S0830.830
- Resource exclusion of individual Indian interests in trust or restricted lands, S1130.150
- Rental Income, S0830.505



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CHAPTER M11

AGED, BLIND, AND DISABLED (ABD) RESOURCES

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OVERVIEW

M1110.001 ROLE OF RESOURCES

A. Introduction

As a program based on need, Medicaid uses the value of a person's countable resources as one of two financial criteria in determining eligibility. The other criterion is income. The following sections explain how to treat resources to determine eligibility in the Aged, Blind and Disabled covered groups in the Medicaid program. Virginia Medicaid follows Social Security Administration rules from the SSI section of the Program Operations Manual System (POMS) SSA's Policy Information Site - POMS. Some of the rules are adapted due to state laws and regulations. We have noted in each section if the section follows SSA policy without deviation by adding "per POMS'. This chapter explains how we count resources.

B. Policy Principles

1. Monthly Determinations

Eligibility with respect to resources is a determination made for each calendar month, beginning with the month of application or, if retroactive eligibility is being determined, the third month prior to the month in which the application is submitted. Resource eligibility exists for the full month if countable resources were at or below the applicable resource limit for any part of the month. *If resource amounts reported are reasonably compatible with values received from electronic verification sources, the evaluation can continue. If reported resource amounts and verified resource amounts are both below the established limit, resource eligibility is assumed to exist. The sources of the resources do not need to match. If both amounts are over the resource limit, additional verification may be needed – must check for exclusions. Again, the sources of the resources do not need to match. If the member attests to having resources below the limit and values received from electronic sources are above the limit, additional verification should be requested.*

2. Countable Resources

Not everything a person owns (i.e., not every asset) is a resource and not all resources count against the resource limit. The location of a resource does not by itself exclude the resource. "The Social Security Act and other Federal statutes require the exclusion of certain types and amounts of resources. Any assets that are resources but not specifically excluded are "countable." See:

- M1110.003 B.2. for the resource limits;
- S1110.100 for the distinction between assets and resources; and
- S1110.210 for a listing of exclusions.

3. Whose Resources Can Count

Medicaid law specifies that resources are only considered available between spouses and from parents to their children under age 21, and for certain blind and disabled children ages 18 to 21.

See M1110.530 for blind and disabled children age 18 to 21.

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M1110.003 RESOURCE LIMITS

A. Introduction

The resource limit is the maximum dollar amount of countable assets an individual, couple, or family may own and still meet the established criteria for Medical Assistance in an ABD category. These amounts are established by law.

B. Policy Principles

1. Resource Ineligibility

An individual (or couple) with countable resources in excess of the applicable limit is not eligible for Medicaid.

2. Resource Limits

ABD Eligible Group	One Person	Two People
Categorically Needy Medically Needy	$2,000	$3,000
ABD with Income ≤ 80% FPL	$2,000	$3,000
QDWI	$4,000	$6,000
QMB SLMB QI	**Calendar Year** **2024** $9,430 **2025** $9,660 ***2026*** *$9,950*	**Calendar Year** **2024** $14,130 **2025** $14,470 ***2026*** *$14,910*

3. Change in Marital Status

A change in marital status can result in a change to the applicable resource limit. The resource limit change is effective with the month that we begin treating both members of a couple as individuals. For example, separation from an ineligible spouse can change the limit from $3,000 to $2,000. See M1110.530 B.

4. Reduction of Excess Resources

Month of Application

Excess resources throughout the month of application causes ineligibility for the application month. Reduction of excess resources within the application month can cause resource eligibility for that month.

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ASSETS vs. RESOURCES

S1110.100 DISTINCTION BETWEEN ASSETS AND RESOURCES

A. Introduction

Not everything an individual owns (assets) are resources for Medicaid purposes. Moreover, in certain situations, an asset that is not a resource may become one at a later date or vice versa. The distinction is important since:

- an asset that is not a resource does not count against the resource limit; and
- proceeds from the sale or trade of a resource (i.e., the amount representing conversion of principal from one form to another) are also resources but what a person receives from a nonresource is subject to evaluation as income at the time of receipt.

EXAMPLE: An individual is the beneficiary of a trust which is not his resource. Therefore, when the trust pays him his monthly allowance, he receives income.

B. Policy Principles

1. Resources Defined

Resources are cash and any other personal or real property that an individual (or spouse, if any):

- owns;
- has the right, authority, or power to convert to cash (if not already cash); and
- is not legally restricted from using for his/her support and maintenance.

2. Resources with Zero Value

Property does not cease to be a resource simply because it has no current market value. Even though there is no value to count, the property remains a resource for so long as it meets the criteria in 1. above. If the property develops a market value at a later time, there has been an increase in the value of a resource rather than a receipt of income.

3. Property That Is Not a Resource

Any property (an asset) that does not meet the criteria in 1. above is not a resource even though it may be an asset (e.g., an individual who has an ownership interest in property but is not legally able to transfer that interest to anyone else does not have a resource).

C. Definitions

1. Real Property

Real property is land, including buildings or immovable objects attached permanently to the land.

2. Personal Property

Personal property is any property that is not real property. The term encompasses such things as cash, tools, life insurance policies, and automobiles.

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D. Related Policies

1. Conserved Fund in Change-Of-Payee Situations

Conserved funds (or other property) remain resources even during a period when they are being held in a bank account or by the paying agency because it is necessary to obtain a new payee or guardian. See S1120.022.

2. Liquid vs. Nonliquid Resources

Except for cash, any kind of real or personal property may be either liquid or nonliquid. For the distinction between liquid and nonliquid resources, and its significance, see S1110.300.

3. Evaluation of Receipt of Property As Income

When an individual first receives property (as a gift or inheritance, for instance, but not as a purchase or trade of one resource for another), the new property is subject to evaluation under the income rules for the month of receipt and under the resources rules thereafter.

4. Discovery of Unknown Assets

For the resources treatment of previously unknown assets, see S1110.117.

S1110.115 ASSETS THAT ARE NOT RESOURCES

A. Policy Principle--General Rule

Assets of any kind are not resources if the individual does not have:

- any ownership interest; and
- the legal right, authority, or power to liquidate them (provided they are not already in cash); or
- the legal right to use the assets for his/her support and maintenance.

EXAMPLE: An individual owns a block of stock jointly with his brother. Although the form of ownership is one which would permit either to sell the property without the other's consent, the brothers have a legally binding agreement that one will not sell without consent of the other. The individual's brother refuses his consent, thereby making the stock not a resource for the individual. However, if the brother should give his consent, the stock would be subject to evaluation under the resources-counting rule beginning with the month following the month of consent.

The value of the stock would **not** be counted as income to the individual in the month consent is given.

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B. Policy Principles--Certain Specific Assets That Are Not Resources

Though not an exhaustive listing, the term "resources" does not apply to the assets described below.

1. Cash to Purchase Medical or Social Services

For 1 calendar month following its receipt, cash paid by a recognized medical or social services program is not a resource provided the cash is:

- not income under S0815.050; and
- not repayment for a bill already paid.

See S1120.110.

2. Home Energy Assistance/ Support and Maintenance Assistance

(HEA/SMA) HEA/SMA which is excluded from income and is not a resource regardless of how long a person retains it (S1120.100).

S1110.117 UNKNOWN ASSETS

A. Policy

An individual may be unaware of his or her ownership of an asset. If this is the case, the asset is not a resource during the period in which the individual was unaware of his/her ownership.

The value of the previously unknown asset, including any monies (such as interest) that have accumulated on it **through the month of discovery by the individual,** is **income** (not a resource) in the **month of discovery.**

For months after the month of discovery, the previously unknown asset is a **resource** subject to the usual resource-counting rules.

B. Procedure-Documentation

When an individual alleges having been unaware of his/her ownership of an asset, obtain a signed statement from the individual. Also obtain any available supporting documentation, including (but not limited to) signed statements from other individuals who are familiar with the individual's situation.

Document the file with your determination regarding the alleged "unknown" resource.

C. Examples

1. As a result of contacting a tax assessor's office, the eligibility worker (EW) learns that the recipient has an ownership interest in previously unreported property (undeveloped land). The property is co-owned with another individual who has always paid the property taxes. Contacts with the recipient and the other individual confirm the recipient's allegations that he was unaware the original owner of the property has died and, therefore, the recipient never knew that he had inherited an ownership interest. The value of the recipient's ownership interest is counted as **income** in the month he learned of the ownership interest and as a **resource** in the following month.

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C. Example (cont.)

2. While in the hospital, the recipient received a check for $25 as a "get-well" gift from her neighbors. She was unaware of the gift. At the time, her affairs were being managed by her daughter, who put the check in a desk drawer and failed to tell the recipient anything about it.

   In the month the recipient learns of the existence of the check, the check is counted as her **income**. In the following month, the $25 is counted as her **resource.**

COUNTABLE VS. EXCLUDED RESOURCES

S1110.200 COUNTABLE RESOURCES

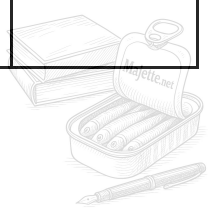
Policy The value of any asset that meets the definition of a resource counts against the applicable resource limit to the extent that the instructions in S1130.100 do not provide for its exclusion.

M1110.210 EXCLUDED RESOURCES

A. Introduction Once you have determined that an asset meets the definition of a resource, it is necessary to determine that resource's effect on eligibility. Certain resources do not count against the resource limit; i.e., they are excluded.

B. List of Resource Exclusions

Exclusion	Reference	No Limit on Value and/or Length of Time	Limit on Value and/or Length of Time
Home serving as the principal place of residence, including the land on which the home stands (*contiguous property exempt for QDWI, QMB, SLMB, QI and ABD 80% FPL).	M1130.100	* X	X
Funds from sale of a home if reinvested timely in a replacement home	*M*1130.110		X
Jointly-owned real property which cannot be sold without undue hardship (due to loss of housing) to the other owner(s)-For QMB, QDWI, SLMB, QI and ABD 80% FPL only	*M*1130.130 Appendix 1 Appendix 2	X	
Real property for as long as the owner's reasonable efforts to sell it are unsuccessful	M1130.140	X	
Restricted, allotted Indian land if the Indian/owner cannot dispose of the land without the permission of other individuals, his/her tribe, or an agency of the Federal Government	*M*1130.150	X	



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B. Description—List of Resource Exclusions

Exclusion	Reference	No Limit on Value and/or Length of Time	Limit on Value and/or Length of Time
Life insurance, depending on its face value	*M*1130.300		X
Burial space or plot held for an eligible individual, his/her spouse, or member of his/her immediate family	M1130.400	X	
Burial funds for an individual and/or his/her spouse	M1130.410		X
Certain prepaid burial contracts	M1130.420		X
Household Goods and Personal Effects	M1130.430	X	
Property essential to self-support	*M*1130.500-.504		X
Resources of a blind or disabled person which are necessary to fulfill an approved plan for achieving self-support	M0810.430 *M*1130.510		X
Retained retroactive SSI or RSDI benefits	*M*1130.600		X
Radiation Exposure Compensation Trust Fund payments	*M*1130.680	X	
German reparations payments made to World War II Holocaust survivors	*M*0830.710 *M*1130.610	X	
Austrian social insurance payments	*M*0830.715 *M*1130.615	X	
Japanese-American and Aleutian restitution payments	*M*0830.720	X	
Federal disaster assistance received because of a Presidentially declared major disaster, including accumulated interest	*M*0830.620 *M*1130.620	X	
Cash (including accrued interest) and in-kind replacement received from any source at any time to replace or repair lost, damaged, or stolen excluded resources	*M*0815.200 *M*1130.630		X
Certain items excluded from both income and resources by other Federal statutes	*M*0830.055 *M*1130.640	Varies	
Agent Orange settlement payments to qualifying veterans and survivors	*M*0830.730 *M*1130.660	X	
Victim's compensation payments	*M*0830.660 *M*1130.665		X
Tax refunds related to Earned Income Tax Credits	*M*0820.570 *M*1130.675		X
Achieving a Better Life Experience (ABLE) accounts	M1130.740		X
Post-PHE Excluded Resources	M1130.720		*X*
Work Incentive Account (WIN)	*M0320.400*		*X*

C. References

- Identifying excluded funds that have been commingled with non-excluded funds, M1130.700

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LIQUID VS. NONLIQUID RESOURCES

S1110.300 DETERMINING THE LIQUIDITY/NONLIQUIDITY OF RESOURCES

A. Policy

1. Definitions

- **Liquid resources** are any resources in the form of cash or in any other form which **can** be converted to cash within 20 workdays.
- **Nonliquid resources** are any resources which are not in the form of cash which **cannot** be converted to cash within 20 workdays.
- Workdays are any days other than Saturdays, Sundays, and Federal holidays.

Liquidity/nonliquidity has no effect on a resource's countability.

B. Reference

Liquid resources do not qualify for exclusion as property essential to self-support unless they represent necessary assets of a trade or business. See S1130.500 B.3.

S1110.305 RESOURCES ASSUMED TO BE LIQUID

A. Introduction

Cash is **always** liquid. In addition, certain noncash items are nearly always liquid.

B. Policy

1. Assumption of Liquidity

Absent evidence to the contrary, we assume that the following types of resources are liquid:

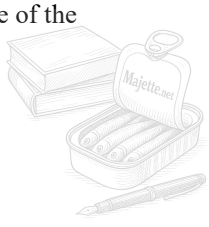
- stocks, bonds, and mutual fund shares;
- checking and savings account and time deposits;
- United States Savings Bonds, Treasury bills, notes and bonds; and
- mortgage and promissory notes.

2. Evidence to the Contrary

If there is no apparent evidence to the contrary of the assumptions in 1. above, we do not seek out any evidence to the contrary. There is no need to document a lack of evidence to the contrary.

We resolve any issue and document the file if:

- liquidity is material to a particular resource; and
- an individual's statement or information in file suggests that one of the above-listed types of resources is not liquid.



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C. Examples-Evidence to the Contrary

1. Recently Issued U.S. Savings Bond: Not a Resource

a. Situation - On January 6, 1994 Ms. Minnie Marbel applied for Medicaid benefits. Among her alleged resources was a $500 series EE U.S. Savings Bond which she had won a month earlier in a Christmas raffle at church. Since series EE bonds are never redeemable for 6 months following issue, the EW questioned whether the minimum retention period had expired.

b. Analysis - The bond's issue date was December 1, 1993. Therefore, Ms. Marbel by law could not redeem it before June 1, 1994. Consequently, the bond not only was not a liquid resource, it was not a resource at all. The value of the bond, including any interest accrued, does not become a liquid resource until July 1, 1994.

2. Guardianship Account -- Guardian Dies: Non-Liquid Resource

a. Situation - Ms. Harriet Dalton had a court-appointed guardian who had sole access to Ms. Dalton's savings account. On September 8, 1988 the guardian filed for Medicaid on Ms. Dalton's behalf. On November 2, while the claim was still pending, the guardian died. Because of the delay in having a new guardian appointed and establishing a new account signatory, there was no one authorized to withdraw funds from the account for at least 60 days (and possibly longer).

b. Analysis - For September through November the account was Ms. Dalton's liquid resource because her guardian had access to it as of the first moment of each month. Beginning in December and until the first of the month in which a new guardian had access to the account, it was a nonliquid resource.

3. Comparison of Analyses in 1. And 2. Above

The guardianship account continues to be a resource because, at all times, Ms. Dalton owned it and had the legal right to use it for her own support and maintenance. The delay in appointing a new guardian who could access it within 20 days does not remove Ms. Dalton's right to the funds.

In the case of the savings bond, neither Ms. Marbel nor anyone acting on her behalf had the right, authority or power to redeem the bond for cash until 6 months from the date of issue.

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S1110.310 RESOURCES ASSUMED TO BE NONLIQUID

A. Introduction

Certain non-cash resources, though they may occasionally be liquid, are nearly always non-liquid.

B. Operating Policy

1. Assumption of Nonliquidity

Absent evidence to the contrary, we assume that the following type of resources are non-liquid.

- automobile, trucks, tractors, and other vehicles;
- machinery and livestock;
- buildings, land and other real property rights; and
- non-cash business property.

2. Evidence to The Contrary

a. If there is no apparent evidence to the contrary of the assumptions in 1. above, we do not seek out any evidence to the contrary. There is no need to document a lack of evidence to the contrary.

b. In very rare situations an individual may volunteer firm evidence that one of the above types of resources is liquid (i.e., its sale has been accomplished or arranged within 20 workdays). Document the file *in the VaCMS case record* and proceed accordingly only if the distinction is material.

C. Operating Policy-- Life Insurance

This subchapter provides no categorical assumption regarding the liquidity or non-liquidity of life insurance policies.

VALUATION OF RESOURCES

M1110.400 WHAT VALUES APPLY TO RESOURCES

A. Policy Principles

1. Definitions

a. The current market value (CMV) or fair market value (FMV) of a resource is:

- Real property – 100% of the local tax assessed value **or** effective 10/4/16, the certified value as determined by an appraiser licensed in the state in which the real property is located. The use of an appraisal is applicable only to non-commercial real property. *A licensed appraiser's certified value can be used if the appraisal was completed no more than six months previous to the date of the application.*

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The cost of the appraisal must be paid by either the applicant/recipient or the individual acting on the applicant or recipient's behalf. Certified appraisals documenting the value of the property must contain the name and license number of the individual conducting the appraisal. A copy of the appraisal must be scanned into the VaCMS case record or placed in the hard case record.

If tax assessment and appraisal are both provided, use the value that is most beneficial to the applicant.

License validity for appraisers in Virginia, if necessary, can be verified through the "License Lookup" tool on the Department of Professional and Occupational Regulation's website at www.dpor.virginia.gov or by calling the Real Estate Appraiser staff at 804-367-2039. A copy of the appraisal must be scanned into the VaCMS case record or placed in the hard case record.

If tax assessment and appraisal are both provided, use the value that is most beneficial to the applicant.

- *Countable motor vehicles:*

  a. Online at Get New Car Prices & Used Car Values | Find Real-world Car Costs (jdpower.com) (J. D. Powers bought NADA and now provides this information).
  b. If the vehicle is not listed on the J.D. Powers website, the value which is assessed for tax purposes, or
  c. If the methods listed above are not available:
    - *a statement from a licensed dealer, or*
    - *the statement of the applicant/recipient*
  d. Information from other websites such as kbb.com, carvana.com or edmunds.com.

b. Equity value (EV) is the CMV of a resource minus any encumbrance on it.

c. An encumbrance is a legally binding debt against a specific property. Such a debt reduces the value of the encumbered property but does not have to prevent the property owner from transferring ownership (selling) to a third party. However, if the owner of encumbered property does sell it, the creditor will nearly always require a debt satisfaction from the proceeds of sale.

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2. Valuation

General Rule
The value of a resource is the amount of an individual's/couple's equity in it.

3. Determining the Countable Value of Real Property

The procedures for determining the countable value of real property are found in Appendices 1 *and 4* to subchapter S1130. An "ABD Home Property Evaluation Worksheet" is found in Appendix 2 to subchapter S1130.

B. Related Policy

See M1110.600 concerning the points in time for establishing resource values.

OWNERSHIP INTERESTS

S1110.500 SIGNIFICANCE OF OWNERSHIP

A. Introduction

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.

B. Description-Types of Ownership

1. Sole vs. Shared Ownership

An individual may have sole ownership of a property or may share its ownership with others. See S1110.510.

2. Fee Simple Ownership

Fee simple ownership, which relates only to real property, is completely free of conditions imposed by others. See S1110.515 A.1.

3. Less than Fee Simple Ownership

a. A life estate interest conveys ownership of limited duration. See S1110.515 A.2. and B.

b. Equitable ownership can occur when an individual does not have legal title to property. See S1110.515 A.2b. and C.

4. Property Rights Without Ownership

a. A leasehold conveys a time-limited control of property but not ownership of it. See S1110.520 B.1.

b. An incorporeal interest in property is a right to use the property but without any right to possess it or sell it. See S1110.520. B.2.

C. Operating Policy--Variance in State Laws with Respect to Ownership

The explanations of ownership in the following sections represent general legal principles. However, specific points may vary with State law and issues may have to be reviewed by the Regional Office and/or Assistant Attorney General's Office.

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S1110.510 SOLE VS. SHARED OWNERSHIP

A. Introduction

An individual may be the sole owner of real or personal property or may share ownership with one or more others.

B. Definitions

1. Sole Ownership

Sole ownership of (real or personal) property means that only one person may sell, transfer or otherwise dispose of the property. However, sole ownership may be subject to conditions imposed by others as, for example, sole ownership of a remainder interest in property. See S1110.515.

2. Shared Ownership

Shared ownership of (real or personal) property means that two or more people own it concurrently. See C. below concerning different types of shared ownership.

C. Descriptions-Shared Ownership

1. Tenancy-In-Common

a. Owners Do Not Have Same Interests

In tenancy-in-common, two or more persons each has an undivided fractional interest in the whole property for the duration of the tenancy. These interests are not necessarily equal; e.g., two joint tenants do not necessarily each own half of the property. One owner may sell, transfer or otherwise dispose of his or her share of the property without permission of the other owner(s) but cannot take these actions with respect to the entire property.

b. No Survivorship Rights

When a tenant-in-common dies, the surviving tenant(s) has no automatic survivorship rights to the deceased's ownership interest in the property. Upon a tenant's death, the deceased's interest passes to his or her estate or heirs.

c. Example

Don, Charles, and Fred Evans own property as tenants-in-common. Charles and Fred each owns an undivided one-fourth interest in the property while Don owns the remaining one-half interest. If Don Evans were to sell his half interest to Stanley Long, Mr. Long would become a tenant-in-common with Charles and Fred Evans. If Mr. Long were then to die so that his property passed to his four children, each of them would own one-eighth interest as tenants-in-common with Charles and Fred who would each continue to own one-fourth interest.

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2. Joint Tenancy

a. Each Owner Has Same Interest

In joint tenancy, each of two or more persons has one and the same undivided ownership interest and possession of the whole property for the duration of the tenancy. In effect, each owner owns all of the property.

b. Survivorship Rights

Upon the death of one of only two joint tenants, the survivor becomes sole owner. On the death of one of three or more joint tenants, the survivors become joint tenants of the entire interest.

c. Conversion to Tenancy-in-Common

In most States, it is possible for joint tenants to take action during their lifetime to convert the joint tenancy to a tenancy-in-common (see 1. above).

3. Tenancy by The Entirety

a. Married Couples Only

A tenancy by the entirety can exist only between the members of a married couple. The wife and husband as a unit own the entire property which can be sold only with the consent of both parties. However, if a marriage has been legally dissolved, the former spouses become tenants-in-common and one can sell his or her share without the consent of the other.

b. Survivorship Rights

Upon the death of one tenant by the entirety, the survivor takes the whole.

D. Operating Policy-- Shared Ownership

1. General Rule

With the exception noted below, we assume, absent evidence to the contrary, that each owner of shared property owns only his or her fractional interest in the property. We divide the total value of the property among all of the owners in direct proportion to the ownership share held by each.

2. Exception: Checking/ Savings Accounts and Time Deposits

For a joint checking or savings account or a jointly-owned time deposit, we assume that all of the funds in the account belong to the applicant(s) recipient(s), in equal shares if there is more than one applicant or recipient (S1140.205 B and .210 B).

3. Determining the Countable Value of Jointly Owned Real Property

The procedures for determining the countable value of jointly owned real property are found in Appendix 1 to subchapter S1130.

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M1110.515 OWNERSHIP IN FEE SIMPLE OR LESS THAN FEE SIMPLE

A. Definitions

1. Fee Simple

Fee simple ownership means absolute and unqualified legal title to real property. The owner(s) has unconditional power of disposition of the property during his or her lifetime. Upon his or her death, property held in fee simple can always pass to the owner's heirs. Fee simple ownership may exist with respect to property owned jointly or solely.

2. Less than Fee Simple Ownership

a. Life Estate

A life estate confers upon one or more persons (grantees) certain rights in a property for his/her/their lifetimes or the life of some other person. A life estate is a form of legal ownership and usually created through a deed or will or by operation of law. See B. below.

b. Equitable Ownership

An equitable ownership interest is a form of ownership that exists without legal title to property. It can exist despite another party's having legal title (or no one's having it). See C. below.

B. Description--Life Estate

1. Rights of Life Estate Owner

a. What Owner Can Do

Unless the instrument (will or deed) establishing the life estate places restrictions on the rights of the life estate owner, the owner has the right to possess, use, and obtain profits from the property and to sell his or her life estate interest.

Whether the value of a life estate is counted as a resource depends on when the life estate was created.

- The value of a life estate created prior to August 28, 2008 is **not** counted as a resource.
- *The value of a life estate created on or after August 28, 2008 but before February 24, 2009 is a countable resource to the owner of the life estate unless the life estate is excluded under one of the real property exclusions contained in Chapter S1l.*
- The value of a life estate created on or after February 24, 2009 is **not** counted as a resource.

Exception: The value of a life estate owned by a QDWI enrollee is countable, regardless of the date on which it was created. See M1140.110 for additional information.



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b. What Owner Cannot Do

A life estate owner owns the physical property only for the duration of the life estate. The owner generally can sell only his or her interest; i.e., the life estate. The owner cannot take any action concerning the interest of the remainderman.

2. Remainder Interest

a. Future Interest in Physical Property

A life estate instrument often conveys property to one person for life (life estate owner) and to one or more others (remaindermen) upon the expiration of the life estate. A remainderman has an ownership interest in the physical property but without the right to possess and use the property until termination of the life estate.

b. Sale of Remainder Interest

Unless restricted by the instrument establishing the remainder interest, the remainderman is generally free to sell his/her interest in the physical property even before the life estate interest expires. In such cases, the market value of the remainder interest is likely to be reduced since such a sale is subject to the life estate interest.

3. Example

Mr. Heath, now deceased, had willed to his daughter a life estate in property which he had owned in fee simple. The will also designated Mr. Heath's two sons as remaindermen. Ms. Heath has the right to live on the property until her death at which time, under the terms of her father's will, the property will pass to her brothers as joint tenants.

C. Policy--Equitable Ownership Interest

Basically, existence of an equitable ownership interest is determined by a court of equity.

1. Unprobated Estate

For Medicaid purposes, an individual may have an equitable ownership interest in an unprobated estate if he or she:

- is an heir or relative of the deceased;
- receives income from the property; or
- has acquired rights in the property due to the death of the deceased in accordance with State intestacy laws.

M1120.215 contains instructions on how to determine whether an interest in an unprobated estate is a resource.

2. Trust

A trust is a right of property established by a trustor or grantor. One party (trustee) holds legal title to trust property which he or she manages for the benefit of another (beneficiary). The beneficiary does not have legal title but does have an equitable ownership interest.

M1120.200 contains instructions concerning resources treatment of trusts in the Medicaid program.



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M1120.201 contains instructions for the resources treatment of trust established on or after August 11, 1993.

3. Equitable Home Ownership

If an individual alleges equitable ownership (e.g., an unwritten ownership interest or right of use for life) obtain any pertinent documents and a signed statement from each of the parties involved regarding any arrangement that has been agreed to. Forward the documents to a medical assistance practice consultant for an opinion from legal counsel.

D. References

The following references pertain to trust situations:

- Financial institution/conservatorship accounts, S1140.200 - S1140.215
- Property held under a State's Uniform Gift to Minors Act, S1120.205
- Situations involving an agent acting in a fiduciary capacity on behalf of another party, S1120.020
- Trust established on or after August 11, 1993, M1120.201

S1110.520 PROPERTY RIGHTS WITHOUT OWNERSHIP OF THE PROPERTY

A. Introduction

An individual may have certain rights with respect to property without also having the right to dispose of the property. However, the individual may have the right to sell his/her right or interest (i.e. the right to use or possess the property).

B. Definitions

1. Leasehold

A leasehold does not designate rights of ownership. Rather, it conveys to an individual use and possession of property for a definite term and usually for an agreed rent.

2. Incorporeal Interests

There are several types of real property rights called "incorporeal interests." They do not covey ownership of the physical property itself. They convey the right to use the property but not to possess it. These rights encompass mineral and timber rights and easements (explained in more detail at S1140.110).

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M1110.530 WHOSE RESOURCES TO CONSIDER

A. Introduction

In addition to resources that actually belong to an eligible (or would-be eligible) individual, Medicaid Law provides that the resources of certain other persons are considered to be available to the individual. Therefore, all appropriate resources determinations include those other persons' resources.

B. Policy

1. Spouse of Adult Individual

The resources of an individual include those of a spouse, and the applicable resource limit is that for a couple, provided that the spouse:

- if **eligible,** lives in the same household as the individual as of the first of the month for which resources are being determined.
- if **ineligible,** lives in the same household as the individual as of the first of the month for which resources are being determined.

For institutionalized individuals with a community spouse, *see subchapter M1480.*

2. Parent(s) of Child under 18

If a blind or disabled child is under age 18 and is living in the same household with a parent, the agency must consider the parent's resources available to the child, whether or not they are actually contributed.

The applicable resource limit for a blind and/or disabled child is always that for an individual.

3. Parent(s) of Child Age 18 to 21

If a blind or disabled child age 18 to 21 is living in the same household with his parent, the agency must consider the parent(s') resources available to the child, whether or not they are actually contributed:

The applicable resource limit for a disabled or blind child is always that for an individual.

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DETERMINING ELIGIBILITY BASED ON RESOURCES

M1110.600 RULE FOR MAKING DETERMINATIONS

A. Policy Principle--Rule

Make all resource determinations per calendar month. Resource eligibility exists for the full month if countable resources were at or below the resource standard for any part of the month. *If resource amounts reported are reasonably compatible with values received from electronic verification sources, the evaluation can continue. If reported resource amounts and verified resource amounts are both below the established limit, resource eligibility is assumed to exist. If both amounts are over the resource limit, additional verification may be needed – must check for exclusions. In all situations the sources of the resources do not need to match. If the member attests to having resources below the limit and values received from electronic sources are above the limit, additional verification should be requested.*

B. Policy Principle--Significance of the Rule

1. Increase in Value of Resources

Consider any increase in the value of an individual's resources in the resources determination the month following the month in which:

- the value of an existing resource increase (e.g., the value of a share of stock goes up or installment payments increase a property's equity value);
- an individual acquires an additional resource (e.g., inherits property); or
- an individual replaces an excluded resource with one that is not excluded (e.g., sells an excluded automobile for nonexcludable cash).

2. Decrease in Value of Resources

Consider any decrease in the value of an individual's resources in the resource determination the month in which:

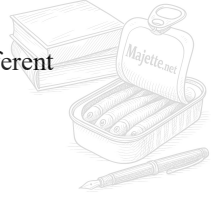
- the value of an existing resource decreases (e.g., the value of a share of stock goes down);
- an individual spends a resource (e.g., withdraws $150 from a savings account to pay bills); or
- an individual replaces a countable resource with one that is not countable (e.g., trades a countable piece of real property for an excluded automobile).

3. Treatment of Assets Under Income and Resource Counting Rules

When an individual receives an asset (real or personal property) during a month, it is evaluated under the appropriate income-counting rules in that month. If the individual retains the item into the month following the month of receipt, it is evaluated under the resource-counting rules. Do not evaluate the same asset under two sets of counting rules for the same month.

Funds cannot be both income and a resource in the same month. Income that has been added to a bank account during the month must be subtracted from the ending balance to ensure that the income is not also counted as a resource. See M1140.200.

EXCEPTION: Trusts established on or after August 11, 1993, have different counting rules. See M1120.201.



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4. Receipts from the Sale, Exchange, or Replacement of a Resource

If an individual sells, exchanges, or replaces a resource, what he/she receives in return is not income. It is a different form of resource. This includes assets which have never been subject to resources counting because the owner sold, exchanged, or replaced them in the same month in which he/she received them.

Capital gains, which are profits made from the sale of capital assets (long-term assets such as land or buildings), are also not income. Any proceeds that remain the month after this type of sale must be evaluated as a resource.

The concept of such transactions not producing income does not apply to receipts from the sale of timber, minerals, or other like items which are part of the land.

C. Example--Receipt of a Resource Considered as Income and Exchanged in Same Month

Miss Laramie, a disabled individual, received a $350 unemployment insurance benefit on January 10 at which time it was unearned income. On January 18, she used the $350 to purchase several shares of stock; i.e., she exchanged one resource (cash) for another resource (stock). We never counted the $350 cash payment as a resource because Miss Laramie exchanged it for stock in the month of receipt. The stock is not income; it is a different form of resource. Since a resource is not countable until the first moment of the month following its receipt, we first count the stock in the resources determination made as of February 1.

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CHAPTER M11

AGED, BLIND, AND DISABLED INDIVIDUALS (ABD) RESOURCES

SUBCHAPTER 20

IDENTIFYING RESOURCES

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M1120 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-34	1/1/25	Page 29
TN #DMAS-31	4/1/24	Table of Contents
TN #DMAS-18	1/1/21	Table of Contents Pages 27, 28, 29 Pages 28a through 28d were added. Pages 28 d is a runover page
TN #DMAS-11	1/1/19	Page 29
TN #DMAS-8	4/1/18	Page 22a
TN #DMAS-7	1/1/18	Table of Contents i, pages 3, 22a, 30
TN #DMAS-5	7/1/17	Pages 15, 17, 18
TN #DMAS-2	10/1/16	On page 6, updated the format of the header. Neither the date nor the policy was changed.
TN #96	10/1/11	Table of Contents Pages 24-26
TN #93	1/1/2010	Page 22

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IDENTIFYING RESOURCES

OVERVIEW

S1120.001 PURPOSE OF SUBCHAPTER

A. Introduction

This subchapter deals with the process of applying the basic principles in subchapter S1110 in determining whether property (an asset) is a resource. If it is a resource, subchapter S1130 provides guidance on possible exclusions. If a resource is not excludable, see subchapter S1140. These guidelines apply to both initial applications and to posteligibility situations.

B. Related Policies

1. Significance of Asset/ Resources Distinction	S1110.100 A.
2. Resources Defined	S1110.100 B.
3. Assets That Are Not Resources	S1110.115; S1120.100 ff.
4. Treatment of Assets as Income/ Resources	S1120.005.
5. Resource Conversion	S1110.600 B.4.

S1120.005 DISTINGUISHING RESOURCES FROM INCOME

A. Introduction

It is important to distinguish between resources and income to know which counting rules to use for any given month. An item is not subject to both income and resources counting rules in the same month.
Exception - Trusts established on of after August 11, 1993, See M1120.201

B. Policy Principles

1. Income-Counting Rules	Items received during a month are evaluated under the income-counting rules.
2. Resource-Counting Rules	Items retained as of the first moment of the month following receipt are subject to evaluation under resource-counting rules.

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C. Example

1. Situation

Beverly Thompson, a single, disabled recipient, received $275 as a birthday gift in January. She used $50 to repay a loan; spent $100 for a Series EE U.S. Savings Bond; and put the remainder ($125) in her savings account. As of February 1, the account balance was $1,400.

2. Analysis

The $275 gift was income to Ms. Thompson in January when she received it. In February, only $125 of the cash gift counts as a resource; the remaining $150 she spent or converted into another form in the same month she received it. The U.S. Savings Bond is not a resource in February since Ms. Thompson cannot legally redeem it for 6 months. However, it will become a resource on August 1, when it is first legally redeemable. The $125 that she put in her savings account is a resource (along with the $1,275 deposited previously) as of February 1.

S1120.010 FACTORS THAT MAKE PROPERTY A RESOURCE

A. Introduction

Property of any kind, including cash, cannot be a resource in a month unless, it meets all three criteria in B. below. However, it is not unusual for a nonresource to become a resource or vice versa.

B. Policy-Resources Criteria

1. Ownership Interest

An individual must have some form of ownership interest in property in order for the property to be considered a resource. The fact that an individual has access to property, or has a legal right to use it, does not make it a resource if there is no ownership interest (S1110.100).

2. Legal Right to Access (Spend or Convert Property)

An individual must have a legal right to access property. Despite having an ownership interest, property cannot be a resource if the owner lacks the legal ability to access funds for spending or to convert noncash property into cash (S1110.100).

The fact that an owner does not have physical possession of property does not mean it is not his/her resource, provided the owner still has the legal ability to spend it or convert it to cash. However, see S1140.240 if a U.S. Savings Bond is involved.

3. Legal Ability to Use for Personal Support and Maintenance

Even with ownership interest and legal ability to access property, a legal restriction against the property's use for the owner's own support and maintenance means the property is not his/her resource (S1110.100).

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C. Policy – Access to Resources

1. Access via an Agent

We consider that an individual has free access to, and unrestricted use of, property even when he/she can take those actions only through an agent; e.g., a representative payee, guardian, etc. (S1120.020). **For real property where reasonable but unsuccessful efforts to sell must be established, see M1130.140.**

2. Access Only via Litigation

When there is a legal bar to sale of property (e.g., if a co-owner legally blocks sale of jointly-owned property), we do not require an individual to undertake litigation in order to accomplish sale or access. The property is not a resource under such circumstances in a month if a legal bar exists anytime during that month.

An individual's interest in an unprobated estate is a countable resource. An heir can initiate a court action to partition. If a partition suit is necessary (because at least one other owner of or heir to the property will not agree to sell the property) in order for the individual to liquidate the interest, estimated partition costs may be deducted from the property's value.

An applicant or recipient's proportional share of the value of property owned jointly with another person to whom the applicant or recipient is not married as tenants in common or joint tenants with the right of survivorship at common law is counted as a resource unless it is exempt property or is unsalable.

3. Access via Petition - Conservatorship Accounts

If State law requires that funds in a conservatorship account be made available for the care and maintenance of an individual, we assume, absent evidence to the contrary, that funds in such an account are available for the individual's support and maintenance and are, therefore, that individual's resource. This is true despite the fact that the individual or his/her agent is required to petition the court to withdraw funds for the individual's support and maintenance. See S1140.215 for instructions concerning conservatorship accounts.

D. Examples

1. Lack of Ownership

a. **Situation** - In response to unstated income development, Mr. John Hart, explains that his brother, Ted, who lives in an adjacent State, allows him (John) access to his bank account in emergencies. John Hart says he withdraws funds to pay an overdue utility bill to avoid shutoff.

The EW confirms that the account is titled "Ted Hart by Ted Hart or John Hart." John Hart states that he uses the funds solely for his own benefit and not as an agent for his brother.

b. **Analysis** - Even though John Hart has unrestricted access to the account and can use the funds at his own discretion, the funds are not his resources because he has no ownership interest in them. The title of the account clearly designates Ted Hart as sole owner. However, whatever funds John withdraws from Ted's account are John's income in the month of the withdrawal.



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c. **Situation** - A member of an Indian tribe states that he has several items, valued at several thousand dollars, that he would not sell because they are ceremonial in nature (clothing and beadwork). The EW questions him about the items and determines they were "entrusted" to him by the tribe for safekeeping.

d. **Analysis** - In order for an asset to be a resource, the individual must have an ownership interest in the asset. Since the individual in the above situation does not own the ceremonial items, they are not his resources.

2. Court Order Restricts Access

a. **Situation -** At the time of his divorce, Mark Thomas, an SSI recipient, was sole owner of the house in which his ex-wife and their two young sons are living. Under the terms of the divorce decree, Mr. Thomas must pay the taxes on the property and maintain it as a home for his ex-wife and the children until the younger boy reaches age 18. The decree also specifies that he is free to sell the property only after the younger boy's eighteenth birthday.

b. **Analysis** - Although Mr. Thomas clearly owns the property, he is legally barred from converting it to cash to be used for his own support and maintenance until 1997. Therefore, it is not his resource until the month following the month of his younger son's eighteenth birthday.

3. Binding Agreement Restricts Access

a. **Situation** - As a gift from their parents, Tom Brown, a Medicaid recipient, and his brother who is not eligible for Medicaid, received some shares of stock valued at $3,000. The stock certificates show that the brothers are joint tenants (S1110.510 C.2.), but the brothers have a legally binding agreement that one will not sell without consent of the other. The EW confirms that Tom's brother will not consent to sell.

b. **Analysis** - Normally, the gift would be valued under the income rules in the month of receipt and the resources rules thereafter. However, since Tom's brother will not consent to sale of the stock, Tom's share of the stock is not income in the month of receipt nor resources thereafter since it cannot be used for Tom's support and maintenance. If Tom's brother consents to sell, Tom's share would be a countable resource beginning with the month following the month that consent was given.

4. Lack of Possession Restricts Ability to Use-Savings Bonds

a. **Situation** - During a posteligibility review, the EW learns that George Jones, a Medicaid recipient, is co-owner along with his father of U.S. Savings Bonds with a face value of $3,500. The EW learns that George's father bought the bonds over a period of years with his own money and designated George as co-owner. The bonds are in the father's safe deposit bo to which he will not give George access under any circumstances.

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b. **Analysis** - The EW questions George's father and confirms that he will not give George the bonds under any circumstances. George's father states that, George can take possession of the bonds only after he (the father) dies. Generally, lack of physical possession of an otherwise liquid resource does not affect its status as a resource. However, physical possession of savings bonds is a legal requirement for cashing them. Although George is a legal owner, he cannot legally redeem the bonds for his own use. Therefore, they are not his resources.

5. Insurance Settlement Restricts Use

a. **Situation** - Bob Warfield, a Medicaid recipient, was injured in an automobile accident. A court awarded him damages of $10,000 to be used solely for medical expenses related to the accident.

b. **Analysis** - Although Mr. Warfield owns the funds and has direct access to them, he is not legally free to use them for his own support and maintenance. Therefore, the award funds are neither income nor resources.

Third party liability should be entered during enrollment.

6. No Access Without Litigation

a. **Situation** - Andrea Matthews, a disabled Medicaid recipient, has been separated from her spouse, who is not eligible for Medicaid, for 5 years. She and her spouse own a summer cottage in another State as tenants-by-the-entirety. Her spouse lives in the cottage and refuses to sell.

b. **Analysis** - If Ms. Matthews were to divorce her husband, she would, as a tenant-in-common, have the right to market her interest in the property without her ex-spouse's consent. However, since we do not require litigation to obtain access, the property is not a resource unless her husband changes his mind about the sale. Therefore, the cottage is not Ms. Matthew's resource. Even if Ms. Matthews could market her ownership interest in the cottage, for a QDWI, QMB, and SLMB coverage only, the cottage would be excluded from countable resources if its sale would cause undue hardship for Mr. Matthews due to loss of housing (S1130.130 in Appendix 2).

S1120.020 TRANSACTIONS INVOLVING AGENTS

A. Introduction

An eligible individual (EI) or deemor may have an agent to act on his/her behalf or may serve as an agent for someone else. When an agency relationship exists, it is important to distinguish an agent's actions on his/her own behalf from those on behalf of the person for whom he/she serves as agent.

B. Definitions

1. Agent

An agent is a person or organization acting on behalf of and/or with the authorization of another person. For Medicaid purposes, the term applies to anyone acting in a fiduciary capacity, whether formal or informal, and regardless of the applicable title (representative payee, conservator, guardian, etc.).

2. Ward

A ward, as used in this section, is the categorical designation of a party for whom an agent has authority to act. This is not necessarily a "ward" in the legal sense.

C. Operating Policies-Agent Holds Assets

1. Actions by Agent

For purposes of this section, an action by someone in his/her capacity as an agent is equivalent to an action by the ward for whom he/she acts. For example, RSDI funds held by a representative payee for a title II beneficiary are the same as funds held by the beneficiary himself.



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2. Status of Assets Held for Ward

Unless there is a legal restriction on the agent's access to assets held for a ward or against their use for the ward's support and maintenance, the assets are the ward's resources. They are not the agent's resources since the agent has no ownership interest in them and often is not legally free to use them for his/her own support and maintenance.

3. Property Title Must Show Ownership

An agent holding property of any kind for a ward must keep it in a form that clearly shows ownership by the ward.

D. Operating Policies- Improperly Titled Financial Account

The most common type of improperly titled account is the savings account designated as held "in trust for" a ward. This form of holding is not a formal trust (M1120.200) and is misleading as to ownership of the funds. If State law does not recognize the funds as the ward's property, see E.3. below. If evaluating an improperly titled account, consult your Regional Coordinator.

1. Singly Owned Account; EI/Deemor Is Ward

a. Agent Agrees Funds Belong to Ward - If there is an agency relationship so that deposits to the account are income to the ward, not the agent (S0810.120): we
- assume the funds are the ward's property; and
- request that the agent change the account designation.

b. Agent Does Not Agree Funds Belong to Ward - If the agent does not agree that the funds belong to the ward and refuses to correct the account title, we do not treat the funds as the ward's resources. See E.4. if the agent is a representative payee. See E.3. b. if the agent is not a representative payee.

2. Singly Owned Account; EI/Deemor Is Agent

Although deposits to the account are not the agent's income per S0810.120.D 2, we treat the account as the agent's resource. The account is the resource of the person shown as owner on the account title.

3. Jointly Owned Account

Regardless of whether the EI/deemor is ward or agent, an agent can rebut ownership of the funds and establish that they are the ward's property (S1140.205).

E. Development and Documentation

1. Verify Agency Relationship

Verify any allegation of an agency relationship per S0810.120 F.

2. Determine Resources

Document your decisions concerning the form and value of resources belonging to the EI/deemor. Follow the guidelines in C. and D. above, as well as in sections dealing with the specific type of property involved.

3. Improperly Titled Financial Account; EI/Deemor Has Agent

a. Agent Acknowledges Funds as Ward's
- Document the file with the agent's signed statement as to the ward's ownership.
- Ask the agent to have the account retitled.
- Treat the funds as the ward's property.

b. Agent Is Not Representative Payee and Does Not Acknowledge Funds as Ward's
If an agent (other than a representative payee) has set up an account incorrectly, will not change the account designation, and will not acknowledge the funds as the ward's:
- document the file with the agent's refusal;
- do not treat the funds as the ward's property; and
- see S0820.120 E. for the income rules that apply when the EI/deemor has an agent.

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4. Representative Payee is Agent Who Does Not Acknowledge Funds As Ward's

a. If the conserved funds are SSI or RSDI funds and the representative payee will not change the account designation and acknowledge the ward's ownership of the funds:

- do not treat the funds as the EI's or deemor's property

b. Situation Changes - Consider the funds the ward's property the month following the month in which:

- the representative payee designates the funds properly; or
- a new representative payee establishes the account correctly.

NOTE: Do not consider any conserved SSI or RSDI funds as the EI's or deemor's income in the month the account is redesignated (S1120.022.B.2.)

F. Related Policies

1. Misuse of Funds by Representative Payee Who Is an EI or Deemor

See S0810.120 D.4. concerning misused funds as income to the agent. If the agent retains the misused funds, consider them his/her resources effective with the month following the month the funds are counted as income.

2. Representative Payee

SSA selects representative payees for recipients who are unable to manage their own funds. Representative payees have financial jurisdiction only over financial transactions involving SSI/RSDI benefits.

3. Agents and Income Determina-tions

For the effect on the income determinations of fees paid to an agent, misuse of funds, and correctly titled accounts, see S0810.120.

S1120.022 CONSERVED FUNDS WHEN FORMALLY DESIGNATED AGENT CHANGES

A. Introduction

1. General

An agent designated formally by an agency or court may conserve funds not used for a ward's (beneficiary's) current needs. If there is a change of agent, the former agent may return these savings to SSA or other paying agency (e.g., Veterans Administration).

2. Funds Reissued

SSA or other paying agency may reissue accumulated funds to a new payee or directly to the ward. The reissued funds may be paid in a lump sum or in installments and may be combined in a check with a current month's benefits.

B. Policy Principles

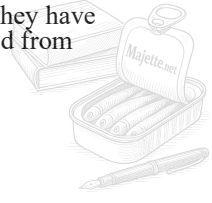
1. Conserved Funds as Resources

Conserved funds are a ward's resources while SSA or another agency is holding them for the ward. This is the case because the ward:

- owns the funds; and
- is legally entitled to use them (or have them used on his/her behalf) for his/her own support and maintenance.

2. Reissued Funds Not Income

Conserved funds are not income to the owner when reissued because they have been his/her resources while held for him/her. They may have changed from nonliquid to liquid in form but they are not new funds.



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3. New Funds Issued Subject to Income Counting Rules If a single check contains both reissued funds and new funds that do not represent income previously charged for a prior month, the new funds are subject to income-counting rules.

ASSETS THAT ARE NOT RESOURCES

S1120.100 HOME ENERGY ASSISTANCE/SUPPORT AND MAINTENANCE ASSISTANCE

A. Policy Principle The term "resources" does not include home energy assistance/support and maintenance assistance (HEA/SMA) which qualifies for exclusion from income.

B. Operating Policy We do not develop for HEA/SMA unless:

- retained funds, plus other countable resources, exceed the applicable resource standard, and
- resources exclusive of the alleged HEA/SMA funds would be within the limit.

C. Development and Documentation When it is necessary to develop resources which include HEA/SMA, obtain the individual's signed statement identifying (if not already documented in file):

- amount of HEA/SMA funds received;
- when received and from what source, and
- amount of remaining funds.

S1120.110 CERTAIN CASH TO PURCHASE MEDICAL OR SOCIAL SERVICES

A. Introduction An individual cannot always disburse in the month of receipt cash given him/her to purchase approved medical or social services. To permit use of such funds in the manner intended, it is reasonable to assume, for a limited time, that the individual will use them to pay for the approved services and, therefore, that they are not available for his/her support and maintenance.

B. Policy

1. What Is Not a Resource Effective July 1, 1988, a cash payment for medical or social services that is not income under S0815.050, also is not a resource for one calendar month following the month of receipt.

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2. Exception The rule in 1. above does not apply to cash received as repayment for medical or social services bills an individual has already paid. Even though not income, such cash is a resource and, if retained, is subject to resource-counting rules as of the first moment of the month following receipt.

3. Determination If the cash was neither income nor payment, it is not a resource for one calendar month following the month of receipt.

D. References

- Commingled funds, S1130.700.

S1120.112 RETROACTIVE IN-HOME SUPPORTIVE SERVICES PAYMENTS TO INELIGIBLE SPOUSES AND PARENTS

A. Introduction

In limited circumstances, governmental programs will pay a spouse or parent to provide a disabled spouse or child with certain in-home supportive (chore, attendant, and homemaker) services (IHSS). IHSS payments are income when received by the ineligible spouse or parent but are not included as income for deeming purposes.

So that the intended benefit of having services provided by a caregiver in the home can be realized, and to avoid Medicaid ineligibility due to excess deemed resources, the regulations provide for a reasonable period of time during which retroactive IHSS payments are not considered resources and, therefore, are not subject to resources deeming.

B. Policy

1. When an IHSS Payment Is Not a Resource A **retroactive** IHSS payment paid to an ineligible spouse or parent to provide chore, attendant, or homemaker services to an eligible individual is not a resource for one calendar month following the month of receipt. If retained into the second calendar month following receipt, the payment is a resource subject to deeming.

This provision applies only to **retroactive** IHSS payments.

2. "Retroactive" IHSS Payment For the purposes of this provision, a "retroactive" IHSS payment is one that is paid after the month in which it was due. If payment is made in the month due, but following the month in which services were rendered, such payment is not considered “retroactive” for purposes of this provision.

3. Interest Included in IHSS Payment If the retroactive IHSS payment includes an interest amount, the entire payment, and any interest included in the retroactive payment, is subject to the rule 1. above.

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S1120.115 DEATH BENEFITS FOR LAST ILLNESS AND BURIAL EXPENSES

A. Introduction

Death benefits, including gifts and inheritances an individual will use to pay the deceased's last illness and burial expenses, may still be on hand the first moment of the month following the month of receipt. It is reasonable to assume, for a limited time, that death benefits will be used for last illness and burial expenses and are not available for support and maintenance.

B. Policy

1. When a Death Benefit Is Not a Resource

Effective August 1991, death benefits, including gifts and inheritances, that are not income under S0830.545, also are not a resource for **one calendar month** following the month of receipt. If retained until the first moment of the second calendar month following receipt, death benefits are resources.

2. Exception--Bills Already Paid

Death benefits that are repayment of bills for last illness and burial expenses the individual has already paid are subject to resources rules beginning with the first moment of the month following the month of receipt.

C. Procedure

1. Development Not Required

Do not develop unless the amount retained plus other countable resources exceeds the applicable resources limit.

2. Development Required

If an individual would have excess resources, determine and document whether death benefits:

- were income under S0830.545; and
- if not income, whether the amounts were for repayment of bills already paid.

If you determine that death benefits should not be counted for one calendar month, document the amounts and that month.

D. References

- Death benefits as income, S0830.545.

E. Example--Death Benefits Not a Resource

1. Situation

As a result of her uncle's death, Barbara Smith, a disabled recipient, receives $4,000 in July as beneficiary of his life insurance policy. She intends to spend the entire amount on his last illness and burial expenses. She has already received bills totaling $900 which she pays. On August 1, she receives a funeral bill for $2,900 and a few days later receives a cash gift of $500 to be used for last illness and burial expenses. She pays the $2,900 funeral bill in August and intends to use the remainder to pay some hospital expenses.

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2. Analysis

Neither the $4,000 Ms. Smith receives in July nor the $500 she receives in August is unearned income. Since she uses $900 of the $4,000 life insurance check in July, as of August 1, she has a $3,100 balance which is not a resource for August. During August she pays the $2,900 bill and then has $200 left. However, the $500 she receives in August gives her $700 to use for funeral expenses. She must spend $200 in August for burial or last illness expenses, otherwise, the $200 will count as a resource September 1. She has until the end of September to spend the remaining $500, otherwise it will count as a resource October 1.

F. Example--Death Benefits Resource

1. Situation

Ruth Taylor, a 68 year old recipient, has total countable resources of $1,980 consisting of a $1,000 savings account and $980 checking account. Her brother died in late October. In November she receives $3,000 as beneficiary of her brother's life insurance policy. She has last illness and burial expenses of $2,750 to pay. There will be no more bills after these.

2. Analysis

Of the $3,000 Ms. Taylor received, $250 is unearned income in November because last illness and burial expenses are only $2,750. The $2,750 is not unearned income and will not be a resource until January 1 if she still has it then. The $250 amount will be a resource on December 1. This money will be added to the money she has in her checking and savings accounts. If the total is more than $2,000, she will be ineligible for Medicaid.

S1120.150 GIFTS OF DOMESTIC TRAVEL TICKETS

A. Policy

This policy is effective for tickets received on or after March 1, 1990.

The value of a ticket for domestic travel received by an individual (or spouse) is not a resource if the ticket is:

- received as a gift;
- not **converted** to cash; and
- excluded from income per S0830.521.

B. Procedure

1. When to Develop

Develop under this section when an individual alleges having retained an uncashed ticket for domestic travel **and** the value of the ticket, plus the value of other countable resources, exceeds the applicable resource limit.

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PROPERTY THAT MAY OR MAY NOT BE A RESOURCE

M1120.200 TRUST PROPERTY

A. Introduction

A trust is a legal arrangement involving property and ownership interests. Property held in a trust may or may not be considered a resource. The general rules concerning resources apply to evaluating the resource status of property held in a trust.

Trusts are often complex legal arrangements involving State law and legal principles that an eligibility worker (EW) is not expected to know or be able to apply without legal counsel.

Therefore, the following instructions may only be sufficient for you to recognize that an issue is present and should be referred to the Regional Coordinator or Assistant Attorney General through your regional office. When in doubt, refer the issue for a legal opinion.

The enactment of OBRA 93 changed the evaluation of trusts established (other than by a will) on or after August 11, 1993. Assets of trusts established other than by a will may be countable as income, resources, or as asset transfers. Trusts established for disabled individuals are treated differently; see M1120.202.

Policy relating to trusts is located in the following sections.

- M1120.200, Trust Property
- M1120.201, Trust Established on or after August 11, 1993
- M1120.202, Trusts Established for Disabled Individuals On or After August 11, 1993
- M1130.520, Trusts Established Between July 1, 1993 and August 11, 1993
- M1140.400 Trust Established By A Will
- M1140.401, Trusts Which Were Not Created by a Will
- M1140.402, Medicaid Qualifying Trust (Created Prior to August 11, 1993)
- M1140.403, Trusts Created After July 1, 1993 and Before August 11, 1993 With Corpus In Excess of $25,000
- M1140.404, Trust Established on or After August 11, 1993

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B. Definitions

1. Trust	A trust is a property interest whereby property is held by an individual (trustee) subject to a fiduciary duty to use the property for the benefit of another (the beneficiary).
2. Grantor	A grantor (also called a settlor or trustor) is a person who creates a trust. An individual may be a grantor if an agent, or other individual legally empowered to act on his/her behalf (e.g., a legal guardian, representative payee for title II/XVI benefits, a person acting under a power of attorney or conservator), establishes the trust with funds or property that belong to the individual. The terms grantor, trustor, and settlor may be used interchangeably.
3. Trustee	A trustee is a person or entity who holds legal title to property for the use or benefit of another. In most instances, the trustee has no legal right to revoke the trust or use the property for his/her own benefit.
4. Trust Beneficiary	A trust beneficiary is a person for whose benefit a trust exists. A beneficiary does not hold legal title to trust property but does have an equitable ownership interest in it.

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5. Trust Principal	The trust principal is the property placed in trust by the grantor which the trustee holds, subject to the rights of the beneficiary plus any trust earnings paid into the trust and left to accumulate.
6. Trust Earnings (Income)	Trust earnings or income are amounts earned by trust principal. They may take such forms as interest, dividends, royalties, rents, etc. These amounts are unearned income to the person legally able to use them for personal support and maintenance.
7. Totten Trust	A Totten trust is a tentative trust in which a grantor makes himself/ herself trustee of his/her own funds for the benefit of another. The trustee can revoke a Totten trust at any time. Should the trustee die without revoking the trust, ownership of the money passes to the beneficiary.
8. Grantor Trust	A grantor trust is a trust in which the grantor of the trust is also the sole beneficiary of the trust.
9. Mandatory Trust	A mandatory trust is a trust which requires the trustee to pay trust earnings or principal to or for the benefit of the **beneficiary** at certain times. The trust may require disbursement of a specified percentage or dollar amount of the trust earnings or may obligate the trustee to spend income and principal, as necessary, to provide a specified standard of care. The trustee has no discretion as to the amount of the payment or to whom it will be distributed.
10. Discretionary Trust	A discretionary trust is a trust in which the trustee has full discretion as to the time, purpose and amount of all distributions. The trustee may pay to or for the benefit of the beneficiary, all or none of the trust as he or she considers appropriate. The beneficiary has no control over the trust. The kind and degree of the "discretion" given to the trustee is determined by the terms of the trust.
11. Medicaid Qualifying Trust	A "Medicaid qualifying trust" is a trust, or similar legal device, established (other than by a will) by an individual or an individual's spouse prior to August 11, 1993 under which the individual may be beneficiary of all or part of the payments from the trust. The distribution of such payments is determined by one or more trustees who are permitted to exercise discretion with respect to the distribution to the individual. EXCEPTION: A trust or initial trust decree established **prior to** April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded is not a "Medicaid Qualifying Trust".
12. Residual Beneficiary	A residual beneficiary is not a current beneficiary of a trust, but will receive the residual benefit of the trust contingent upon the occurrence of a specific event, e.g., the death of the primary beneficiary.
13. Fiduciary	A person or other entity that holds something in trust for another and has a legal obligation to act in the best interests of that person in all matters regarding the property held, as the executor of a will who is responsible for preserving assets and investing wisely, when required to do so.



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C. Policy-Accounts That May or May Not Be Trusts

1. Accounts That Are Not Trusts

The following accounts and instruments are similar to trusts and may be titled as trusts, but should generally not be developed under these instructions for Medicaid purposes.

a. Conservatorship Accounts

These accounts, established by a court, are usually administered by a court-appointed conservator for the benefit of an individual. They differ from a trust in that the "beneficiary" retains ownership of all of the assets, although in some cases they may not be available for support and maintenance. (See S1140.215 for instructions pertaining to conservatorship accounts.)

b. Patient Trust Accounts

Many nursing homes and institutions maintain so called "patient trust accounts" for individuals to provide them with toiletries, cigarettes, candy and sundries. Although titled trust accounts, these are agency accounts. The individual owns the money in the account which the institution is merely holding for him or her and making disbursements on his or her behalf as necessary. (See S1120.020, S0810.120 for information on transactions involving agents.)

2. "In Trust For" Financial Accounts

These accounts may or may not be trusts depending on the circumstances in the individual case. Examples of the most common situations follow:

a. Representative Payee Accounts

One of the most common types of "in trust for" accounts are representative payee accounts. These accounts are not trusts, but improperly titled accounts and are misleading as to the actual owner of the funds. If a representative payee deposits current or conserved benefits in an account, the account must be titled to reflect the beneficiary's ownership interest. (See S1120.020 and S0810.120 for instructions pertaining to agency accounts.)

b. Totten Trusts

An "in trust for" financial institution account may be a Totten trust if an individual deposits his or her own funds in an account and holds the account as owner for the benefit of another individual(s).

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D. Policy - Trust as Resources

1. Trusts Which Are Resources

a. General

If an individual (applicant or recipient) has legal authority to revoke the trust and then use the funds to meet his food, clothing or shelter needs, or if the individual can direct the use of the trust principal for his/her support and maintenance under the terms of the trust, the trust principal is a resource for Medicaid purposes.

If the individual can sell his beneficial interest in a trust, that interest is a resource. For example, if the trust provides for payment of $100 per month to the beneficiary for spending money, absent a prohibition to the contrary, the beneficiary may be able to sell the right to future payments for a lump-sum payment.

- M1120.200, B, 11
- M1140.402, Medicaid Qualifying Trust

b. Authority to Revoke Trust or Use Assets

- Grantor

  In some cases, the authority to revoke a trust is held by the grantor. Even if the power to revoke a trust is not specifically retained, a trust may be revocable in certain situations. (See B.8. above and 3. below for information on grantor trusts.) Additionally, State law may contain presumptions as to the revocability of trusts. If the trust principal reverts to the grantor upon revocation and can be used for support and maintenance, then the principal is a resource.

- Beneficiary

  A beneficiary generally does not have the power to revoke a trust. However, the trust may be a resource to the beneficiary, in the rare instance, where he/she has the authority under the trust to direct the use of the trust principal. (The authority to control the trust principal may be either specific trust provisions allowing the beneficiary to act on his/her own or by ordering actions by the trustee.) In such a case, the beneficiary's equitable ownership in the trust principal and his/her ability to use it for support and maintenance means it is a resource.

  The beneficiary's right to mandatory periodic payments may be a resource equal to the present value of the anticipated string of payments unless a valid spendthrift clause or other language prohibits anticipation of payments.

  While a trustee may have discretion to use the trust principal for the benefit of the beneficiary, the trustee should be considered a third party and not an agent of the beneficiary, i.e., the actions of the trustee are not the actions of the beneficiary, unless the trust specifically so provides.

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- Trustee

  Occasionally, a trustee may have the legal authority to revoke a trust. However, the trust is not a resource to the trustee unless he/she becomes the owner of the trust principal upon revocation. The trustee should be considered a third party. Although the trustee has access to the principal for the benefit of the beneficiary, this does not mean that the principal is the trustee's resource. If the trustee has the legal authority to withdraw and use the trust principal for his/her own support and maintenance, the principal is the trustee's resource for Medicaid purposes in the amount that can be used.

- Totten trust

  The creator of a Totten trust has the authority to revoke the financial account trust at any time. Therefore, the funds in the account are his/her resource.

2. Trusts Which May Not Be A Resource

If an individual does not have the legal authority to revoke the trust or direct the use of the trust assets for his/her own support and maintenance, the trust principal is not the individual's resource.

The revocability of a trust and the ability to direct the use of the trust principal depends on the terms of the trust agreement and/or on State or federal law. If a trust is irrevocable by its terms and under State law cannot be used by an individual for support and maintenance, it may not be a resource. Evaluate the trust in accordance with the following sections.

- M1120.201, Trusts Established on or after August 11, 1993
- M1120.202, Trusts Established for Disabled Individuals on or after August 11, 1993.
- M1130.520, Trusts Established Between July 1, 1993 and August 10, 1993
- M1140.400, Trust Created By A Will
- M1140.402, Medicaid Qualifying Trust (created prior to August 11, 1993)
- M1140.403, Trusts Created After July 1, 1993 and before August 11, 1993 with Corpus in Excess of $25,000

3. Revocability of Grantor Trusts

Virginia follows the general principle of trust law that if a grantor is also the sole beneficiary of a trust, the trust is revocable regardless of language in the trust document to the contrary.

Virginia recognizes the irrevocability of a grantor trust if there is a named "residual beneficiary" in the trust document who would, for example, receive the principal upon the grantor's death or the occurrence of some specific event.

NOTE: The above policies regarding grantor trusts may or may not apply in some States.



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E. Policy – Disbursements from Trusts

1. When Trust Principal Is Not a Resource

If the trust principal is not a resource, disbursements from the trust may be income to the beneficiary, depending on the nature of the disbursements. Regular rules to determine when income is available apply.

a. Disbursements Which are Income

Cash paid directly from the trust to the individual is unearned income.

b. Disbursements Which Result in Receipt of In-kind Support and Maintenance

Food, clothing or shelter received as a result of disbursements from the trust by the trustee to a third party are income in the form of in-kind support and maintenance and are not counted for Medicaid purposes.

c. Disbursements Which Are Not Income

Disbursements from the trust by the trustee to a third party that result in the individual receiving items that are not food, clothing or shelter are not income. For example, if trust funds are paid to a provider of medical services for care rendered to the individual, the disbursements are not income for Medicaid purposes.

2. When Trust Principal Is a Resource – Trusts Created By Will or Prior to Aug. 11, 1993

If the trust principal is a resource to the individual, disbursements from the trust principal received by the individual are not income, but conversion of a resource. *However, trust earnings are income.* See S1110.100 for instructions pertaining to conversion of resources from one form to another and F.2. below for treatment of income when the trust principal is a resource.

3. When Trust Principle is a Resource – For Trust Created on or After August 11, 1993

Effective August 11, 1993:

- payments for the benefit of the individual are counted as unearned income;
- corpus is a resource, and
- payments to other individual(s) are evaluated as asset-transfer;
- trust earnings, e.g., interest, are income.

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F. Policy Earnings/Additions to Trusts

1. Trust Principal Is Not a Resource

a. Trust Earnings

Trust earnings are not income to the trustee or grantor unless designated as belonging to the trustee or grantor under the terms of the trust; e.g., as fees payable to the trustee or interest payable to the grantor.

Trust earnings are not income to the Medicaid *applicant*/recipient who is a trust beneficiary unless the trust directs, or the trustee makes, payment to the beneficiary.

b. Additions to Principal

Additions to trust principal made directly to the trust are not income to the grantor, trustee or beneficiary. Exceptions to this rule are listed in c. and d. below.

c. Exceptions

Certain payments are non-assignable by law and, therefore, are income to the individual entitled to receive the payment under regular income rules. They may not be paid directly into a trust, but individuals may attempt to structure trusts so that it appears that they are so paid. Non-assignable payments included:

- *Temporary Assistance to Needy Families (TANF);*
- Railroad Retirement Board-administered pensions;
- Veterans pensions and assistance;
- Federal employee retirement payments (CSRS, FERS) administered by the Office of Personnel Management;
- Social Security title II and SSI payments; and
- Private pensions under the Employee Retirement Income Security Act (ERISA) (29 U.S.C.A. section 1056(d)).

d. Assignment of Income

A legally assignable payment (see c. above for what is not assignable), that is assigned to a trust, is income for Medicaid purposes unless the assignment is irrevocable. If the assignment is revocable, the payment is income to the individual legally entitled to receive it.

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2. Trust Principal Is a Resource

a. Trust Earnings

Trust earnings are income to the individual for whom the trust principal is a resource, unless the terms of the trust make the earnings the property of another. See S0810.030 for when income is counted.

b. Additions to Principal

Additions to principal may be income or conversion of a resource, depending on the source of the funds. If funds from a third party are deposited into the trust, the funds are income to the individual. If funds are transferred from an account owned by the individual to the trust, the funds are not income, but conversion of a resource from one account to another.

G. References

- Agency Relationships, S1120.020, S0810.120
- Financial Institution Accounts, S1140.200
- Third Party Vendor Payments, S0835.360

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M1120.201 TRUSTS ESTABLISHED ON OR AFTER AUGUST 11, 1993

A. Introduction

The enactment of OBRA 93 affects the treatment of trusts. For purposes of determining an individual's eligibility for Medicaid, the rules specified in this section shall apply to a trust established by such individual on or after August 11, 1993.

EXCEPTION: Certain trusts established for disabled individuals. See M1120.202.

B. Definitions

1. Assets

Assets means both income and resources of an individual and an individual's spouse. Assets of a trust established other than by a will may be countable as income, resources, or as asset transfers.

2. Revocable Trust

A revocable trust is a trust that can be legally revoked by the individual who established it. If a trust is revocable, the entire amount of the principle or corpus is counted as a resource.

3. Irrevocable Trust

An irrevocable trust is a trust that cannot be legally revoked by the individual who established it.

C. Policy

1. Who Established Trust

An individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by a will:

- the individual,
- 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,
- 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.

NOTE: The individual does not establish a trust when a funeral home director is named as the "grantor" on the trust document. See M1140.404.

2. Treatment of Trust Assets

In the case of a trust the corpus of which includes assets of an individual and assets of any other person or persons, the provisions of this section shall apply to the portion of the trust attributable to the assets of the individual.

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This section shall apply without regard to:

- the purpose for which a trust is established,
- whether the trustees have or exercise any discretion under the trust,
- any restrictions on when or whether distributions may be made from the trust, or
- any restriction on the use of *or* distribution from the trust.

a. In the case of a **revocable trust:**
   - the corpus of the trust shall be considered resources available to the individual.
   - Payments from the trust to or for the benefit of the individual shall be considered income of the individual.
   - Any other payments from the trust shall be considered assets disposed of by the individual.

b. In the case of an **irrevocable trust** if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered
   - resources available to the individual, and
   - payments from that portion of the corpus or income to or for the benefit of the individual, shall be considered income of the individual, and
   - payments from that portion of the corpus or income for any other purpose, shall be considered a transfer of assets by the individual.

   Any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to or for the benefit of an individual shall be considered,
   - as of the date *the trust is established* (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for evaluation of asset transfers, and
   - the value of the trust shall be determined for purposes of such asset transfer by including the amount of any payments made from such portion of the trust after such date.

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M1120.202 TRUSTS ESTABLISHED FOR DISABLED INDIVIDUAL ON OR AFTER AUGUST 11, 1993

A. Introduction

Irrevocable trusts established after August 11, 1993 solely for the benefit of disabled individuals will not affect Medicaid eligibility. The following policy must be met for trusts of disabled individuals.

Disability must be met as defined by SSA or SSI.

B. Policy

1. Trusts for Disabled Individual Under Age 65 (Individual Trust)

A trust containing the assets of an individual under age 65 who is disabled and which is established for the benefit of such individual by a

- a parent,
- a grandparent
- legal guardian of the individual,
- a court, or
- *the individual (when the trust was established on or after December 12, 2016)*

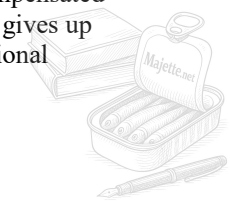
The trust policy in M1120.201 will not be applied, if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual.

2. Trusts for Disabled Individuals ("Pooled" Trust Funds)

A pooled trust is one containing the assets of a disabled individual (no age requirement). The trust must meet the following conditions to be exempt from the trust policy in M1120.201.

- The trust was established by and is managed by a non-profit association.
- A separate account is maintained for each beneficiary of the trust but, for purposes of investment and management of funds, the trust pools these accounts.
- Accounts in the trust are established solely for the benefit of disabled individuals by the parent, grandparent, or legal guardian of such individuals, by such individuals or by a court.
- To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State Plan.

For an individual who meets the definition of an institutionalized individual in M1410,010 B.2, the placement of the individual's funds into a pooled trust when the individual is age 65 years or older must be evaluated as an uncompensated transfer, if the trust is structured such that the individual irrevocably gives up ownership of funds placed in the trusts. See M1450.550 D for additional information.



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3. Transfers of Income into a Trust Established for a Disabled Individual

The treatment of income transferred into a *trust established for a disabled individual or pooled trust* as described in M1120.202 is dictated *for Medicaid eligibility purposes* by federal rules for the treatment of *transferring* such income *into* a Qualified Income Trust, also referred to as a Miller Trust. *Although* Virginia **does not** recognize Miller trusts, *the Medicaid income exclusion provided for in a Miller trust* is equally applicable *in states that do not have Miller Trusts to trusts established for disabled individuals*.

*Under Miller Trust rules, income received and placed into a trust established for a disabled individual or pooled trust is not counted in determining the individual's income eligibility. Additionally, if the **right** to income is transferred to the trust, the income is not counted because it does not meet the Supplemental Security Income (SSI) and Medicaid definitions of income.*

Transfers of income and the right to income into a trust established for a disabled individual or pooled trust are not considered uncompensated transfers of assets when the individual is under age 65.

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S1120.205 UNIFORM GIFTS TO MINORS ACT

A. Introduction

1. General

Virginia like most states has adopted the Uniform Gifts to Minors Act (**UGMA)** which permits making to minors gifts which are free of tax burdens. The UGMA is sometimes called the Uniform Transfers to Minors Act.

When a gift is made to a minor under the Uniform Gifts to Minors Act (U.G.M.A.), the minor does not have the right to liquidate the property until he/she reaches an age (age of majority) specified by State law.

In Virginia the age of majority was lowered from age 21 to age 18 for gifts, under the U.G.M.A., made after June 30, 1973. A 1984 amendment, which became effective July 1, 1984, extended the definition of "minor" to include a person who has not attained the age of 21 years if the gift to the minor expressly provides that the custodial property shall be conveyed to the minor on his/her attaining the age of 21 years. Such provisions may be made by making the gift under the "Virginia Uniform Gifts to Minors Act (21)."

2. UGMA Provisions

Under UGMA legislation:

- an individual (donor) makes an **irrevocable gift** of money or other property to a minor (the donee);
- the gift, plus any earnings it generates, is under the **control of a custodian** until the donee reaches the age of majority established by State law;
- the **custodian has discretion** to provide to the minor or spend for the minor's support, maintenance, benefit, or education as much of the assets as he/she deems equitable; and
- the donee **automatically receives control** of the assets upon attainment of majority.

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B. Policy Principles

1. UGMA and Resources

a. General

Since a custodian of UGMA assets cannot legally use any of the funds for his or her own personal benefit, they are not his or her resources. Similarly, once there is a gift under UGMA, additions to or earnings on the principal are not income to the custodian who 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 UGMA principal.) For example, if the donor is a deemor who receives rental income and adds it to a child's UGMA funds, we would have to consider the rental income as income for deeming purposes.

b. While Donee Remains a Minor

- UGMA property, including any additions or earnings, is not income to the **minor;**
- the custodian's UGMA disbursements to the minor **are income to the minor**;
- the custodian's UGMA disbursements on behalf of the minor may be income to the latter if used to make certain third party-vendor payments.

c. When Donee Reaches Majority

All UGMA property becomes available to the donee and subject to evaluation as income in the month of attainment of majority.

*M*1120.210 RETIREMENT FUNDS

A. Definitions

1. Retirement Funds

Retirement funds are annuities or work-related plans for providing income when employment ends (e.g., pension, disability, or retirement plans 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.

2. Periodic Retirement Benefits

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.

3. Value of a Retirement Fund

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 penalty deduction. However, any taxes due are not deductible in determining the fund's value.

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B. Policy Principle

A retirement fund owned by an eligible individual is a resource if he/she has the option of withdrawing a lump sum even though he/she is not eligible for periodic payments. However, if the individual is eligible for periodic payments, the fund may not be a countable resource.

A previously unavailable retirement fund is not income to its recipient when the fund becomes available. The fund is subject to resources counting rules in the month following the month in which it first becomes available.

C. Operating Policies

1. Termination of Employment

A retirement fund is not a resource if an individual must terminate employment in order to obtain any payment.

2. Fund Not Immediately Available

A resources 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 (e.g., 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 nonliquid resource.

3. Claim of Periodic Payment Denied

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 resources determination for the month following that in which the individual receives the denial notice.

D. Development and Documentation

1. Evidence

If an individual has a retirement fund, obtain evidence of the availability of payments from the retirement fund. Determine if the individual is eligible for lump sum or periodic payments.

2. Determination

If the individual can withdraw a lump sum, the retirement fund is a resource in the amount that is currently available.

E. Related Policies

***1.* Nonliquid Resource**

Absent evidence to the contrary, assume that resources in the form of retirement funds are nonliquid (S1110.300 B.).

***2.* Deeming Exclusion**

If an ineligible spouse, or parent, owns a retirement fund, we exclude it from the deeming process. See S0830.500 regarding the treatment of interest income.

NOTE: If the individual is a married institutionalized individual with a community spouse, the retirement funds are evaluated as resources in the resource assessment and the eligibility determination (see M1480).

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F. Example

1. Situation Jeff Grant currently works 3 days a week for a company where he has been employed full-time for 20 years. Under his employer's pension plan, Mr. Grant has a $4,000 retirement fund. The EW confirms that Mr. Grant could withdraw the funds now, but there would be a penalty for early withdrawal and he would forfeit eligibility for an annuity when he stopped working.

2. Analysis Since Mr. Grant can withdraw the retirement funds without terminating employment, they are a resource in the amount available after penalty deduction. This is true despite the fact Mr. Grant forfeits eligibility for periodic annuity payments in the future. All sources of available support (unless otherwise excluded) are considered in determining eligibility.

S1120.215 INHERITANCES AND UNPROBATED ESTATES

A. Introduction Property in the form of an interest in an undivided estate is to be regarded as an asset when the value of the interest plus all other resources exceed the applicable resource limit, unless it is considered unsalable for reasons other than being an undivided estate. An heir can initiate a court action to partition. If a partition suit is necessary (because at least one other owner of or heir to the property will not agree to sell the property) in order for the individual to liquidate the interest, estimated partition costs plus *the individual's (applicant/recipient) attorney fees* may be deducted from the property's value. However, if such an action would result in the applicant/recipient securing title to property having *a* value less than the cost*(s)* of the *partition action,* the property would not be regarded as an asset.

An ownership interest in an unprobated estate may be a resource if an individual:

- is an heir or relative of the deceased; or
- receives any income from the property; or
- under State intestacy laws, has acquired rights in the property due to the death of the deceased.

The procedure for determining the countable value of an unprobated or undivided estate is found in Appendix 1 to subchapter S1130.

B. For QDWI, QMB, SLMB, QI and ABD 80%FPL The policy for treatment of an unprobated or undivided estate for the QDWI covered group is in Appendix 1 to chapter S11. The policy for treatment of an unprobated or undivided estate for the QMB, SLMB, QI and ABD 80% FPL covered groups is in Appendix 2 to chapter S11.

***C.* Operating Policies**

1. When to Develop We develop for this type of resource only if:

- the property in question is not excludable under any of the provisions in S1110.210 B.; and
- counting the property's value would result in excess resources.

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2. Ownership Interest

There is an ownership interest in an unprobated estate if:

- documents (e.g., a will or court records) indicate an individual is an heir to property of a deceased; or
- an individual has use of a deceased's property or receive income from it; or
- documents establish, or the individual alleges, a relationship between himself and the deceased which, under State intestacy laws, awards the individual a share in the distribution of the deceased property; and
- the inheritance, use of income, and distributions are uncontested.

3. When Unprobated Estate Can Be a Resource

We do not consider that an inheritance is a resource until the month following the month in which it meets the definition of income. See S0830.550 for the income rules on inheritances. Thereafter, if retained, we evaluate the property as a resource.

S1120.220 *CASH LOANS*

A. Definitions

1. Loan

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

2. Negotiable Agreement

A negotiable agreement is (e.g., a loan) where the owner of the agreement itself can transfer it from one person to another to include the whole amount of money expressed on its face.

***3.* Bona Fide Agreement**

A bona fide agreement is legally valid *under the applicable State's law* and made in good faith.

B. Policy--General

The following rules relate only to the principal amounts involved in the credit arrangements described in A. above. They do not include a creditor's receipt of interest which is unearned income.

1. Borrower

a. Agreement *is a Bona Fide Loan*

- *The loan agreement itself is not a resource.*
- *The cash provided by the lender is not income but is the borrower's resource if retained in the month following the month of receipt.*

b. Agreement *is* Not *a* Bona Fide *Loan*

- *The loan agreement itself is not a resource.*
- *The cash provided by the lender is income in the month received and is a resource if retained in the month following the month it was received.*



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2. ***Lender***

a. ***Agreement is a Negotiable, Bona Fide Loan***

- *A negotiable, bona fide loan agreement is a resource of the lender valued at the outstanding principal balance.*
- *The cash provided to the borrower is no longer the lender's resource because the lender cannot access it for his or her own use; the loan agreement replaces the cash as the lender's resource.*
- *Payments received from the borrower against the loan principal are conversions of a resource, not income. If retained, the payments are counted as the lender's resource starting in the month following the month of receipt.*

b. ***Agreement is Neither Bona Fide Nor Non-negotiable***

- *The agreement is not a resource of the lender because the loan cannot be sold.*
- *Payments received against the principal are income to the lender, not conversion of a resource.*
- *The cash provided to the borrower may be a resource if the lender can access it for his or her own use.*

c. Agreement is Non-negotiable and Bona Fide

- *The agreement is not a resource of the lender because the loan cannot be sold.*
- *The cash provided to the borrower is no longer the lender's resource because the lender cannot access it for his or her own use; the loan agreement is not a resource because it cannot be transferred.*
- *Payments received from the borrower against the loan principal are income. If retained, count the payments as the lender's resource starting in the month following the month of receipt.*

NOTE: *Interest income received by the lender is unearned income whether the loan is bona fide or not. If the loan payments received by the lender include both principal and interest, only consider the interest portion as income.*

C. ***Informal Loans***

1. Policy

An informal loan is a loan between individuals who are not in the business of lending money or providing credit. An informal loan can be oral or written. An informal loan is "written" when the parties to the loan commit to writing the terms of their agreement.

An informal loan (oral or written) is bona fide if it meets all of the following requirements.

- ***Enforceable under State law***
  A bona fide loan is an agreement that must be enforceable under the applicable State law.



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- ***Loan agreement in effect at time of transaction***
  The loan agreement must be in effect at the time that the lender provides the cash to the borrower. Money given to an individual with no contemporaneous obligation to repay cannot become a loan at a later date.

- ***Acknowledgement of an obligation to repay***
  A loan is a cash advance from a lender that the borrower must repay, with or without interest. For a bona fide loan to exist, the lender and the borrower must acknowledge the obligation to repay. When money or property is given and accepted based on any understanding other than it is to be repaid by the receiver, there is no loan for Medicaid purposes. A statement by the individual that he or she feels personally responsible to pay back the friend or relative on its own does not create a legal obligation to repay the individual who provided the cash. Similarly, the lender's statement that the borrower must only repay the cash if he or she becomes financially able to do so does not, on its own, create a legal obligation to repay.

- ***Plan for repayment***
  The loan must include a plan or schedule for repayment, and the borrower's express intent to repay by pledging real or personal property or anticipated future income (such as retirement insurance benefits starting in a year when they turn 62). The claimant may use anticipated income such as Title II, Title XVI, Veterans benefits, etc., to establish a plan for a ***feasible*** *repayment of the loan as long as the loan states the claimant* ***must*** *pay the money back.*

- ***Repayment plan must be feasible***
  The plan or schedule must be feasible. In determining the plan's feasibility, consider the amount of the loan, the individual's resources and income, and the individual's living expenses.

2. Procedures *Follow these procedures to determine whether an informal loan is bona fide and to determine the resource value, if any, for the individual.*

a. Document the loan allegation

- *If there is a written agreement between the parties, obtain a copy*

- *If there is no written agreement, obtain signed statements from the borrower and the lender.*

b. Determine whether the loan is bona fide

Determine whether the loan is bona fide. If the loan is bona fide, the cash proceeds are not income to the borrower but are a resource if retained until the following month. For the lender, the loan agreement itself is a resource if it is bona fide and negotiable. The borrower's repayment of principal is not income to the lender, but the interest portion is unearned income.



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c. Determine the resource value of the loan

(1). Eligible individual is the borrower

- *Count the loan proceeds, if retained, as a resource starting in the month after the month the borrower received the proceeds.*

- *Determine the resource value of the proceeds of the loan that the borrower still holds (if any).Use procedures appropriate to the type of resource being evaluated.*

(2) Eligible individual is the lender

- *Assume that the bona fide loan agreement is negotiable, is a resource, unless the lender raises questions about the negotiability of the agreement, and wants to rebut this assumption.*

- *The agreement is a resource starting in the month after the month that the lender provides the proceeds to the borrower.*

- *Assume that the agreement's resource value is its outstanding principal balance unless the lender disagrees and wants to rebut this assumption.*

  EXAMPLE: *Prior to filing for SSI, Mr. Jones made a $1,500 cash loan to his brother. Subsequently, Mr. Jones received $300 in repayment. At the time of filing for SSI, the outstanding principal balance for the loan was $1,200 and is a countable resource.*

d.. Offer rebuttal rights

If the outstanding principal balance combined with the individual's other resources causes ineligibility, inform the individual that the outstanding principal balance will be counted in determining resources unless he or she submits:

- *Evidence of a legal bar to the sale of the agreement; or*

- *An estimate from a knowledgeable source showing the current market value (CMV) of the agreement is less than its outstanding principal balance. Knowledgeable sources include anyone in the business of making such estimates (e.g., banks or other financial institutions, private investors, real estate brokers). The estimate must show the name, title, and address of the source.*

e. Document the loan determination in the case record.

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C. ***Procedures for Formal Loans***

1. Applicant/ Member is Lender

With a formal loan, there is rarely a question about whether the loan is bona fide. The key issues are determining the resource value of the loan agreement for the lender and the amount of interest income received.
If the value of the loan agreement could affect resource eligibility:

- *Obtain the written loan agreement. Assume the agreement is bona fide and negotiable unless the creditor presents convincing evidence of a legal bar to transferring ownership.*
- *Assume if the agreement is a resource, that its value is its outstanding principal balance. If the individual wishes to rebut the value, follow the instructions in S1120.200 C.2.d above.*
- *Determine the amount of interest income the lender receives using the formal loan agreement or an amortization schedule. Document the case record.*

2. Applicant/ Member is Borrower

With a formal loan, the key issue is determining whether the borrower retains proceeds of the loan that are countable as resources. Follow these steps to determine the countable resources:

- *Assume a formal loan is bona fide. However, the proceeds of the loan are potentially countable resources of the borrower whether or not the loan is bona fide or negotiable.*
- *Determine the value of the loan proceeds using procedures appropriate to the type of resource being evaluated. Document the case record.*

E. **References**

- Interest income, S0830.500.
- Relationship between income and resources, M1120.005 and S1120.005
- Loan proceeds not being income, S0815.350 B.1.
- Promissory Note definition, S1140.300 A.2.
- Loan definition S1140.300 A.3.
- Property Agreement definition, S1140.300 A.4.

F. **Example-- Contractor Sale**

1. Situation

Mr. Dottle, an aged applicant, tells the EW that he has an agreement to sell unused farmland in a nearby county to a neighbor for $1,800 plus interest. His neighbor has already paid $1,200 to Mr. Dottle. The sales contract specifies that Mr. Dottle will receive one additional payment of $600 plus interest.

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2. Analysis

The EW correctly recognizes that the farmland is no longer Mr. Dottle's resource even though it is still his property; because he is bound by an agreement to sell that land, he cannot transfer title to anyone else. Mr. Dottle has converted his ownership interest in the land into a contract. Unless there is a legal restriction against converting the contract into cash, it is his resource in the amount of the $600 principal balance (absent convincing evidence of a lesser CMV).

If the contract is a resource, any payment against the principal represents a conversion of that resource.

If the contract is not a resource, payment against the principal is income.

Regardless of the resource status of the contract, any interest payment he receives is income.

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***G.* Example--Installment Sale Contract**

Henry Little, a Medicaid applicant, recently became a widower and moved out of the family home to live in a rented apartment. He has just entered into an installment sale contract on his former home with Thomas Higgins, a Medicaid recipient. Mr. Higgins made a $6,000 down payment on the house, using retroactive SSI benefits paid under a court order, and immediately moved into his new home in which he already has an equitable ownership interest, even though he does not yet have title. The outstanding principal balance on the installment agreement is $8,000.

1. Situation

2. Analysis

The EW must determine resources eligibility for both men. Although Mr. Little still has title to the house, he cannot sell it; rather, its value as a resource to Mr. Little has folded into the value of the installment contract. However, the installment sale contract (which the EW confirms has no legal restrictions against its sale) is Mr. Little's resource in the amount of the outstanding principal balance unless he presents convincing evidence that its CMV is a lower amount.

The installment sale contract has no bearing on Mr. Higgins' eligibility, as either income or resources. His ownership interest in the house he is buying from Mr. Little is an excluded resource since it is his principal place of residence.

M1120.225 REVERSE MORTGAGES

A. Definition

A reverse mortgage is a contract with a bank or other lending institution whereby the bank provides the borrower with monthly payments which do not have to be repaid as long as the individual lives in the home. These payments are a loan against the equity in the home and must be repaid when the individual dies, sells his home, or moves.

The individual, not the bank or lending institution, continues to retain ownership of the home and is responsible for property taxes and insurance.

B. Policy

The payments from a reverse mortgage are loan proceeds and are not income to the borrower. Proceeds retained after the month of receipt are a resource.

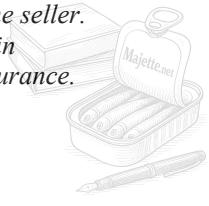
M1120.300 RESOURCES UNDER SALES CONTRACT

A. Definition

A sales contract is a binding legal agreement. When a house is "under contract," it means that the seller has accepted an offer from a potential buyer, but the sale is not yet final. There are contingencies that need to be met before the closing. These contingencies can include inspections, financing, and other conditions.

B. Policy

Once the contract is signed, and until the transaction is complete, the property under contract is not considered a countable resource to the seller. The individual, not the bank or lending institution, continues to retain ownership of the home and is responsible for property taxes and insurance.



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M1120.235 HEALTH AND MEDICAL SAVINGS ACCOUNTS

A. Introduction

The Medicare Prescription Drug, Improvement, and Modernization Act, signed into law on December 8, 2003, created the Health Savings Accounts (HSAs) system. An HSA is a tax-exempt trust or custodial account used to pay for the qualified medical expenses listed in the Internal Revenue Service (IRS) publication 502, of the account beneficiary, spouse, or dependents. HSAs are set up with qualified trustees, which can be banks, insurance companies or any entity already approved by the IRS to be a trustee of individual retirement arrangements (IRAs) or Archer MSAs.

Medical Savings Accounts, also known as MSAs or Archer MSAs, are trust-like accounts set up solely as an IRS-related, tax-exempt financial instrument for medical expense purposes. HSAs superseded MSAs; however, some valid MSAs still exist based on previously existing law.

B. Policy Principles

Generally, HSAs and MSAs are countable resources for Medicaid purposes because individuals may use those funds to pay for expenses unrelated to their medical needs. However, there are some HSAs and MSAs that may not count towards the resource limit. For HSAs and MSAs that are not countable resources, see Medicaid Works M0320.400.D.2.

Unused account funds remain in the account, drawing interest on a tax-favored basis, until needed for future medical expenses or retirement. The resource value of an HSA or MSA is the balance in the account available for withdrawal.

C. Health Savings Accounts

HSAs require individuals to have coverage under a high deductible health plan (HDHP). Although individuals generally use HSAs to pay for qualified medical expenses listed in the IRS publication 502 (Medical and Dental Expenses), individuals may use HSA funds at any time for expenses unrelated to their medical needs.

D. Medical Savings Accounts

Individuals generally use MSAs to pay for qualified medical expenses, as. listed in the IRS publication 502 (Medical and Dental Expenses). Deposits made toward the savings plan may be tax-deductible, and can be used to pay for out-of-pocket medical expense, like paying a premium, satisfying a deductible, covering office visits, paying for prescription drugs, etc.

Distributions from an MSA is not income, however an MSA distribution would be counted as a conversion of a resource.

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CHAPTER M11

AGED, BLIND, AND DISABLED INDIVIDUALS (ABD) RESOURCES

SUBCHAPTER 30

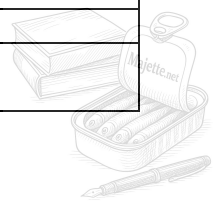
IDENTIFYING RESOURCES

RESOURCE EXCLUSIONS

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M1130 Changes

Changed With	Effective Date	Pages Changed
TN# DMAS-35	7/1/25	Table of Contents page ii, Pages 24, 26, 34, 74
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TN #DMAS-27	4/1/23	Table of Contents, page ii Pages 77, 78 Page 77b added
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TN #DMAS-18	1/1/21	Pages 31, 33, 34
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TN #DMAS-9	7/1/18	Pages 1, 3
TN #DMAS-7	1/1/18	Pages 45,78-79 Appendix 1, pages 3,5
TN #DMAS-5	7/1/17	Pages 13, 15, 78, 79 Page 14 is a runover page.
TN #DMAS-3	1/1/17	Table of Contents, page ii Page 76 Page 77 is a runover page. Pages 78 and 79 were added.
TN #DMAS-1	6/1/16	Pages 4, 14, 15
TN #100	5/1/15	Pages 13, 15, 21, 31, 33, 34 Pages 16 and 32 are runover pages.
UP #9	4/1/13	Table of Contents, page ii Pages 5, 62 Pages 62a was added.
TN#97	9/1/12	Page 14
Update #7	7/1/12	Page 24
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TN #95	3/1/11	Pages 28, 29, 33
TN #94	9/1/10	Pages 20, 20a, 28-29a
TN #93	1/1/10	Pages 63-65 Pages 70, 74, 75
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M1130.000 RESOURCES EXCLUSIONS

REAL PROPERTY

M1130.100 THE HOME

A. Policy Principles -- General Rules

This policy only applies to SSI Recipients, ABD Individuals with Income ≤ 300% SSI, and ABD Medically Needy (MN) covered groups. It does NOT apply to the following ABD covered groups:

- Qualified Disabled and Working Individuals (QDWI),
- Qualified Medicare Beneficiaries (QMB),
- Special Low-income Medicare Beneficiaries (SLMB),
- Qualified Individuals (QI), and
- ABD 80% FPL.

The home property resource exclusion for the QDWI covered group is in Appendix 1 to Chapter S11. The home property resource exclusion for the QMB, SLMB, QI and ABD 80% FPL covered groups is in Appendix 2 to Chapter S11.

1. Home Exclusion

Ownership of a dwelling occupied by the applicant as his home does not affect eligibility.

2. Definition of the Home

An individual's home is property that serves as his or her principal place of residence.

A home means the house and lot used as the principal residence and all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000.

In any case in which the definition of home as provided here is more restrictive than that provided in the State Plan for Medical Assistance in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value.

3. Principal Place of Residence

An individual's principal place of residence is the dwelling the individual considers his established or principal home and to which, if absent, he intends to return. It can be real or personal property, fixed or mobile, and located on land or water. Only one resource can be exempted as home property. *See M1130.100.D2 and M1460.530.B.*

4. Individual Owns the Land but Not the Shelter

For purposes of excluding "the land on which the shelter is located" (see A.2. above), it is not necessary that the individual own the shelter itself.

EXAMPLE: If an individual lives on his own land in someone else's trailer, the land meets the definition of home and is excluded.



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B. Operating Policy -- Home Lot

1. Land

The home exclusion applies to the plot of land on which the home is located. The excluded home lot size may vary according to the locality's building requirements.

For localities with set minimum building lot size use the lesser of:

- *the* plat;
- *the* survey; or
- *the* locality's minimum size for a building lot.

For localities with no minimum building lot requirements, use the lesser of:

- *the* plat;
- *the* survey; or
- one acre.

2. Buildings

The home exclusion applies to all buildings on land excluded in B.1. above.

C. Operating Policy -- Contiguous Property Allowed Under Home Exclusion

The home exclusion may be applied to property contiguous to the home. Property adjoining the home lot may come under the home exclusion by using one of two different calculations. Apply the calculation which is most advantageous.

1. $5,000 Assessed Value of Contiguous Land

The home exclusion applies to land adjoining the home plot if not completely separated from it by land in which neither the individual nor his or her spouse has an ownership interest. **$5,000 of assessed value of land contiguous to the home lot can be included in the home exclusion**.

Easements and public rights of way (utility lines, roads, etc.) do not separate other land from the home plot.

2. Contiguous Property Essential to the Operation of the Home

The equity value of countable contiguous property may cause resources to exceed the maximum limit. In these cases, reevaluate the home property applying the definition of the home used in the State Plan for Medical Assistance in Virginia in effect on January 1, 1972. At that time a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value.

Property essential to the operation of the home means:

a. land used for regular production of any food/goods for the household's consumption only, including:

- vegetable gardens;
- pastureland for livestock raised for milk or meat;
- land to raise chickens, pigs, etc;
- outbuildings used to process and/or store any of the above.

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The amount of land necessary to support animals named above is established by the local extension service. However, only actual land being used to support the animals will be allowed.

b. driveways connecting the homesite to public roadways.

c. land necessary to **the** homesite to meet local zoning requirements (e.g. building site, mobile home sites, road frontage, distance **from** road, etc.).

d. land necessary for compliance with state local health requirements (e.g., distance between home and septic tank(s));

e. water supply for the household.

f. existing burial plots.

g. outbuildings used in connection with dwelling, such as garages or tool sheds.

3. ABD Home Property Evaluation Worksheet

See Appendix 2 to this subchapter for the "ABD Home Property Evaluation Worksheet**."**

D. Limitations On Home Property Exclusion

1. Property That No Longer Serves as the Principal Place of Residence

Property ceases to be the principal place of residence, and is no longer excludable as the home, as of the date that an individual who has left the home determines that he does not intend to return to it. *See M1460.530.B for additional information*.

Such property, if not excluded under another provision, will be included in determining countable resources.

2. 6-Month Exemption

An institutionalized individual's former *home in which he has an ownership interest, and which he occupied as his residence before becoming institutionalized* is an excluded resource for six months beginning with the month following the month of the *individual's* admission to a medical institution. The following are types of medical institutions:

- chronic disease hospitals,
- hospitals and/or training centers for the mentally retarded,
- institutions for mental diseases (IMDs),
- intermediate care facilities(ICFs),
- nursing facilities, and
- rehabilitation hospitals.

After six months the former residence is counted as an available resource.

The six-month home exclusion allowed for an institutionalized individual's former home also applies to the home owned by an individual receiving Medicaid *home* and community-based services *(HCBS)* in another person's home, providing the individual resided in the home prior to receipt of Medicaid *HCBS*. See M1460.530 for additional information.

3. Extended Exclusion for Institutionalized Individual

An institutionalized individual's home property continues to be excluded if it is occupied by his:

- spouse;
- minor dependent child under age 18;
- dependent child, **under** age 19, **who attends** school or vocational training; or
- individual's parent or adult child who:
  - has been determined to be disabled according to the Medicaid disability definition, and
  - lived in the home with the individual for at least one year prior to the individual's institutionalization, and
  - is dependent upon the individual for his shelter needs.

E. Development and Documentation-- Initial Applications

1. Ownership

a. Verify Ownership

Verify an individual's allegation of home ownership. Have the individual submit one of the items of evidence listed in b.- d. below.

For manufactured (mobile) homes, *if a mobile home is assessed and taxed by the county/locality as real estate (not personal property), it is treated as real property. If the mobile home is registered and titled at the DMV and taxed as personal property, it is treated as personal property.*

b. Evidence of real property ownership;

- tax assessment notice;
- recent tax bill;
- current mortgage statement;
- deed;
- report of title search;
- evidence of heirship in an unprobated estate (e.g., receipt of income from the property, a will, or evidence of relationship recognizable under State intestate distribution laws in cases where the home is unprobated property).

c. Evidence of personal property ownership (e.g., a mobile home):

- title,
- current registration.

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d. Evidence of life estate or similar property rights:

- a deed,
- a will,
- other legal document.

e. Equitable Ownership

If an individual alleges equitable ownership (e.g., an unwritten ownership interest or right of use for life) obtain any pertinent documents and a signed statement from each of the parties involved regarding any arrangement that has been agreed to. Forward the documents to a medical assistance practice consultant for an opinion from legal counsel.

2. Principal Place of Residence--Operating Assumption

If the individual does not own more than one residence and there is no evidence that raises a question about his principal place of residence, assume that the alleged home is the individual's principal place of residence.

3. Indication of More than One Residence

If an individual alleges or other evidence indicates ownership of more than one residence, obtain his signed statement concerning such points as:

- how much time is spent at each residence;
- where he is registered to vote;
  - which address he uses as a mailing address or for tax purposes.

Determine the principal place of residence accordingly and document the determination in the case file.

4. Evidence Indicates Non-adjoining Property

a. Individual Agrees With Evidence

If evidence indicates that land the individual owns does not adjoin the home plot, and the individual agrees that it does not:

- **obtain** his statement to that effect; and
- **develop** the non-adjoining portion per S1140.100 (Non-home Real Property) or S1130.500 (Property Essential to Self-Support), as applicable.

b. Individual Disagrees With Evidence

If the individual maintains that all the land adjoins the home plot, document the file with:

- a sketch of the land showing the boundaries of the various plots and the location of the shelter used as the home; and
- evidence of how the land is treated for tax assessment purposes.

The sketch may be by the individual, from public records, or by EW (from direct observation).



The tax assessment information may be in the form of a tax assessment notice or obtained from the appropriate tax jurisdiction.

c. Combined or Single Holding for Tax Assessment

Assume that the land is a single piece of property in which all the land adjoins the home plot if:

- it is recorded and treated as a single holding for tax assessment purposes; or
- the original holding has been subdivided, but still is treated as a single holding for tax assessment purposes.

d. More Than Single Holding for Tax Assessment

If the land is recorded and treated as two or more holdings for tax assessment purposes, use the sketch to determine whether other holdings adjoin the home plot.

5. Absences From The Home

a. Summary of Development

If the individual is in an institution, determine whether a spouse or dependent relative is living in the home (see b. below).

If no spouse or dependent relative is living in the home, or if the absence is for a reason other than institutionalization, determine *if the individual intends to return when the purpose of the absence (such as medical care, rehabilitation, vacation/visit, education, employment, military service) is completed.*

NOTE: If a previously undeveloped absence from the home has ended, assume that the individual always intended to return. The absence, regardless of duration, will not affect the home exclusion.

b. Spouse or Dependent Relative Development

Obtain a signed statement from the individual as to:

- whether anyone is living in the home while the individual is in the institution;
- if so, how that person is related to the individual, if at all; and
- if related (except for the individual's spouse), how that person is dependent on the individual for shelter needs, if at all.

Absent evidence to the contrary, accept the allegation.

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6. Value of Home Lot

Verify the current assessed value of the home lot from the locality's Real Estate Assessment Office.

NOTE: The home lot assessed value is usually more than the value assessed to the contiguous property. Therefore, prorating the total assessed land value on the real estate tax assessment bill may not give the true assessed value of the home lot.

7. Total Home Exclusion Value

a. Add Together:

- the assessed value of the home lot as verified in 6. above, and
- $5,000 of contiguous assessed property value.

This total equals the amount of assessed land value allowed under the Home Exclusion.

If excess resources exist and any countable contiguous property was included in the evaluation, the Home Exclusion must be re-evaluated.

b. Add Together:

- the assessed value of the home lot as verified in 6. above, and
- the assessed value of contiguous property essential to the operation of the home.

This equals the amount of assessed property value allowed under the Home Exclusion used under the State Plan for Medical Assistance in Virginia in effect on January 1, 1972.

F. Procedure – Post-eligibility

If, after Medicaid eligibility is established, an individual receives real property—for example, as an inheritance or gift—which may be excludable as his home, apply the policy and procedures in A. and B. above to determine whether the home exclusion applies.

Redevelop the exclusion from resources of an individual's home only if something raises a question about the correctness of the original determination or indicates that the exclusion may no longer apply (e.g., a change of address).

G. References

- Home replacement funds, S1130.110
- Real property whose sale would cause undue hardship due to loss of housing, to a co-owner, Appendix 2 to chapter S11.
- Real property following reasonable but unsuccessful efforts to sell it, **M1130.140.**

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S1130.110 HOME REPLACEMENT FUNDS

A. Policy Principles

1. General

When an individual sells an excluded home, the proceeds of the sale are excluded resources if the individual:

- plans to use them to buy another excluded home, and
- does so within 3 full calendar months of receiving them.

2. Installment Sales Contracts

If an individual receives the proceeds under an installment contract, the contract is an excluded resource for as long as the individual:

- plans to use the entire down payment and the entire principal portion of a given installment payment to buy another excluded home; and
- does so within 3 full calendar months of receiving such down payment or installment payment.

B. Operating Policy

1. Proceeds Defined

a. If Paid in a Lump Sum

The proceeds are the net amount the seller receives at settlement.

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b. If Paid in Installments The proceeds consist of:

- any down payment; and
- that portion of any subsequent payment that is not interest.

2. Allowable Uses of Proceeds

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:

- down payment;
- settlement costs;
- loan processing fees and points;
- moving expenses;
- necessary repairs to or replacements of the new home's structure or fixtures (e.g., roof, furnace, plumbing, built-in appliances) that are identified and documented prior to occupancy; and
- 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.

3. Timely Use of Proceeds

a. Timely
"Within 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.

b. Use
"Using" the proceeds includes obligating them by contract as well as actually paying them out.

c. Proceeds Not Used Timely --Lump Sum
The exclusion of the unused funds will be revoked retroactively to the date of their receipt.

d. Proceeds Not Used Timely--Installment Payments
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.

4. Reinstatement of Exclusion After Revocation

a. General
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.

b. Effective Date
Reinstatement of the exclusion is effective as of the date the individual signs a new statement of intent (see C.2.b. below) and affects resource determination for that month.



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5. Example--Installment Payments Not Used Timely

An installment contract has a principal balance of $5,000 as of July 1. On July 10, the buyer makes a payment of $200. As of October 31, the recipient has used only $150 of the July payment in connection with the purchase of a new home.

The exclusion of the unused $50 - and of the installment contract itself - is revoked back to July 10. As a result, the $50 and the value of the contract as of August 1 ($4,800) are included in a revised determination of resources for August.

C. Development and Documentation--Initial Applications

1. Explanation To Individual

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 exclusion.

2. Statement Of Intent

a. General

Obtain a signed statement from the individual as to whether he or she intends to use the proceeds to buy another home by the date specified. If so, the statement also must reflect his or her understanding that the exclusion of any funds not used by the date specified will be revoked retroactively.

b. Installment Contracts

When the proceeds are being paid in installment, the individual's statement of intent must reflect his or her understanding that, if the noninterest 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.

3. Documenting Proceeds Of Sale

Document the file with a copy of the settlement sheet, contract for sale and/or other evidence that shows the net proceeds of the sale and how paid or payable, i.e.: paid in full at statement, dates and amounts of downpayment and installment payments, interest, etc.

a. Lump-Sum Proceeds

Set a special review to contact the individual in the month in which the exclusion period for the proceeds expires.

b. Installment Contact

Set the special review for the month in which the exclusion period for the downpayment on the prior home expires. If no downpayment is made, review the case the month in which the exclusion period for the first monthly payment expires.



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c. Required Evidence Document the file with the same types of evidence used to document
the proceeds of the sale of the prior home (see 3. above) and, if necessary, with bills, receipts, or other evidence of related allowable expenses

4. Proceeds Used to Replace Home

a. Lump-Sum Proceeds
If the amount paid at settlement for the new home equals or exceeds the lump sum received for the old home, and there is no question about where any excess came from, cease development.

b. Installment Payments
Unless there is a question of unstated income or previously undetected resources, cease current development if:

- the downpayment on the new home equals or exceeds the downpayment received from the sale of the prior home; and
- monthly payments on the new home equal or exceed the noninterest portion of the installment payments being received on the prior home.

5. Proceeds Not Used to Replace Home

a. Lump Sum Proceeds or Downpayment
Document use of proceeds for related allowable expense (B.2. above) if:

- the amount paid at settlement for the new home is less than the lump-sum proceeds of the sale of the prior home; or
- the downpayment on the new home is less than the downpayment received from the sale of the prior home.

If not all of the proceeds will be used timely, redetermine resources for the months after the proceeds were received. Do not exclude:

- the unused portion of the lump-sum proceeds or downpayment; or
- the value of an installment contract.

NOTE: Any proceeds spent at all, whether or not for an allowable use, will not affect the resources determination for the month after they were spent.

b. Installment Payments
If the noninterest portion of the payments the individual receives on the old home exceeds the amount of the payments he or she makes on the new home, document use of the excess for related allowable expenses.

If the individual cannot provide evidence of allowable expenses for which a given month's excess can be earmarked for timely use, the installment contract cannot be excluded for that month.

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D. Development and Documentation--Post-Eligibility

Do not develop for the continuing applicability of the home replacement funds exclusion unless something indicates that less than the entire noninterest portion of the installment payments is being applied to the purchase of the replacement home.

1. Federal Disaster Assistance

See S1130.620 regarding the exclusion of funds received under the Disaster Relief and Emergency Assistance Act of 1974 or under some other Federal statute because of a catastrophe declared by the President to be a major disaster.

2. Commingled Funds

See S1130.700 if funds excluded under this provision are commingled with other funds.

3. Interest

Interest earned on funds excluded under this provision is not excluded from income or resources by this provision. See S0830.500 for its treatment as income.

E. Related Policies

1. Federal Disaster Assistance

See S1130.620 regarding the exclusion of funds received under the Disaster Relief and Emergency Assistance Act of 1974 or under some other Federal statute because of a catastrophe declared by the President to be a major disaster.

2. Commingled Funds

See S1130.700 if funds excluded under this provision are commingled with other funds.

3. Interest

Interest earned on funds excluded under this provision is not excluded from income or resources by this provision. See S0830.500 for its treatment as income.

S1130.130 REAL PROPERTY WHOSE SALE WOULD CAUSE UNDUE HARDSHIP, DUE TO LOSS OF HOUSING, TO A CO-OWNER FOR QDWI, QMB, SLMB, QI and ABD 80% FPL ONLY

A. Policy Principles

1. Exclusion

*The value of an individual's ownership interest in jointly owned real property is an excluded resource **for as long as** sale of the property would cause undue hardship, due to loss of housing, to a co-owner.*

2. Undue Hardship

Undue hardship would result if such co-owner:

- *uses the property as his or her principal place of residence;*
- *would have to move if the property were sold; and*
- *has no other readily available housing.*

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3. Exclusion Applies to Certain Groups

This exclusion only applies to:

Qualified Disabled Working Individuals (QDWI)
- *Qualified Medicare Beneficiary (QMB)*
- *Special Low Income Beneficiary (SLMB)*
- *Qualified Individuals (QI-1 and QI-2)*
- *ABD with Income ≤ 80% FPL (ABD 80% FPL).*

This exclusion does not apply to other ABD covered groups.

B. Development and Documentation-- Initial Applications and Post-Eligibility

1. Allegations of Loss of Housing for Co-Owner

If someone alleges that the sale of certain real property would force a co-owner living on it to move, obtain:

- *the individual's signed statement to that effect, and*
- *evidence of joint ownership (see S1130.100 B.1.b.-d.).*

If co-ownership is not proven, skip to 3. below. Otherwise, obtain the statement in 2. below.

2. Required Statement from Resident Co-Owner

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; and*
- *has other living quarters readily available.*

Apply the policy principle in A. above to determine whether, on the basis of the statements of the individual and the co-owner, the sale of the property would cause undue hardship to the co-owner.

Accept any reasonable allegation from the co-owner that there is no readily available housing (e.g., no other affordable housing available or no other housing with necessary physical modifications for a handicapped individual).

3. Determination-Not Undue Hardship

If the property cannot be excluded on the basis of undue hardship:

- *document the file to that effect;*
- *issue appropriate notice.*

4. Determination-Undue Hardship

If the property can be excluded on the basis of undue hardship:

- *document the file to that effect;*
- *issue appropriate notice.*

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M1130.140 REAL PROPERTY FOLLOWING REASONABLE BUT UNSUCCESSFUL EFFORTS TO SELL

A. Policy Principles

1. Exclusion

Real property, including a life estate in real property created on or after August 28, 2008 but before February 24, 2009, that an individual has made reasonable but unsuccessful efforts to sell, will continue to be excluded for as long as:

- the individual continues to make reasonable efforts to sell it; and
- including the property as a countable resource would result in a determination of excess resources.

This exclusion is effective the first of the month in which the most recent application was filed or up to three months prior if retroactive coverage is required.

B. Operating Procedure

The "current market" value (CMV) of real property located in Virginia is the tax assessed value of the property **or**, effective 10/4/16, the certified value as determined by an appraiser licensed in Virginia.

For property located outside of Virginia the CMV is determined by applying the tax assessed value of the property to the local assessment rate, if the rate is not 100%, ***or*** *the certified value as determined by an appraiser licensed in the state in which the real property is located*.

A licensed appraiser's certified value can be used if the appraisal was completed no more than six months previous to the date of the application. The use of an appraisal is applicable only to non-commercial real property. See M1110.400.

1. Initial Effort Established

The following criteria define reasonable efforts to sell. The listing price must not exceed 100% of CMV in order for the initial effort to sell to be met.

A reasonable effort to sell is considered to have been made:

a. As of the date the property becomes subject to a realtor's listing agreement (must be actively marketed) if it is listed at no more than current market value **AND** the listing realtor verifies that it is unlikely to sell within 90 days of listing given particular circumstances involved; for example

- owner's fractional interest;
- zoning restrictions;
- poor topography;
- absence of road frontage or access;
- absence of improvements;
- clouds on title;
- right of way or easement;
- local market conditions; or

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b. When at least two realtors employed by different realty companies refuse to list the property. The reason for refusal must be that the property is unsalable at CMV (other reasons are not sufficient – documentation of the property's deficiencies must be provided); or

c. When the applicant has personally advertised his property at or below CMV for 90 days by use of a "Sale by Owner" sign located on the property and by other reasonable efforts, such as newspaper advertisements, reasonable inquiries with all adjoining land-owners, or other potential interested purchasers.

d. For property which is an interest in an undivided estate and for jointly owned property when a co-owner refuses to sell, an initial reasonable effort to sell shall have been made when all other co-owners have refused to purchase the applicant's or recipient's share, and at least one of the other co-owners has refused to agree to sell the property.

e. For property owned by an individual who is incompetent and has no one authorized to sell real property on his behalf, when court action is initiated for appointment of a guardian or conservator to secure the court's approval to dispose of the property, an initial effort to sell shall be deemed to have been made beginning the date the hearing for appointment of a guardian is placed on the court docket and continuing until the court authorizes sale of the property or through the sixth month after the initiation of the court action, whichever comes first. Any period of time in excess of six months to secure appointment of a guardian and authorization to sell by the court is not deemed reasonable and the property loses this exemption.

Upon authorization, and only upon authorization, the guardian must place the property on the market according to the criteria in M1130.140 B.1.a-d and make a continuing effort to sell the property as described in M1130.140 B.3.

2. Retroactive Exclusion

There will be applications received with property already listed for sale. Inform the applicant of Reasonable Efforts to Sell policy. If the real property was already listed for more than the CMV when the individual applied for Medicaid, a reasonable effort to sell was made for the retroactive period and the month of application if:

- the property was listed at no more than 100% CMV

or

- the property was listed at or below 150% of CMV and the initial effort to sell requirement described above is met except for the listing price.

If the list price was initially higher than100% of the CMV, the listed sales price must be reduced to no more than 100% of the CMV to meet the continuing efforts to sell requirement.

If property was not listed when the application was filed or was listed higher than 150% of CMV, a reasonable effort to sell exclusion cannot be established for the retroactive period.



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3. Continuing Effort to Sell

Notwithstanding the fact that the recipient made a reasonable effort to sell the property and failed to sell it, and although the recipient has become eligible, the recipient must make a continuing reasonable effort to sell until the property is sold or Medicaid coverage is canceled. Depending on how the initial effort to sell was met, a continuing effort to sell is met as follows:

a. When the property was listed at no more than the CMV and the listing realtor verified that the property is unlikely to sell within 90 days of listing per M1130.140 B.1.a, the listing agreement must continually be renewed at no more than 100% of the taxed assessed value, until the property is sold. If the list price was initially higher than the tax-assessed value, the listed sales price must be reduced to no more than 100% of the tax-assessed value.

b. In the case where at least two realtors have refused to list the property per M1130.140 B.1.b, the recipient must personally try to sell the property by efforts described in B.1.c. above, for 12 months.

c. In the case of recipient who has personally advertised his property for a year without success per M1130.140 B.1.c, (the newspaper advertisements, "for sale" sign, do not have to be continuous; these efforts must be done for at least 90 days within a 12 month period), the recipient must then:

- subject his property to a realtor's listing agreement (must be actively marketed) priced at or below current market value; or
- meet the requirements of M1130.140 B.1.b. above, which are that the recipient must try to list the property and at least two realtors must refuse to list it because it is unsaleable at current market value; other reasons for refusal to list are not sufficient.

d. When there is jointly owned property which a co-owner has refused to sell or when the property is an interest in an undivided estate, and the initial effort to sell was met per M1130.140 B.1.d., a partition suit is necessary in order to liquidate the property A continuing reasonable effort to sell the property shall be demonstrated by filing suit with the court to partition the property within 60 days of proving the property is otherwise unsaleable (in accordance with section B.1.e.) and shall continue until the property is sold or 9 months, whichever is less. Any period of time in excess of 9 months to sell shall not be deemed reasonable and the property loses this exemption.

4. After Continuing Effort Has Been Established

Even when real property is excluded while reasonable efforts to sell it are met, the sale of real property for less than *its CMV* is subject to an asset transfer penalty for the Medicaid payment of long-term care services (see M1450). However, if the individual made a continuing effort to sell the property for 12 months, then the individual may sell the property between 75% and 100% of its *CMV* without a penalty.

If the individual sells his property at less than 75% of *its CMV*, he must submit documentation from the listing realtor, or knowledgeable source if the property was not listed with a realtor, that the sale price was the best price the recipient can expect to receive for the property at this time. In this situation a sale can take place for less than 75% of *its CMV* without penalty.



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5. Date Property is Disregarded

After the applicant has demonstrated that his property is unsalable by following the procedures in Section B., the property is disregarded in determining eligibility starting the first day of the month in which the most recent application was filed, or up to three months prior to the month of application if the applicant met all other eligibility requirements in the period. A recipient must continue his reasonable efforts to sell the property as required in B.3.

S1130.150 INTERESTS OF INDIVIDUAL INDIANS IN TRUST RESTRICTED LANDS

A. Policy

In determining the resources of an individual (and spouse, if any) who is of Indian descent from a federally recognized Indian tribe, **any** interests of the individual (or spouse) in trust or restricted lands are excluded from resources.

B. Procedure

If an individual Indian alleges an interest in trust or restricted land:

- obtain for the file a copy of any document or documents that might identify it as such; and/or
- verify the allegation with the appropriate Indian agency.

If verification is by phone, document the case record. Prepare a determination on the basis of the evidence.

C. References

- Income derived from individuals interests in trust or restricted lands, S0830.850
- Other resource exclusions from members of Indian tribes, S0830.830

M1130.160 OTHER REAL PROPERTY

A. Policy Principles

1. Countable

Ownership of other real property generally precludes eligibility. The property's equity value is counted with all other countable resources.

2. Exceptions

a. When equity value of the property, plus all other resources, does not exceed the appropriate resource limit;

b. The property is smaller than the county or city zoning ordinances allow:

- for home sites or building purposes, or
- property has less than the amount of road frontage required by the county or city for building purposes, and
- adjoining land owners will not buy the property;

c. The property has no access, or the only access is through the exempted home site;

d. The property is contiguous to the recipient's home site and the survey expenses required for its sale reduce the value of such property, plus all other resources, below applicable resource limitations; or

e. The property cannot be sold after a reasonable effort to sell it has been made.



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B. Procedures for Determining the Countable Value of Real Property

The procedures for determining the countable value of real property, and examples, are found in Appendix 1 to this subchapter.

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PERSONAL PROPERTY

M1130.200 AUTOMOBILES

A. Policy Principles

1. Automobile Defined

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

2. Current Market Value Defined

The CMV of an automobile is the average trade-in value listed in the NADA Guide.

3. Exclusion Regardless of Value

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

4. Other Automobiles

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

5. Rebuttal of NADA Value

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

6. Rebuttal of Ownership

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

- *a statement from the applicant/enrollee **and** the other individual indicating why the automobile is listed in the applicant's/enrollee's name, including the person who actually uses the automobile and in whose possession it is kept, and*
- *cancelled checks or records from the lender indicating that the other individual has made all payments on the automobile.*

*If the applicant/enrollee does not use the automobile and can provide documentation that another person has made all the payments on the automobile, it is **not** a resource to the applicant/enrollee.*

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B. Operating Policy-- More than One Automobile Owned

1. General Rule

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

2. Determining Equity Value

Use the following method to determine equity value:

- Determine the average trade-in value for each automobile from the NADA Guide. In the event the automobile is not listed, the value assessed by the locality for tax purposes may be used.
- Determine the equity value in each automobile by subtracting the debt from NADA value.
- Exempt the automobile with the highest equity value.

3. References

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

M1130.300 LIFE INSURANCE

A. Definitions

1. Life Insurance Policy

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

2. Face Value

Face value (FV) is the amount of basic death benefit contracted for at the time the policy is purchased. The face page of the policy may show it as such, or as the "amount of insurance"," the amount of the policy," "the sum insured," etc. A policy's FV does not include:

- the FV of any dividend addition, which is added after the policy is issued (see 5. below);
- additional sums payable in the event of accidental death or because of other special provisions; or
- the amount(s) of term insurance, when a policy provides whole life coverage for one family member and term coverage for the other(s).

3. Cash Surrender Value

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

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4. Dividends

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

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

5. Dividend Additions and Accumulations

a. Additions

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

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

b. Accumulations

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

Dividend accumulations cannot be excluded from resources under the life insurance exclusion, even if the policy that pays the accumulations is excluded from resources. Unless they can be excluded under another provision (e.g., as set aside for burial), they are a countable resource.

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6. Proceeds

Proceeds of a life insurance policy are the FV of the policy plus any additions payable at maturity or death.

Proceeds do not include dividends or interest that are left to accumulate in the policy (see 5.b. above). Also, proceeds do not include a policy's CSV.

7. Supplementary Contract

A supplementary contract is not a life insurance policy. It is an agreement whereby, when the policy matures or the insured dies, the proceeds are paid not in a lump sum, but in an alternative manner selected by the individual, usually as an annuity (see B.5. below).

8. Burial Insurance

A burial insurance policy is a contract whose terms preclude the use of its proceeds for anything other than payment of the insured's burial expenses.

NOTE: If a policy has a CSV to which the owner has access, the policy is not burial insurance for Medicaid purposes.

9. "Accelerated Life Insurance Payments"

Accelerated life insurance payments are proceeds paid to a policyholder prior to death. Although accelerated payment plans vary from company to company, all of the plans involve early payout of some or all of the proceeds of the policy.

Most accelerated payment plans fall into three basic types, depending on the circumstances which cause or "trigger" the payments to be accelerated. These are the:

- **long-term care model**, which allows policyholders to access their death benefits should they require extended confinement in a care facility or, in some instances, health care services at home;
- **dread disease or catastrophic illness model,** which allows policyholders to access their death benefits if they contract or acquire one of a number of specified covered conditions; and
- **terminal illness model,** which allows policyholders to access their death benefits following a diagnosis of terminal illness where death is likely to occur within a specified number of months.

Some companies refer to these payments as "living needs", "accelerated death", or “viatical” payments.

Depending on the type of accelerated payment plan, receipt of accelerated payments may reduce the policy's FV by the amount of the payments and may reduce CSV in a manner proportionate to the reduction in FV. In some cases, a lien may be attached to the policy in the amount of the accelerated payments and a proportionate reduction in CSV results.

See B.6. below for policy regarding accelerated payments and E. below for procedures.



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B. Policy

1. Life Insurance as a Resource

A life insurance policy owned by the individual is a resource if it generates a CSV. Its value as a resource is the amount of the CSV.

A life insurance policy which is irrevocably assigned to another person is not a resource to the individual, but it needs to be evaluated as an asset transfer (subchapter M1450). When the life insurance policy is irrevocably assigned to a funeral home or trust to fund the individual's burial contract, go to section M1130.425.

2. Limited Exclusion

A life insurance policy is an excluded resource, **for individuals age 21 and over,** if its FV and the FV of any other life insurance policies the individual owns on the same insured total $1,500 or less. However, the FV of some policies does not count toward this $1,500 total (see 3. below). **Life insurance policies on individuals under age 21 are excluded from resource evaluations.**

We do **not** include the FV of dividend additions in determining whether a policy is a countable or excludable resource. If the policy is a countable resource, we include the **CSV** of dividend additions in determining the resource value of the policy.

3. FV of Burial and Certain Term Insurance Not Counted

In determining whether the total FV of the life insurance policies an individual owns on a given insured is $1,500 or less, the FV of the following are not taken into account:

- burial insurance policies; and
- term insurance policies that do not generate a CSV.

4. Relation to Burial Fund Exclusion

The maximum of *$3,500* that can be excluded as set aside for the burial expenses of an individual must be reduced by the FV of:

- any burial insurance policy for the burial expenses of the individual;

  Exceptions: *Huff-Cook Mutual Burial Association life insurance policies (which may be designated as Care Plans on the policy) sold prior to April 7, 1993 do not reduce the $3,500 burial fund exclusion. Huff Cook life insurance policies sold from April 7, 1993 through November 30, 1993 reduce the burial fund exclusion. Huff-Cook/Settlers life insurance policies sold on or after December 1, 1993 do not reduce the $3,500 burial fund exclusion unless they are assigned to pay for a pre-need funeral contact.*

- any insurance policy on the life of the individual that is excluded under the life insurance exclusion in B.2. above;

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- a life insurance policy of any value that was assigned to a funeral provider or of which a funeral provider has been made the irrevocable beneficiary, if the policy owner has irrevocably waived his or her right to, and cannot obtain, any CSV the policy may generate. The amount by which the $3,500 exclusion is reduced equals the face value of the policy MINUS the total cost of burial space items identified in the contract.

(See **M1130.410** for instructions regarding the burial fund exclusion and **M1130.410** C.1.d. for more discussion of burial insurance.)

5. Eligibility for Other Benefits

a. Supplementary Contracts

Supplementary contracts normally provide for an annuity. We treat such contracts in accordance with the instructions on filing for other benefits, for any benefit with choices about method of payment.

b. Accelerated Life Insurance Payments

Accelerated payments are not "benefits" for purposes of the Medicaid "filing for other benefits" provision. We do not require a policyholder to apply for accelerated payments as a condition of obtaining or retaining Medicaid eligibility.

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6. Accelerated Life Insurance Payments

a. Income and Resources Treatment

Since accelerated payments can be used to meet food, clothing, or shelter needs, the payments are income in the month received and a resource if retained into the following month and not otherwise excludable.

b. Payments Not "Conversion of a Resource"

The receipt of an accelerated payment is not treated as a conversion of a resource for Medicaid purposes. This is because, under an accelerated arrangement, an individual receives proceeds from the policy, not the policy's resource value--which is its CSV.

C. Procedure Initial Application

1. Using the Individual's Records for Verification

a. Ask the individual to submit:

- all the life insurance policies he or she owns; and
- the most recent annual dividend statement issued for each policy.

b. For countable and excludable policies, use these records to verify:

- the owner;
- the insured;
- the FV;
- whether the policy pays dividends and, if it does, what option the individual selected for their disposition (i.e. accumulations, additions, applied to premiums, paid by check); and
- if dividend accumulations, their current amount.

c. **Additionally, for countable policies,** use these records to verify:

- whether the policy generates a CSV and, if it does,
- the current CSV (including the CSV of any dividend additions and any loans on the policy which reduce the CSV). *Some insurance policies include a CSV table. For policies that do not pay dividends, if the table lists a CSV value for the specific number of years the individual has owned the policy, no additional verification is needed.*

2. Contacting an Insurance Company or Agent for Verification

If examination of a policy does not reveal an item of information listed in 1. above, obtain that information from the individual's agent or the insurance company, subject to the operating assumptions in 4. below. Do so by phone, if possible, and document the information in the case record.

3. Exception to Verification

Do **not** verify employer-provided term insurance.

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4. Operating Assumptions

Apply the following assumptions in determining what development is required. Absent evidence to the contrary, assume that a:

- term policy without a table of CSV's, if it appears otherwise complete, does **not** generate a CSV;
- policy that does not generate a CSV also does **not** pay dividends;
- policy issued by a nonparticipating or stock company does **not** pay dividends;
- 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.

5. Determination

a. General

Apply the policy in B. above to determine whether each insurance policy owned is a resource and, if it is, whether to count or exclude its CSV in the resource determination.

b. Dividend Additions

Do **not** include the **FV** of dividend additions in determining whether a policy in a countable or excluded resource (B.2. above)

If the policy is a **countable** resource, do include the **CSV** of dividend additions in determining the resource value of the policy.

If the policy is a **excluded** resource, do **not** include the CSV of dividend additions in determining the individual's countable resources.

c. Dividend Accumulations

Do not exclude dividend accumulations under the life insurance provision, even if you exclude the policy that pays the accumulations.

Count the accumulations as resources, even if you exclude the policy itself because the policy's FV is $1,500 or less unless the accumulations are excludable under another provision (for example, because they have been set aside for burial).

d. Income Treatment of Dividends

See S0830.500 C. regarding the income treatment of life insurance policy dividends.

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D. Procedure Accelerated Life Insurance Payments

If an individual receives accelerated payments, and the payments do **not** preclude Medicaid eligibility due to excess income or resources, determine whether the FV and/or CSV of the policy must be verified.

Reverify the policy if, prior to receipt of the accelerated payments:

- the policy's CSV precluded Medicaid eligibility, but the individual may now be resource-eligible; or
- the policy was an excluded resource and its FV reduced the maximum burial fund exclusion available to the individual (see B.4. above).

If reverification is necessary, examine the policy and any other relevant documentation in the individual's possession to determine the effect of the accelerated payments on FV and CSV. If necessary, contact the life insurance company for the necessary information.

If the individual expects to receive accelerated payments in the future, explain the effect of any further reduction in the policy's FV on the maximum burial fund exclusion available (if applicable).

E. References

- Income treatment of life insurance dividends, S0830.500 C.
- Life insurance funded burial contracts, **M1130.425**.

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M1130.400 BURIAL SPACES

A. Policy –The Exclusion

1. General

A burial space or agreement which represents the purchase of a burial space held for the burial of the individual, his or her spouse, or any other member of his or her immediate family is an excluded resource, regardless of value.

Cemetery plots are not counted as resources, regardless of the number owned, except when evaluating eligibility as QDWI. For QDWI, exclude one cemetery plot (see Appendix 1 to chapter S11). Accept declaration regarding ownership of cemetery plots. Verification is not required.

2. No Effect on Burial Funds Exclusion

The burial space exclusion is in addition to, and has no effect on, the burial funds exclusion (M1130.410).

3. Multiple Burial Spaces

When items other than cemetery plots serve the same purpose, exclude only one per person. For example, exclude a cemetery plot and a casket for the same person, but not a casket and an urn.

4. Burial Spaces After Approval

Burial spaces do not need to be re-verified after application approval unless the Medicaid recipient reports a change.

B. Definitions

1. Burial Space

A burial space is a(n).

- Gravesite (either an existing grave or a plot);
- crypt;
- mausoleum;
- casket;
- urn;
- niche; or
- other repository customarily and traditionally used for the deceased's bodily remains.

The term also includes necessary and reasonable improvements or additions to such spaces, including but not limited to:

- vaults;
- headstones, markers, or plaques;
- burial containers (e.g., for caskets); and
- arrangements for the opening and closing of the gravesite.

For example, a contract for care and maintenance of the gravesite, sometimes referred to as endowment or perpetual care, can be excluded as a burial space.

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2. Agreement Which Represents the Purchase of a Burial Space

An agreement which represents the purchase of a burial space is a contract with a burial provider for a burial space held for the eligible individual or a member of his/her immediate family.

3. Individual's Immediate Family

"Individual" means the Medicaid recipient or **applicant**. **" Immediate family" means:**

- parents, including adoptive parents;
- minor or adult children; including adoptive and stepchildren;
- siblings (brothers and sisters), including adoptive and stepsiblings.

"Immediate family" also includes the spouse of the above relatives. If the relative's relationship to the recipient is by marriage only, the marriage must be in effect in order for the burial space exclusion to continue to apply. For example, a burial space held for a sister-in-law is no longer excludable if she and the recipient's brother divorce.

4. Held For

A burial space is "held for" an individual when someone currently has:

- title to and/or possesses a burial space intended for the individual's use (e.g., has title to a burial plot or owns a burial urn stored for his or her own use); or

- a contract with a funeral service company for specified burial spaces for the individual's burial (i.e., an agreement which represents the individual's current right to the use of the items at the amount shown).

Until the purchase price is paid in full, a burial space is not "held for" an individual under an installment sales contract or similar device if:

- the individual does not **currently** own the space;
- the individual does not **currently** have the right to use the space; and
- the seller is not **currently** obligated to provide the space.

Until all payments are made on the contract, the amounts paid may be considered burial funds. See M1130.410.

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C. Procedure-- Development and Documentation

The following procedures do **not** apply to installment burial contracts or insurance funded burial contracts. For installment contracts, see **M1130.420**. For insurance funded contracts, see **M1130.425**.

1. General

a. If an individual alleges owning only one burial space, or an individual and spouse allege owning no more than two spaces, **assume** that the spaces are excluded.

b. If an individual or individual and spouse allege owning more than one or two spaces, respectively, obtain a signed statement showing;

- the name of the person for whose burial each space is intended; and
- the relationship of each such person to the individual. Exclude only those spaces that are alleged to be for the burial of the individual, the spouse, or a member of the immediate family.

- *Burial spaces do not need to be reverified unless the Medicaid member reports a change.*

2. Agreements Which Represent the Purchase of a Burial Space

a. General

If the contract shows the purchase of a specified burial space at a specified price, determine whether such space is held for the individual or member of the individual's immediate family per B.4. above.

If the space is held for the individual, determine if the contract is irrevocable or revocable. If irrevocable, it is not a resource. If the contract is revocable, it is an excludable resource. (See **M1130.420** C.3. on single-purpose burial space contracts.)

b. Installment Contract

If the contract calls for installment payments, determine whether the value of the burial space has to be treated as burial funds (**M1130.420** C.5.c.).

D. References

Burial funds exclusion, M1130.410.
Prepaid burial contracts, **M1130.420**.
Interest earned on excluded burial space purchases agreements, S0830.501.

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M1130.410 BURIAL FUNDS EXCLUSION

A. Policy Principle

Up to $3,500 of burial funds may be excluded for each member of the ABD assistance unit (i.e., the individual and the individual's spouse, if living together).

NOTE: Burial funds exclusion is separate and apart from burial space exclusion.

For QDWI, see Appendix 1 to chapter S11.

B. Definitions

1. Burial Funds

Burial funds are resources that have been specifically set aside and clearly designated in writing for the cremation or other burial-related expenses of the individual or the individual's spouse.

Burial funds may be:

- irrevocable burial trusts established on or after August 11, 1993 *(irrevocable burial trusts established **before** August 11, 1993 are not countable based on the law in effect at that time);*
- revocable burial trusts;
- revocable burial contracts;
- other revocable burial arrangements (including the value of certain installment sales contracts for burial spaces);
- cash;
- financial accounts (e.g., savings or checking accounts);
- other financial instruments with a definite cash value (e.g., stocks, bonds, certificate of deposit, life insurance policies, etc.).

Property other than that listed in this definition will not be considered burial funds and may not be excluded under the burial funds provisions. For example, a car, real property, livestock, etc., are **not** burial funds.

NOTE: The entire amount of an irrevocable trust established on or after 8/11/93 by a funeral director for an individual for the purpose of paying for funeral and burial expenses is excluded if the following two step process is followed:

1) the individual signs a pre-need contract with a funeral home director promising prepayment in return for specific funeral merchandise and services and pays the agreed upon amount in the form of a direct cash payment or purchase of a life insurance policy or annuity to the funeral director, and

2) the funeral home director in turn places the money, life insurance policy or annuity into a trust.

2. Expenses for Burial Funds Exclusion Purposes

a. Expenses Included

Expenses included for burial funds exclusion purposes are generally those related to preparing a body for burial and any services prior to burial.

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They usually include, for example: transportation of the body, embalming, cremation, flowers, clothing, services of the funeral director and staff, etc.

b. Expenses Not Included

Usually, expenses for items used for interment of the deceased's remains are not included for burial funds exclusion purposes. Such items may be subject to the burial space exclusion (**M1130.400**). However, items that do not qualify for the burial space exclusion, e.g., a space being purchased by installment contract, may be excluded under the burial fund exclusion.

C. Policy--General

1. Amount of Funds That Can Be Excluded

a. Maximum Exclusion

We can exclude up to $3,500 each in funds set aside for:

- the burial expenses of the individual; and
- the burial expenses of the individual's spouse (eligible or ineligible) .

This exclusion is separate from and in addition to the burial space exclusion.

Funds paid on an installment contract do **NOT** qualify for the **burial space exclusion.**

Funds paid on an installment contract for burial spaces may qualify for the burial fund exclusion.

b. Reductions in Maximum Exclusion

The maximum $3,500 that can be excluded from countable resources is reduced by:

- the face value of life insurance (not including term policies) owned by and insuring the individual and/or the individual's spouse, if the cash surrender value of such policies has been excluded from countable resources (cash surrender value of life insurance is excluded when the total face value per insured individual aged 21 or over does not exceed $1,500), and
- the face value (not including the value of burial space items) of an irrevocable burial trust established before 8/11/93 *or other irrevocable arrangement specifically designated for the purpose of meeting the individual's or spouse's burial expenses,* regardless of whether the arrangement is owned by the individual or someone else, and
- the face value of burial insurance, regardless of whether the burial insurance is owned by the individual or someone else, and



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- the face value of burial contracts (not counting the value of burial space items), regardless of whether the contract is owned by the individual or someone else.

c. Exceptions Related to Huff-Cook/Settlers Policies

Huff-Cook Mutual Burial Association life insurance policies (which may be designated as Care Plans on the policy) sold prior to April 7, 1993 **do not reduce** the $3,500 burial fund exclusion.

Huff-Cook life insurance policies sold from April 7, 1993 through November 30, 1993 **reduce** the burial fund exclusion.

Huff-Cook/Settlers life insurance policies sold on or after December 1, 1993 **do not reduce** the $3,500 burial fund exclusion unless they are assigned to pay for a pre-need funeral contact.

d. EXAMPLE – Burial Fund Exclusion

Mrs. Brown has the following burial resources:

$2,000 designated savings account
$ 200 irrevocable burial contract

$3,500 maximum exclusion
- 200 irrevocable burial contract
$3,300 available exclusion
-2,000 excluded burial funds
$1,300 still available for exclusion

Treatment - We exclude the $2,000 savings account. Two years later, Mrs. Brown wants to add to her designated burial savings account, which now has a balance of $2,150 due to accumulated interest. She can increase the amount of excluded funds in the account by up to $1,300. Note that when determining the amount still available for burial fund exclusion, we disregard the amount of interest which accumulated in the account.

e. Subsequent Purchase of Excluded Life Insurance or Irrevocable Burial Contract

A subsequent purchase of an excluded life insurance policy or an irrevocable burial contract reduces the amount of the available burial funds exclusion as described in b. above. The reduction is effective the month after the month in which the life insurance or the irrevocable burial contract was purchased.

f. Burial Insurance

Burial insurance policies are not life insurance policies (see **M1130.300** for a definition of burial insurance). For Medicaid purposes, burial insurance is an irrevocable arrangement whose face value reduces the maximum burial funds exclusion by the policy's face value.

Exceptions: Huff-Cook Mutual Burial Association life insurance policies sold prior to April 7, 1993 do not reduce the $3,500 burial fund exclusion.



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Huff-Cook/Settlers life insurance policies sold on or after December 1, 1993 do not reduce the $3,500 burial fund exclusion unless they are assigned to pay for a pre-need funeral contact.

e. Increases in Value of Burial Funds

Any appreciation in the value of excluded burial funds is excluded from resources (and from income), even if the total of the burial funds thus excluded exceeds the $3,500 maximum. This includes interest earned by burial funds, provided the interest is left to accumulate as part of the funds.

2. Increases in Amount of Excluded Burial Funds

a. Designated Amount is $3,500

Interest earned on excluded burial funds and appreciation in the value of excluded burial arrangements are excluded from resources if left to accumulate and become part of the separate burial fund.

b. Designated Amount is Less than $3,500

Until $3,500 (or such other lesser amount established in accordance with C.1.b.) in burial funds has been designated, additional amounts can be excluded under the burial funds provision if the individual designates them for burial expenses. Interest on excluded burial funds is not included in determining if the $3,500 maximum has been reached.

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c. *Designated Amount is greater than $3,500*

While an individual may designate greater than $3,500 for burial, only up to $3,500 may be excluded for burial. The remainder of the designated amount will be evaluated as a countable resource. If the individual is determined eligible, interest and appreciation that accumulates on the excluded portion of the burial fund will be excluded. Interest and appreciation that accrue over time on the non-excluded portion will be evaluated as a countable resource.

3. Burial Funds Must Be Kept Separate from Non-burial-Related Assets

a. If burial funds are commingled with nonburial-related assets, the exclusion does not apply.

b. Examples

A single burial contract for $4,500 of burial services and $2,000 in burial spaces does not have to be separated into 2 contracts since the whole amount is burial-related, even though we can only exclude $3,500 of the contract as a burial fund.

A bank account containing $1,200, $500 of which is designated for burial and $700 of which is other funds the individual uses for living expenses, is **not** allowable and the $500 may **not** be excluded as a burial fund. If the $500 is moved to a separate account, the exclusion may be applicable the month in which the funds are separated.

4. Funds Used for Another Purpose

a. General

If some or all of the excluded funds were withdrawn and used for another purpose, the funds withdrawn may have been either transferred or retained as a resource. If the funds were transferred, the asset transfer policies in subchapter M1450 are applicable. If the funds have been retained as a resource, the resource policies in Chapter S11 are applicable. Any excluded funds remaining in the designated burial fund continue to be excluded.

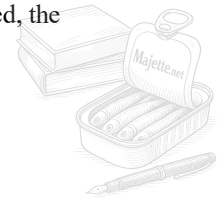
b. Change of Form

Transferring excluded burial funds from one form to another (e.g., from a certificate of deposit to a burial contract) is not use for another purpose.

c. Examples - Use for Another Purpose

A loan against the cash surrender value (CSV) of a life insurance policy that has been designated for burial expenses **is not** use for another purpose **if** the loan is for the purchase of another burial fund.

Use of a burial fund as collateral for a loan **is** use for another purpose because the loan creates an encumbrance on the funds. Since the funds are not available for the individual's burial as long as they are encumbered, the funds cannot be considered set aside for the individual's burial.



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5. When to Develop Use for Another Purpose

Determine if excluded burial funds have been used for some purpose other than as burial funds only if:

- there is some indication that excluded funds may have been used for another purpose, and
- the sum of the excluded funds (including any that may have been spent) and countable resources exceeded the applicable (individual or couple) resources limit as of the month in which the excluded funds may have been used for another purpose, and
- the individual was eligible for the month in which the excluded burial funds may have been used for another purpose.

6. How to Develop Use for Another Purpose

If the criteria in 1. above indicate a need to pursue the issue of use for another purpose:

- obtain the individual's signed statement as to whether any of the funds were so used and, if so, the amount;
- obtain any pertinent evidence, including signed statements from other individuals who may know about the funds in question.
- follow resource policy if funds have been retained as a resource.
- follow asset transfer policy if funds were transferred.

***7.* Deeming Considerations**

If the individual is a blind or disabled child under age 21 who lives with his parent, resources (and income) of the parent are deemed to the child. The burial funds exclusion applies to resources that belong to the parent and are designated as set aside for the burial expenses of the parent and/or his or her spouse.

D. Designation of Burial Funds

1. How Designation May Be Made

Burial funds may be designated by the applicant at the time of application or during the initial application processing period or by an enrollee at any time after eligibility has been determined. Burial funds may be designated by:

- an indication on the burial fund document (e.g., the title on a bank account); or
- a signed statement.

See Appendix 3 for a sample burial funds designation form. A printable version of the form is located *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Training-Documents*.

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2. Signed Statement Designating Burial Funds

A signed statement must include:

- the value and owner of the resources;
- for whose burial the resources are set aside;
- the form(s) in which the resources are held (burial contract, bank account, etc.); and
- the date the individual first considered the funds set aside for the burial of the person specified.

3. Date of Intent

We accept the individual's allegation as to the date he or she first considered the funds set aside for burial unless there is evidence that the funds were used and replaced after that date.

4. Effective Date of Exclusion

Once the date that burial funds were considered set aside for burial has been established, the first month for which the exclusion affects resource determination is the latest of:

- the month in which the funds were considered to have been set aside, or
- the month of application, if the funds were considered set aside before the month (or first month of retroactive period, if retroactive coverage is requested).

5. Designating Life Insurance as a Burial Fund

When designating a countable life insurance policy as a burial fund, the policy itself is designated. However, because the countable value of the policy is its cash surrender value, it is the cash surrender value at the time of designation that is applied toward the burial funds exclusion when determining countable resources.

If life insurance is designated as a burial fund, the individual can also designate any dividend accumulations on the life insurance policy (**M1130.300 A.5.b.**) as a burial fund. Dividend accumulations are a separate resource (i.e. **not** considered as an increase in the value of the CSV) and must be designated as burial funds separate from the life insurance policy itself.

6. Designation Remains

Once a burial fund is designated, it remains a burial fund until:

- eligibility terminates or
- the individual states in writing that the funds are no longer set aside for burial.

E. Procedure-Initial Applications Development and Documentation

1. Ask About Burial Funds

Unless the individual is ineligible for a reason other than resources, inquire to determine the presence of excluded burial funds.

NOTE: Make sure the individual understands what we mean by a burial fund and the effect a burial fund could have on countable resources and income.

2. Verify Form and Separation of Funds

Verify that the funds meet the definition of burial funds in B.1. above and that the funds are separated from all other non-burial-related assets (C.3. above). Burial funds must meet both of these requirements before we can exclude them. If funds cannot be excluded, tell the individual why (e.g., if the funds are not separate from non-burial assets).

3. Determine Date Funds Set Aside for Burial

If an individual alleges having set aside funds for burial, determine the date they were first considered as set aside and document the file with supporting evidence.

- If the funds are already clearly designated (e.g., by the title of a savings account), accept any official record which shows the title of the account and which establishes that the designation was in effect prior to the month of application.
- If the funds are **not** already clearly designated, obtain the statement described in D. above.
- See D.4. above regarding effective date of the exclusion for funds considered set aside for burial prior to filing.

4. Verify Value of Funds

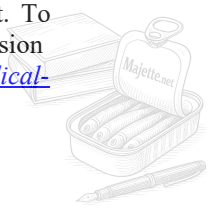
Verify the value of any burial funds to be excluded, using the instructions that apply to the specific resources in question.

5. Determine Amount of Exclusion Available

Document the file with evidence of:

- the face value of life insurance owned by and insuring the individual or the individual's spouse if the cash surrender value of such policies has been excluded from countable resources (cash surrender value of life insurance is excluded when the total face value per insured individual age 21 or over does not exceed $1,500), and
- the face value (not including the value of burial space items) of an irrevocable burial trust established before 8/11/93 or other irrevocable arrangement specifically designated for the purpose of meeting the individual's or spouse's burial expenses, regardless of whether the arrangement is owned by the individual or someone else, and
- the face value of burial insurance whether owned by the individual or someone else, and
- the face value of burial contracts (not counting the value of burial space items) whether the contract is owned by the individual or someone else.

Should the $3,500 maximum exclusion be reduced by life insurance, any irrevocable arrangement including an irrevocable burial trust established before 8/11/93, burial insurance, or a burial contract, document the amount by which the exclusion will be reduced, including the computation of the amount. To make this computation, you may use the electronic Burial Funds Exclusion Worksheet located at: *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Training-Documents*..



F. Procedures-Renewal or a Reported Change

1. Verify Funds Already Excluded

If the case record shows excluded burial funds, *the current value does not need to be re-verified unless the Medicaid recipient reports a change (such as using the funds for another purpose).* When $3,500 or less was initially designated as a burial fund, increases in the burial fund due to appreciation or accumulated interest are excluded even if they result in the total burial fund exclusion exceeding the $3,500 maximum.

If more than $3,500 was initially designated for burial funds exclusion, interest and appreciation that have subsequently accrued on the excluded portion of the burial fund are excluded. Interest and appreciation that have subsequently accrued on the countable portion are countable. To calculate the countable value of a burial fund at renewal or when a change is reported you may use the electronic "BFE Increased Value Determination Worksheet". The worksheet is located on the Virginia Department of Social Services Local Agency web site (*FUSION*) at: *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Training-Documents*.

If the funds have decreased, see G. below.

2. Enrollee Wishes to Designate Funds

If an enrollee wishes to designate funds for burial, proceed as you would for an initial application. This applies whether no funds are currently excluded or less than $3,500 (excluding appreciation or accumulated interest) is currently excluded.

3. Apply Burial Funds-Related Income/ Resources Exclusions

See H. below.

G. Procedure-Burial Funds Are Used for Another Purpose

1. When to Evaluate Use for Another Purpose

Determine if excluded burial funds have been used for some other purpose only if:

- there is some indication that excluded funds may have been used for another purpose, and
- the sum of the excluded funds (including any that may have been spent) and countable resources exceeded the applicable (individual or couple) resources limit as of the month in which the excluded funds may have been used for another purpose, and
- the individual was eligible for the month in which the excluded burial funds may have been used for another purpose.



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2. How to *Evaluate* Use for Another Purpose

If the criteria in 1. above indicate a need to pursue the issue of use for another purpose:

- obtain the individual's signed statement as to whether any of the funds were so used and, if so, the amount;
- obtain any pertinent evidence, including signed statements from other individuals who may know about the funds in question.

H. Procedure--Posteligibility Application of Burial Fund - Related Income/Resource Exclusions

1. Recipient Is Eligible for All Months During Period of Review

If the individual remained eligible throughout the period of review:

- exclude from income any interest earned on the excluded burial funds if that interest has been allowed to accumulate as part of such funds; and
- exclude from resources, in addition to the funds previously excluded,
- any interest on such excluded burial funds that has been excluded from income and any appreciation in the value of such excluded funds.

I. References

Burial space exclusion, M1130.400.`
Prepaid burial contracts, M1130.420.
Burial insurance, M1130.300.
Interest on excluded burial funds, S0830.501.
Insurance funded burial contracts, M1130.425.

M1130.411 BURIAL FUNDS EXCLUSION-- JULY 1, 1988 THROUGH JULY 31, 1994

A. Introduction

The instructions in **M1130.410** apply to the burial funds exclusion for July 1, 1988 through June 30, 1994 with the exceptions noted below**.**

B. Policy

1. Form of Burial Funds

For months prior to August 1, 1994 burial funds could be in the form of **any** resource, liquid or nonliquid.

2. Commingled Funds

For months prior to August 1, 1994, burial funds could be commingled with other resources (burial-related or nonburial-related), but the funds had to be separately identifiable in order to be excluded (S1130.700).

M1130.420 PREPAID BURIAL CONTRACTS

A. Definition

A prepaid (or preneed) burial contract is an agreement whereby the buyer pays in advance for a burial that the seller agrees to furnish upon the death of the buyer or other designated individual.

B. Policy--General

1. Contract Is a Resource

If a burial contract is revocable or salable, it is a resource. However:

- any portion of the contract that clearly represents the purchase of burial spaces may be excludable, regardless of value (**M1130.400**); and
- some or all of any remaining value of the contract may be excludable as burial funds (**M1130.410**).

2. Contract Is Not a Resource

a. Contract Not Saleable

When a burial contract is funded totally by an irrevocable trust, irrevocably assigned life insurance policy or annuity, the contract is NOT saleable. Do not develop the prepaid burial contract further. Determine whether the trust, the life insurance policy or annuity is a resource using the following policy:

- trusts in sections M1120.200 through 202, M1140.400 through 404.
- life insurance in sections M1130.300 and M1140.310.

b. Contract Issued in Another State

If a burial contract is issued in another State and cannot be revoked or be sold without significant hardship, it is not a resource. However:

- any portion of the contract that represents burial **funds** reduces the $3,500 maximum otherwise available for the burial funds exclusion; but
- any portion that represents the purchase of burial spaces has no effect on the burial funds exclusion.

3. Contract Revocability

State law determines whether a contract is revocable. Some burial contracts may be partly revocable. For example, if the total value of an otherwise irrevocable contract exceeds the limit set for irrevocability by State law, the excess is revocable.

4. Burial Insurance and Burial Trusts

Prepaid burial contracts do not include burial insurance as defined in **M1130.300** or burial trusts as described in M1120.200.

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5. Provider Places Funds in Trust

If an individual contracts with a provider of burial services and the **provider** places the funds in trust with the funeral provider named as the grantor on the trust document, this individual has purchased a preneed contract; this is a compensated "transfer" of funds.

C. Policy --Evaluations Contracts

1. Conditions for Liquidation

A prepaid burial contract may have conditions attached to its liquidation or revocation. If either of the following conditions exists, the contract is not a resource.

- Significant hardship may result from the conditions required for selling or revoking a contract. Significant hardship means an unrealistic demand on the buyer; e.g., having to move out of state. If an EW determines that such would be the case, the file must contain a determination to that effect.

- State law or contractual terms may require **mutual consent** of buyers and seller in order to sell or revoke a contract. If the seller will not consent, or will consent only under conditions that would pose a significant hardship to the buyers, the file must reflect those facts.

NOTE: If a condition creating hardship or some other obstacle to liquidation is not evident on the face of the contract, assume it is revocable or salable and, therefore, a resource. The burden is on the applicant/recipient to provide evidence to the contrary.

2. Value of Contract as a Resource

If a burial contract is a resource, use as its value:

- the amount payable to the owner upon revocation; or

- if the contract is not revocable but is salable, its CMV.

3. Single Purpose Burial Space Contracts

a. General

Apply the burial space exclusion to any single-purpose burial space contract that is a resource **if:**

- the contract lists all of the burial spaces **and** either includes a value for each space or the total value of all the spaces combined; and

- the seller's obligation to provide those items is not contingent on further payment (as in certain installment contracts); i.e., the items are actually being held for the individual's future use.

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b. Exception
Treat as burial funds (i.e., as subject to the *$3,500* maximum or as reducing that maximum):

- the unidentified portion of a contract that implies it covers only burial spaces but does **not** identify some or all of the spaces, or does not include either a value for each burial space or the total value of all the spaces combined; and
- the amount paid on an installment contract for burial spaces if the contract does not entitle the person to the spaces until the full purchase price has been paid.

NOTE: Once full payment has been made, these items can become subject to the unlimited burial space exclusion because at the point of full payment the contract becomes an agreement representing the purchase of a burial space (M1130.400).

4. Single-Purpose Contracts for Burial Expenses

A single-purpose contract for burial expenses (M1130.410) includes only services that are consider burial **funds** and that are subject to, or reduce the amount of, the burial funds exclusion.

5. Contracts for Both Burial Spaces and Burial Expenses

a. Irrevocability Designation
If a combined contract designates which portion is irrevocable and which is not, that designation is controlling. That is, if the contract designates only the burial space purchase as irrevocable, the portion dealing with burial funds is revocable and is subject to the burial funds exclusion.

b. Maximum on Irrevocable Amount
Virginia does not have a set maximum irrevocable amount set by law. However, if a State has a law which sets a maximum on the amount that can be irrevocable, but the contract does not designate which part is irrevocable and the contract value exceeds the State maximum, we apply the maximum to burial **spaces** first.

- If space purchases exceed the maximum, we consider the excess revocable but subject to the burial space exclusion.
- If space purchases are less than the maximum, we apply the remainder of the maximum to burial funds items.

NOTE: Irrevocable burial funds reduce the amount available for excluding other burial funds.

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Manual Title	Chapter	Page Revision Date
Virginia Medical Assistance Eligibility	**M11**	**August 1994**
Subchapter Subject	Page ending with	Page
M1130.000 ABD RESOURCE EXCLUSIONS	**M1130.420**	**40**

c. Installment Contracts

We treat as burial funds the amount **paid** for any spaces and services in a combined contract being purchased in installments **if** the contract.

- does not entitle the individual to the spaces and services listed until the full purchase amount has been paid ; or
- relieves the seller of the obligation to provide the spaces and services listed at the price listed until the contract is paid in full.

Once the contract has been paid in full, we apply the space and funds exclusions as appropriate.

D. Procedure-- Development and Documentation

1. General

a. **Develop** initially whether a prepaid burial contract exists and is a resource.

b. **Document** the file with respect to:
- revocability;
- liquidity (as needed); and
- value, if the contract is a resource or involves burial funds

c. In **posteligibility** situations:
- **develop and document** any newly acquired contract per a. and b. above;
- **do not redevelop** a contract if prior development showed that it is not a resource and does not contain burial funds;
- **redevelop and document** a contract if prior development showed that installment payments could affect applicability of the funds/space exclusions or that it included burial funds (revocable or irrevocable).

2. Valuing a Revocable Contract

For revocable burial contracts, State law usually sets refund guidelines that may vary by contract. If you cannot determine the refund amount by examining the contract, have the individual contact the provider or, if necessary, make the contact yourself.

3. Valuing an Irrevocable but Transferrable Contract

If a contract is irrevocable but can be liquidated some other way (e.g., through sale), **assume** that the contract's CMV is the amount that has been paid on it.

If the individual disagrees with this assumption, he or she can rebut it with an estimate from a disinterested knowledgeable source such as the State Funeral Directors Association or a local funeral director.

4. Single-Purpose Contract

Develop and document the factors outlined in 1. above, following the guidelines above, as appropriate.

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5. Contract for Both Spaces and Funds

a. Determine whether the contract designates which portion (if any) is irrevocable.

b. If designated, develop each portion as appropriate per **M1130.400** or **M1130.410.**

c. If the contract does not designate, apply the State maximum for irrevocability, if any, first to the total value of all burial spaces and then to the value of the burial funds. (See E. below for examples.)

Any burial spaces not covered are subject to the burial space exclusion. Any burial funds not covered are subject to the burial funds exclusion.

d. If you cannot determine which amounts represent the purchase of spaces and which represent burial funds, and which parts of the contract, if any, are irrevocable, the individual has not satisfactorily identified funds versus spaces. In that event, consider the entire contract as a resource in the form of burial funds.

E. Examples--

1. Installment Contract

a. Situation

An individual owns a revocable contract for his own burial. The contract, which covers both spaces and funds, gives the following breakout:

$ 700	- casket
350	- vault
200	- opening/closing
225	- embalming
300	- use of facilities
525	- services of director and staff
$2,300	- total value of contract

The contract provides that, until the full price of the contract has been paid, the seller has the option to be released from any obligation to provide the items and services at the contract price. Rather, the seller can charge prices current at the time of death, allowing a credit for amounts already paid.

b. Treatment

Until the contract has been paid in full, we consider all payments to be funds set aside for burial. Amounts paid in excess of the maximum available for exclusion as burial funds are countable resources.

When the contract has been paid in full, the spaces listed in a. above are subject to the burial space exclusion. The $1,050 value of the remaining items is subject to the burial funds exclusion.

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M1130.425 LIFE INSURANCE FUNDED BURIAL CONTRACTS AND THE BURIAL SPACE/FUNDS EXCLUSIONS

A. Definitions

1. Life Insurance Funded Funeral Arrangements

A life insurance funded burial contract involves an individual purchasing a life insurance policy on his or her own life and then assigning, revocably or irrevocably, either the proceeds or ownership of the policy to a third party, generally a funeral provider. The purpose of the assignment is to fund a burial contract.

Life insurance funded burial contracts are **not** burial insurance (**M1130.300** A.8.).

2. Proceeds

Proceeds of a life insurance policy are the face value of the policy plus any additions payable at maturity or death. This does not include dividends, cash surrender value (CSV) or interest.

B. Policy-General

1. Operating Assumptions

We assume that the burial contract itself (without the insurance policy assigned to fund it) has no resource value. We also assume that the contract is not salable because it is a part of a larger arrangement involving life insurance that has been assigned to another party as payment for contract goods and services. This means that the value of the burial arrangement is the value of the life insurance policy.

2. State Limits on the Amount of Funeral Contracts That May Be Made Irrevocable

State limits on the amount of funeral contracts that can be made irrevocable generally address the face amount of the contract that can be made irrevocable. Since we are concerned with the irrevocable assignment of ownership of an insurance policy to fund a burial contract and not with the face amount of the contract itself, State dollar limits are usually of no consequence in evaluating the policy for Medicaid purposes unless State law specifically limits irrevocable assignment of ownership of insurance polices funding burial contracts.

3. Dividend Accumulations

We do not exclude from resources dividend accumulations of a life insurance policy as part of the value of the policy or the burial contract. Dividend accumulations are separate resources and must be designated separately in order to qualify for the burial funds exclusion. (See **M1130.300 A.5.b.** and **C.6.c**)

If ownership of the life insurance policy has been irrevocably assigned, we assume, absent evidence to the contrary, that the dividend accumulations are also assigned.

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C. Policy--Effect Of Assignment of Ownership On Burial Exclusions

1. Revocable Assignment

a. Burial Spaces
The burial space exclusion does not apply. This is because the funeral provider has not received any payment and no purchase of burial spaces has been made. The provider has no obligation to provide any spaces until the individual dies and therefore no spaces are being held for the individual.

b. Burial Funds
The burial funds exclusion may apply. The resource value of the burial contract is equal to the CSV of the life insurance policy, subject to the *$3,500* burial funds exclusion.

c. Example
Mrs. Emma White has a burial contract funded by the revocable assignment of ownership of a life insurance policy. The face value of both the burial contract and the life insurance policy is *$5,000* and the CSV of the life insurance policy is currently *$3,700*. The total resource value of Mrs. White's burial contract is equal to the CSV of *$3,700.*

The burial space exclusion does not apply to Mrs. White's contract (per above). However, we can exclude *$3,500* of the CSV under the burial funds exclusion. The remaining $200 of the CSV will be considered a countable resource.

2. Irrevocable Assignment

a. Burial Spaces
The burial space exclusion may apply, depending on the nature of the contract (**M1130.400**.). Any portion of the contract that represents the purchase of a burial space has no effect on the burial funds exclusion.

b. Burial Funds
The life insurance policy and the burial contract are not resources for Medicaid purposes because the Medicaid recipient no longer owns them. The face value of the burial funds portion of the contract (if any) offsets the *$3,500* burial funds exclusion because the contract represents an irrevocable arrangement available to meet the individual's burial.

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c. Example Mr. Bill Atkins made provision for his burial by irrevocably assigning ownership of a life insurance policy on his life to a funeral home to fund a burial contract. The face value of the life insurance policy is *$5,000.*

The burial contract identifies the purchase of $1,300 of burial spaces and *$3,700* of burial funds. The *$3,700* burial funds portion of the contract is not a resource, but, since the assignment of policy ownership is irrevocable, the *$3,700* burial funds portion exceeds the *$3,500* burial funds exclusion that he is entitled to so Mr. Atkins may not have any other excluded burial funds. The $1,300 space purchase is not a resource either, and does not reduce the burial funds exclusion.

D. Policy--Effect Of Assignment Of Proceeds On Burial Exclusions

1. Revocable Assignment

a. Burial Spaces
The burial space exclusion does not apply to the CSV of the life insurance policy. This is because the funeral provider has not received any payment and no purchase of burial spaces has been made. The provider has no obligation to provide any spaces until the individual dies and, therefore, no spaces are being held for the individual.

b. Burial Funds
The resource value of the burial contract is equal to the CSV of the life insurance policy. Treat the CSV according to the policy described in c. below.

c. Treatment of CSV

- If the face value of all life insurance policies on the individual's life is $1,500 or less, exclude the CSV under the life insurance exclusion (**M1130.300 B**.).

- If the face value of all policies exceeds $1,500, treat the CSV of the policy according to the burial funds exclusion, if applicable. See **M1130.410** for instructions on the burial funds exclusion.

d. Examples

- Ms. Lydia Fisher has a $1,300 burial contract funded by the revocable assignment of the proceeds of an insurance policy with a face value of $1,300 on her life. The CSV of the policy is $1,000. If this is the only life insurance policy she owns on her life, then the life insurance policy would be excluded under the life insurance exclusion and the burial exclusions would not apply.

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The life insurance policy's face value of $1,300 reduces the maximum $3,500 burial fund exclusion by that same amount. Ms. Fisher may have an additional $2,200 in excluded burial funds.

- If Ms. Fisher has another life insurance policy on her life and the total face value of the two policies exceeds $1,500 (the life insurance exclusion does not apply), then the CSV may be excludable under the burial funds exclusion. No burial space exclusion applies per a. above.

2. Irrevocable Assignments

The eligibility worker must review the policy. If it is found the life insurance policy permit*s the* irrevocable assignment of policy proceeds without requiring the irrevocable assignment of ownership, submit a copy of the policy to the Regional *Consultant for review.*

E. Policy--Life Insurance Policy Placed in a Trust

A life insurance company may provide an individual with the option of irrevocably transferring ownership of a revocable life insurance policy that funds a burial contract to a trust established by the company.

1. Treatment of Policy's CSV

If an individual assigns a life insurance policy to a trust the CSV (if any) will not continue to be a countable resource; if

- the individual neither owns nor has the legal right to direct the use of trust assets to meet his or her maintenance needs*;* and
- a *revocable* assigned life insurance policy funds a funeral contract and the policy is placed irrevocably in a trust then the policy's CSV is not a resource for Medicaid purposes.

2. Treatment Of Dividends

If the policy's CSV is not a resource, assume, absent evidence to the contrary, that any dividends paid on the policy are also not a resource.

3. Individual Retains Right to Change Funeral Firm

Under an irrevocable trust arrangement, the life insurance policy's CSV is not a resource even if the individual retains the right to change the funeral firm that will provide the burial goods and services.

4. Burial Fund Exclusions Offset

A *revocable* assigned life insurance policy placed in an irrevocable life insurance trust is treated the same as a life insurance policy for which the ownership has been irrevocably assigned to fund a burial contract (see C.2 above). This means that the value of the burial funds portion of the contract (IF ANY) reduces the $3,500 burial funds exclusion.

This is the case because the burial funds portion of the contract represents an irrevocable arrangement that is available to meet the individual's burial expenses.

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F. Procedure--General

1. Development and Documentation

Follow instructions in **M1130.410** E. regarding the development and documentation of burial funds. See additional instructions below.

a. Life Insurance Policy

Examine the life insurance policy and document whether the ownership/proceeds of the policy have been assigned (revocably or irrevocably) and, if so, to whom.

If ownership or proceeds of the life insurance policy have been **revocably** assigned, follow regular life insurance development procedures. (See **M1130.300** C. for further development and documentation requirements.)

If ownership of the life insurance policy has been **irrevocably** assigned, apply the policy principles in C.2. above to determine the policy's resource status.

If an insurance policy that funds a funeral arrangement is placed **irrevocably in trust**, apply the policy principles in E. above to determine the policy's resource status. For out-of-state contracts contact the regional specialist.

In all cases, document the file with a copy of:

- the life insurance policy;
- the assignment; and
- any other related documents.

b. Options for Developing Policies Issued by Nonparticipating or Stock Companies

If the insurance policy funding the burial contract is issued by a nonparticipating or stock company (and therefore does not pay dividends), you may be able to curtail development as to the policy's CSV. You can use the CSV chart attached to the policy instead of contacting the life insurance company. See **M1130.300** C.5. for more information.

c. Burial Contract

Examine the burial contract and determine what items and/or arrangements have been contracted. Document the file with a copy of the burial contract.

2. Determine Applicability of Burial Space/Fund Exclusions

Apply the policy principles in C. and D. above and determine:

- the value of the contract that is excludable as a burial space (if any) (**M1130.400**); and
- the value of the contract that is excludable as burial funds (if any) (**M1130.410**).

Put your determination in the file.

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G. Procedures--Redetermination Development

For a previously developed life insurance funded burial contract, redevelop and document the value of the contract using applicable life insurance development procedures if:

- ownership and/or proceeds of the policy have been **revocably** assigned (i.e., the CSV of the policy must be reverified); or
- ownership of the policy has been **irrevocably** assigned (or a revocably assigned policy has been placed irrevocably in trust) and the individual has other excluded burial funds (i.e., the value of the contract reduces the amount of other funds that may be excluded).

M1130.430 HOUSEHOLD GOODS AND PERSONAL EFFECTS

A. Policy Principle

Household goods and personal effects are excluded resources for Medicaid evaluations.

B. Definitions

1. 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, but are not limited to: furniture, appliances, televisions sets, carpets, cooking and eating utensils, dishes, etc.

2. 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 or her. They include, but are not limited to: clothing, jewelry, personal care items, prosthetic devices, and educational or recreational items such as books, musical instruments, or hobby materials.

S1130.455 GRANTS, SCHOLARSHIPS, FELLOWSHIPS, AND GIFTS

A. Policy Principle

Section 435 of The Social Security Protection Act of 2004, Public Law 108-203, provides a 9-month resource exclusion for grants, scholarships, fellowships, and gifts used to pay for tuition, fees, and other necessary educational expenses at any educational institution, including vocational and technical education.

B. Definitions

1. Grants, Scholarships, and Fellowships

Grants, scholarships, and fellowships are amounts paid by private nonprofit agencies, the U.S. Government, instrumentalities, or agencies of the U.S., State and local governments, foreign governments, and private concerns (e.g. a private citizen) to enable qualified individuals to further their education and training by scholastic or research work, etc.

2. Gifts

A gift is something a person receives which is not repayment for goods or services the person provided and is not given because of a legal obligation on the giver's part. To be a gift, something must be given irrevocably (i.e., the



donor relinquishes all control). "Donations" and "contributions" (including crowdsourcing and crowdfunding) may meet the definition of a gift. See M0830.520.

3. Tuition, Fees, and Other Necessary Educational Expenses

Educational expenses include laboratory fees, student activity fees, transportation, stationery supplies, books, technology fees, and impairment-related expenses necessary to attend school or perform schoolwork (e.g., special transportation to and from classes, special prosthetic devices necessary to operate school machines or equipment, etc.).

C. Policy – Assistance Under Title IV Of The Higher Education Act Of 1965 (HEA) Or Bureau Of Indian Affairs (BIA)

1. Title IV of HEA or BIA Involvement

All student financial assistance received under HEA, or under BIA student assistance programs, is excluded from income and resources, regardless of use. The resource exclusion for this educational assistance does not have a time limit, i.e. regardless of how long the assistance is held, it is excluded from resources.

Examples of HEA Title IV Programs:

- *Pell grants*
- *State Student Incentives*
- *Academic Achievement Incentive Scholarships*
- *Byrd Scholars*
- *Federal Supplemental Educational Opportunities Grants (FSEOG)*
- *Federal Educational Loans (Federal PLUS Loans, Perkins Loans, Stafford Loans, Ford Loans, etc.)*
- *Upward Bound*
- *Gear Up (Gaining Early Awareness and Readiness for Undergraduate Programs)*
- *LEAP (Leveraging Educational Assistance Partnership)*
- *SLEAP (Special Leveraging Educational Assistance Partnership)*
- *Work-Study Programs.*

***NOTE**: State educational assistance programs, including work-study, funded by LEAP or SLEAP are programs under Title IV of HEA.*

2. Interest and Dividends Earned on Title IV of HEA or BIA Educational Assistance

- *Interest and dividends earned on unspent educational assistance under Title IV of HEA or under BIA are excluded from income. See M0830.500.*

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D. Policy - Other Grants, Scholarships, Fellowships, and Gifts

Any portion of a grant, scholarship, fellowship, or gift used or intended to be used to pay the cost of tuition, fees, or other necessary educational expenses at any educational institution, including vocational and technical education, is excluded from resources for 9 months beginning the month after the month it was received. This exclusion does not apply to any portion set aside or actually used for food or shelter.

Grants, scholarships, fellowships, and gifts that are retained after the 9-month exclusion period are countable resources beginning the month following the end of the 9th month.

If any portion of this excluded educational assistance is used for something other than tuition, fees, or other necessary educational expenses or the individual no longer intends for the funds to be used to pay tuition, fees, or other necessary educational expenses, then the funds are income at the earliest of the following points: in the month they are spent, or the month the individual no longer intends to use the funds to pay tuition, fees, or other necessary educational expenses.

Interest and dividends earned on unspent educational assistance under Title IV of HEA or under BIA are excluded from income. Interest or dividends earned on other forms of excluded educational assistance are counted as income. Interest or dividends earned on countable educational assistance are excluded from income. See M00830.500.

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REAL OR PERSONAL PROPERTY

S1130.500 PROPERTY ESSENTIAL TO SELF-SUPPORT – OVERVIEW

A. Introduction

The Social Security Act provides for the exclusion from resources of property that the Secretary determines is so essential to an individual's means of self-support as to warrant exclusion.

B. Policy Principles

1. Categories Of Property Excluded Under This Provision

Resources excluded under this provision generally fall into 3 categories. Each is listed below and then described in more detail in a subsequent section.

a. Property Excluded Regardless of Value or Rate of Return

This category encompasses:

- property used in a trade or business (effective 5/1/90);
- property that represents government authority to engage in an income producing activity;
- property used by an individual as an employee for work (effective 5/1/90); and
- property required by an employer for work (before 5/1/90).

See S1130.501.

b. Property Excluded up to $6,000 Equity, Regardless of Rate of Return

This category includes **nonbusiness** property used to produce **goods** or **services** essential to daily activities. For example, it covers land used to produce vegetables or livestock **solely** for consumption by the individual's household. See S1130.502.

c. Property Excluded up to $6,000 Equity if it Produces a 6% Rate of Return

This category encompasses:

- property used in a trade or business in the period before 5/1/90;
- nonbusiness income-producing property. However, the exclusion does not apply to equity in excess of $6,000 and does not apply if the property does not produce an annual return of at least 6% of the excluded equity. If there is more than one potentially excludable property, the rate of return requirement applies individually to each. See S1130.503.

2. Current Use Criterion

Resources that are excluded under this provision must be in current use in the type of activity described. If not in current use, there must be a reasonable expectation that the required use will resume. See S1130.504.

3. Liquid Resources

Liquid resources are not considered property essential to self-support except when used as part of a trade or business.

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C. Policy--Limitations On Development

It is not necessary to develop for the exclusion of property essential to self-support if:

- the combined value of the self-support property and other countable resources does not exceed the applicable resource limit;
- the value of other countable resources (including any equity over
- $6,000 when B.1.b. or c. is involved) exceeds the applicable resource limit;
- the individual is ineligible for a **nonfinancial** reason; or
- the property was excluded under the State plan in effect for October 1972 and the individual meets the "grandfathering" criteria.

D. Related Policies

1. Home Property

When an individual uses home property to perform self-support activities, the property is excluded under S1130.100, regardless of its value, rate of return, or current use.

2. Plan For Achieving Self-Support (PASS)

The primary differences between the exclusion of property essential to self-support and the exclusions provided for under a PASS (see *M0810.430*) are that the PASS exclusions:

- cover income as well as resources;
- apply to the blind and disabled, but not to the aged;
- have a time limit; and
- do not have an inherent dollar limit.

Consider the overall resource situation to ensure that the individual receives the benefit of the most advantageous exclusion for him or her.

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*M*1130.501 ESSENTIAL PROPERTY EXCLUDED REGARDLESS OF VALUE OR RATE OF RETURN

A. Policy Principles

1. The Exclusion

The properties described in 2, 3, and 4 below are excluded as essential to self-support regardless of value or rate of return. However, they must be in current use or, if not in use for reasons beyond the individual's control, there must be a reasonable expectation that the required use will resume.

2. Trade Or Business Property

Property essential to self-support used in a trade or business is excluded from resources regardless of value or rate of return effective 5/1/90.

3. Government Permits

Government permits represent authority granted by a government agency to engage in income producing activity. Examples are commercial fishing permits granted by a State Commerce Commission and tobacco crop allotments issued by the U.S. Department of Agriculture.

4. Personal Property Used by an Employee

Personal property used by an employee for work is excluded from resources. Excluded items include tools, safety equipment, uniforms, etc.

B. Development and Documentation-- General

The rules in C., D., and E. below apply unless development can be eliminated in accordance with S1130.500 C.

C. Development and Documentation -- Property Used in a Trade or Business

1. Trade or Business Not Being Excluded

When an individual alleges owning trade or business property not already being excluded, consider if a valid trade or business exists, and if the property is in current use (see S1130.504). Obtain a statement giving the information below. Absent evidence to the contrary, accept the responses to items a.-d. Verify e. with the business tax returns.

a. a description of the trade or business;
b. a description of the assets of the trade or business;
c. the number of years it has been operating (see 4. below);
d. the identity of any co-owners;
e. the estimated gross and net earnings of the trade or business for the current tax year (see 3. below).

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2. Redetermination of Excluded Trade or Business Property

Consider current use of the property in the trade or business. Obtain and verify the individual's allegations as to the estimated gross and net earnings of the trade or business for the current tax year for income purposes (see S0820.230).

3. Use of Tax Returns

a. Use Most Recent Tax Return

Obtain a copy of the business tax return (i.e., 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; and
- Form 1065, U.S. Partnership Return of Income.

b. Current Tax Return Not Available

If the current tax return is not available, obtain a copy of the latest tax return available.

4. Questionable Trade or Business

If a trade or business has operated a year or less, or there is a question of bona fides, develop to determine whether a trade or business actually exists.

5. Liquid Resources Used in a Trade or Business

Effective May 1, 1990, all liquid resources used in the operation of a trade or business are excluded as property essential to self-support. Obtain an individual's signed allegation that liquid resources are used in the trade or business.

D. Development and Documentation Government Permits

1. Individual's Statement

Permit Alleged

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 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; and
- how the license, permit, or other property is being used; or
- if it is not being used, why not.

If the property is not being used, see S1130.504 for development.

2. Supporting Evidence

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 to have a permit. In North Carolina, a person growing flue-cured tobacco would



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have to 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.

3. Common Government Permits

a. Alaska Limited Entry Fishing Permit (ALEFP)
An ALEFP is one of the two most commonly encountered types of property representing required government authority to engage in an income producing activity. Alaska's Commercial Fisheries Entry Commission first issued ALEFP's in 1973 to control commercial salmon fishing. These permits are required for individuals who engage in the fishing trade.

b. 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 *(USDA)* Agricultural Stabilization and Conservation Services. 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.

c. Tobacco Quota Buy-Out Program

The Tobacco Quota Buy-Out Program is administered by the USDA. The program involves a contract between the USDA and the land owner and/or the producer (the individual, other than the land owner, who grows the crop) and provides payments to the land owner and/or producer for their tobacco "base" or quotas. The unpaid balance of the contract is a countable resource.

E. Development and Documentation -- Personal Property Used by an Employee

1. Individual's Statement

If an individual alleges owning items that are used in his or her work as an employee, obtain his or her statement to include:

- the name, address, and telephone number of the employer;
- a general description of the items;
- a general description of his or her duties; and
- whether the items are currently being used.

If the individual is temporarily not working (e.g., job loss, seasonal employment), or the property is not otherwise in current use, see S1130.504.

2. Supporting Evidence

Absent evidence to the contrary, accept the individual's statement.

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S1130.502 ESSENTIAL PROPERTY EXCLUDED UP TO $6,000 EQUITY REGARDLESS OF RATE OF RETURN

A. Policy Principles

1. The Exclusion

Up to $6,000 of the equity value of nonbusiness property used to produce goods or services essential to daily activities is excluded from resources.

- CMV less balance of any recorded liens against the property

There is no requirement that the property produce a certain rate of return. The property must be in current use or, if it is not in use for reasons beyond the individual's control, there must be a reasonable expectation that the required use will resume.

2. Equity Exceeds $6,000

Any portion of the property's equity value in excess of $6,000 is not excluded under this provision.

3. Nonbusiness Property Producing Essential Goods or Services

Nonbusiness property essential to self-support can be real or personal property. It produces goods or services essential to daily activities if, for example, it is used to:

- grow produce or livestock solely for personal consumption in the individual's household; or
- perform activities essential to the production of food solely for home consumption.

NOTE: While this category of property may encompass a vehicle used solely in a nonbusiness self-support activity (e.g., a garden tractor, or a boat used for subsistence, fishing), it does not include any vehicle that qualifies as an automobile (see S1130.200 A.).

B. Development and Documentation--Initial Applications and Posteligibility

1. Individual's Statement

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 giving:

- a description of the property;
- how it is used; and
- an estimate of its CMV and any encumbrances on it.

Absent evidence to the contrary, accept the statement.

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2. Supporting Evidence of Value

a. Real Property
Determine the CMV and, if necessary, the EV of real property in accordance with S1140.100.

b. Personal Property
Have the individual obtain a CMV estimate from a knowledgeable source. The estimate must:

clearly identify the source;
contain a description of the item whose CMV is being estimated; and
show the basis for the estimate.

NOTE: If a knowledgeable source provides a value range, use the lower edge of the range.

3. Current Use Criterion

If the property is not in current use, see S1130.504 for development.

S1130.503 ESSENTIAL PROPERTY EXCLUDED UP TO $6,000 EQUITY IF IT PRODUCES A 6 PERCENT RATE OF RETURN

A. Policy Principles

1. The Exclusion

Up to $6,000 of the equity value of nonbusiness income producing property (and business income producing property for months of eligibility before May 1, 1990) can be excluded from resources if the property produces a net annual return equal to at least 6% of the excluded equity.

2. Equity Exceeds $6,000

Any portion of the property's equity value in excess of $6,000 is not excluded under this provision.

3. Rate of Return Less Than 6%

If the property produces less than 6% return, the exclusion can apply only if:

- the lower return is for reasons beyond the individual's control (e.g., crop failure or illness); and
- there is a reasonable expectation that the property will again produce 6% return (see C. below).

Otherwise, none of the EV is excluded under this provision.

4. More Than One Income Producing Property

If an individual owns more than one piece of income producing property;

- the 6% return requirement applies individually to each; and
- the $6,000 EV limit applies to the total EV of all the properties meeting the 6% return requirement.

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If all properties meet the 6% test but the total EV exceeds $6,000, that portion of the total EV in excess of $6,000 is not excluded under this provision.

B. Examples

1. Rental Property With an EV in Excess of $6,000

At redetermination, Mr. Cameron states that he now lives in an apartment and is renting out his formerly excluded home, which has an EV of $10,000. Even if the property produces a 6% rate of return, $4,000 of its equity cannot be excluded under this provision.

2. Multiple Income Producing Activities

Mr. Patterson owns a mobile home (not his residence) that has a CMV and EV of $3,000. He owns other property that has a CMV and EV of $2,000. The mobile home produces a net annual rental income of $750, and the other property produces less than $50 a year.

Since the mobile home produces more than a 6% return, its EV is excluded. Since the other property produces less than a 6% return, its EV is not excluded.

C. Operating Policy—Time Limit for Resumption of 6% Return

1. General Rule

If the earnings decline was for reasons beyond the individual's control, up to 24 months can be allowed for the property to resume producing a 6% return. The 24 month period begins with the first day of the tax year following the one in which the return dropped to below 6%. See E. below for development.

2. Initial Applications

In an initial application, if the tax returns show that the activity has operated at a loss for the two most recent years or longer, the property cannot be excluded unless the individual submits current receipts and records to show that it currently is producing a 6% return.

3. Trade or Business in Operation for One Year or Less

If a trade or business has operated for a year or less, develop to determine whether a trade or business actually exists.

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D. Development and Documentation—Non-business Property

1. Income Producing Real Property

a. Individual's Statement

When an individual alleges owning non-business real property that produces income (e.g. land or house for rent), obtain his or her signed statement concerning:

- the number of years 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; and
- the estimated net and gross income from the property for the current tax year.

b. Supporting Evidence

Absent evidence to the contrary, accept the statement with respect to years of ownership, identity of owners and description of the property.

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 Medicaid application. If no tax return is available, obtain other appropriate evidence from the individual (e.g. a copy of the lease agreement for the period in question). If it is necessary to verify EV, see S1140.042.

NOTE: When redetermining the status of property already excluded under this provision, only the value and income need to be redeveloped.

2. Income Producing Personal Property

See S1130.502 B. for development of the property's use and value. In addition, obtain the individual's statement giving net and gross income from the property for the current tax year. Verify the property's rate of return by reviewing a copy of Schedule E of Form 1040 for the tax year prior to filing or redetermination. If no tax return is available, obtain the appropriate evidence from the individual to establish the income alleged.

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E. Development and Documentation--Rate of Return Less Than 6%

Apply these instructions in determining the excludability of nonbusiness income producing property (and business property for periods before May 1, 1990) when the tax return shows an earnings rate of less than 6%.

1. Individual's Explanation

Record the individual's explanation of the earnings decline in the file.

2. Supporting Evidence

Obtain evidence of prior years' earnings (e.g., tax returns for at least 2 years prior to the current tax year) to determine whether the activity has produced a 6% rate of return before.

NOTE: When no tax returns are available, use other evidence such as receipts, check registers, invoices, sales slips, bank statements, etc.

3. Circumstances Beyond The Individual's Control

a. Special Review

If evidence establishes that the earnings decline is for reasons beyond the individual's control, he or she has up to 24 months from the end of the tax year in which the earnings went below 6% to meet the 6% requirement. Set a special review to check progress after 12 months.

b. 12-Month Follow-up

If the 12-month follow-up shows that the activity is again producing a 6% return, further follow-up is necessary.

If the activity still is not producing 6% return but the individual is actively pursuing it, allow an additional 12 months.

If the individual has ceased actively pursuing the activity, include the value of the property in determining resources for the month after the month of review.

c. 24-Month Period Ends

If the property still is not producing a 6% return, include the value of the property in determining resources for the month following the month in which the 24-month period ends.

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S1130.504 ESSENTIAL PROPERTY--CURRENT USE CRITERION

A. Policy Principle

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:

- it has been in use; and
- there is a reasonable expectation that the use will resume.

B. Policy--Time Limit for Resumption of Use

1. 12-Month Rule

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.

2. 12-Month Extension

The 12-month period can be extended for an additional 12 months if nonuse is due to a disabling condition (see D. below).

C. Procedure--General

1. Individual's Statement

If property is not in current use, obtain the individual's signed statement as to:

- the date of last use;
- the reason(s) the property is not in use; and
- when the individual expects to resume the self-support activity, if at all.

2. Explanation to Individual

Explain that we can exclude the property for up to 12 months if resumption of the self-support activity can reasonably be expected to occur within that time.

3. No Intent to Resume Activity

If the individual does not intend to resume the self-support activity, the property is a countable resource for the month after the month of last use. However, see 5. below.

4. Intent To Resume Activity

a. Special Review Set
If the individual intends to resume use of the property, prepare a special review for 12 months from the date of last use.

b. Special Review Evaluation
In the month of special review, contact the individual to see whether he or she has resumed use of the property. If not, the property is a countable resource for the month after the month in which the 12-month period expired.

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5. Change of Intent

If, after property has been excluded because an individual intends to resume self-support activity, the individual decides not to resume such activity, the exclusion ceases to apply as of the date of the change of intent. Thus, unless excluded under another provision, the property is a resource for the following month.

D. Procedure -- Disabling Condition

1. Individual's Statement

If an individual alleges that self-support property is not in current use because of a disabling condition, obtain the individual's signed statement as to:

- the nature of the condition;
- the date *they* ceased the self-support activity; and
- when *they* intend to resume the activity, if at all.

2. Special Review

Prepare a special review as to whether up to an additional 12 months will be allowed for resuming use of the property.

NOTE: Medical review is not an indicator of an individual's intent or ability to do at least some work.

S1130.510 RESOURCES SET ASIDE AS PART OF A PLAN FOR ACHIEVING SELF-SUPPORT

A. Introduction

A plan for achieving self-support (PASS) allows blind and disabled (but not aged) individuals to set aside income and/or resources necessary for the achievement of ~~its~~ goals.
A Work Incentive Account (WIN) allows blind and disabled individuals to work and set aside income while also being eligible as an SSI OR SSDI recipient

B. Policy Principle

Resources set aside as part of an approved PASS are excluded.

WIN accounts are excluded up to the SSI Threshold amount if an individual is enrolled in Medicaid Works.

C. Development and Documentation

PASS resources are determined by SSI. See M0810.430 for additional information about PASS. *See M0320.400 for additional information on WIN accounts.*

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M1130.520 TRUSTS ESTABLISHED BETWEEN JULY 1, 1993 AND AUGUST 10, 1993

A. Introduction

Trusts established between July 1, 1993 and August 10, 1993 can have up to $25,000 disregarded from countable resources.

B. Definitions

1. MQT

A trust or similar legal device (SLD) is a legal instrument established other than by a will which:

Is established by an individual or spouse (also includes trusts established by a guardian or representative payee for an incompetent adult or any child);
The individual may be beneficiary of all or part of the funds;
Is either revocable or irrevocable;
Trustees have discretion (whether or not the discretion is actually exercised) in distributing funds to the beneficiary;
May or may not be established for purposes other than to enable the beneficiary to qualify for medical assistance.

2. "SLD"

An "SLD" is a legal instrument:

Under which the individual transfers or surrenders property to another individual;
In which a second individual has legal responsibility to manage the property for the first individual;
Which can include oral trusts, constructive trusts, and trusts created in law, in addition to trusts created by a written legal document; and
Which may not be labeled a "trust" but seems to meet all of the MQT criteria listed above.

C. Policy

Some trusts have provisions which place limits on the discretion of the trustee either directly or indirectly to make payments from the trust to the grantor when the grantor makes a Medicaid application, or requires medical, hospital, or long-term care services. **Any restricting clauses in trusts created after July 1, 1993, are void if they limit the discretion of the trustee when the grantor applies for Medicaid or needs medical, hospital, or long-term care services.**

1. Trusts Less Than $25,000

Trust(s) Less than $25,000 created after July 1, 1993 and before August 11, 1993

None of the principle is counted as a resource for single or multiple trusts created after July 1, 1993 and before August 11, 1993 when corpus or corpora **is less than $25,000.** The maximum **amount** of income payable from the trust according to its terms is considered available income whether or not it is actually paid to the applicant or recipient.

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2. Trusts Greater Than $25,000

Trust(s) Greater than $25,000 created after July 1, 1993 and before August 11, 1993

A single trust or multiple trust created after July 1, 1993 and before August 11, 1993, when the corpus or corpora is more than $25,000, may have partial exclusion of the corpus.

D. Development/ Documentation

1. Verify Trust(s)

- **Obtain copy of trust(s) document(s).**
- Verify **current value of the** corpus or corpora of the trust(s).

2. Apply Disregard

a. Prorate $25,000 by the number of trusts

b. Subtract prorated amount from corpus or corpora of the trust(s).

3. Countable Resource

The remainder of the corpus or corpora of the trust(s)

- that may be paid under the terms of the trust
- without any limits imposed by **any** void restrictive clause
- is counted as an available resource to the applicant or recipient regardless of whether or not:
- the trust is irrevocable; or
- the trust was established for purposes other than to make the individual eligible for Medicaid; or
- the trustee exercises his discretion to distribute trust payments to the applicant/recipient.

E. References

Trusts Created After July 1, 1993 and Before August 11, 1993 with Corpus in Excess of $25,000, M1140.403.

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RETAINED CASH AND IN-KIND PAYMENTS

S1130.600 RETROACTIVE SSI AND SS PAYMENTS

A. Definitions

1. Retroactive SSI Benefits — Retroactive SSI benefits -- which include any federally administered State supplementation -- are SSI benefits issued in any month after the calendar month for which they are paid. Thus, benefits for January that are issued in February are retroactive.

2. Retroactive SS Benefits — Retroactive SS benefits are those issued in any month that is more than a month after the calendar month for which they are paid. Therefore, SS benefits for January that are issued in February are not retroactive, but SS benefits for January that are issued in March are retroactive.

B. Policy Principles

1. 9-Month Exclusion — The unspent portion of retroactive SSI and SS benefits received on or after 11/01/05 is excluded from resources for the nine (9) calendar months following the month in which the individual receives the benefits.

2. 6-Month Exclusion — The unspent portion of retroactive SSI and SS benefits received before 11/01/05 is excluded from resources for the six (6) calendar months following the month in which the individual receives the benefits.

C. Related Policies

1. Interest — Interest earned by funds excluded under this provision is not excluded from income under this provision. Develop interest per S0830.500.

2. Commingled Funds — See S1130.700 if excluded funds have been commingled with other funds.

S1130.601 DEDICATED ACCOUNTS FOR PAST-DUE BENEFITS DUE TO INDIVIDUALS UNDER 18 WHO HAVE A REPRESENTATIVE PAYEE

A. Background and Definitions — *Section 213 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, P.L. 104-193, enacted August 22, 1996, requires that when an eligible individual under age 18 is eligible for past-due Supplemental Security Income (SSI) monthly benefits which exceeds the amount specified in SSI policy, the representative payee **must** establish a dedicated account in a financial institution into which the past-due benefits will be paid. Subsequent amounts of past-due benefits that exceed this amount must also be paid into this account.*

1. Dedicated Account — *A dedicated account is an account in a financial institution, the sole purpose of which is to receive and maintain SSI past-due benefits which are required or allowed to be paid into such an account and the use of which is restricted by section 1631(a)(2)(F) of the Social Security Act. Funds other than those allowed by SSI policy may not be deposited into a dedicated account.*



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2. Past-Due SSI Benefits

Past-due SSI benefits are:

a. benefits due but unpaid which accrue prior to the month payment was effectuated;
b. benefits due but unpaid which accrue during a period of suspension for which the recipient was subsequently determined to have been eligible; and
c. any adjustment to benefits which results in an accrual of unpaid benefits.

B. Policy Principles

1. Resources

Past-due benefits and other underpayments described above deposited into a dedicated financial institution account and any accrued interest or other earnings on such an account are excluded from resources. For any month that funds other than accrued interest or other earnings on the account are commingled in this account, the exclusion does not apply to any funds in the account.

***EXCEPTION:** Funds, other than past-due benefits, required by a financial institution to open the dedicated account may be commingled in the account, but only until the end of the month following the month that the past-due benefits are paid. However, these funds other than past-due benefits in the account are **not** excluded from resources.*

2. Interest and Other Earnings

Interest and other earnings (e.g., dividends) earned on and left to accrue in the excluded dedicated account are excluded from income and resources.

3. Exclusion During a Period of SSI Suspension or Termination

Restrictions on the use of funds in a dedicated account continue to apply during a period of suspension of SSI benefits (e.g., status S06), non-pay (e.g., status N04), and eligibility but no payment (status E01). The exclusion from resources of the funds in the account continues to apply during a period of suspension, non-pay, or eligibility but no payment, prior to termination (i.e,, the 12 months prior to status T31).

Once an individual's eligibility has been terminated, the exclusion of the funds in a dedicated account cannot be carried over if the individual establishes a new period of SSI eligibility by filing a new application for SSI. Reopening of a prior period of eligibility following termination is not a new period of eligibility and, therefore, the exclusion may be reapplied. Any remaining funds are a countable resource.

4.. Nine (9)-month Exclusion of SSI Underpay-ments from Resources

*When an individual receives past-due benefits that **may** be, but have not yet been, deposited into a dedicated account, the exclusion in S1130.600 applies for the lesser of 9 months or until the payee deposits the payment into the dedicated account.*

S1130.605 NETHERLANDS WUV PAYMENTS TO VICTIMS OF PERSECUTION

A. Background

The Netherlands' Act on Benefits for Victims of Persecution 1940-1945, WUV (Wet Uiterking Vervlgingsslachtoffers), provides payments to individuals who, during the German and Japanese occupation of the Netherlands and the Netherlands East Indies (now the Republic of Indonesia), were victims of persecution during World War II because of their race, religion, belief or homosexuality and, as a result of that persecution presently are suffering from illnesses or disabilities. There are 4 types of payments available to individuals who meet the eligibility rules for payment under the WUV program--periodical income, NMIK (compensation for non-definable disability expenses), reimbursements of persecution-related disability expenses and partial compensation for persecution related disability expenses.

B. Policy

1. The Resource Exclusion

Unspent WUV payments made by the Dutch government are excluded from resources.

2. Interest on Unspent Payments

Interest earned on unspent WUV payments *prior to July 1, 2004* is not excluded from income or resources. *Interest earned on unspent WUV payments on or after July 1, 2004 is excluded from income and resources* (See S0830.500 for development.)

C. Procedure

1. When to Develop

When an individual would otherwise be ineligible due to excess resources, determine if applying this exclusion would permit eligibility. If the exclusion would permit eligibility, develop per 2. below.

NOTE: If the individual is resources-eligible even without the application of this exclusion, it is not necessary to develop under this section.

2. Development and Documentation

If an individual alleges that his/her resources include unspent Netherlands WUV payments:

a. Using the documents in the individual's possession, document the date(s), and amount(s) of such payment(s). If the individual has no documentation or it is incomplete, contact the Consulate General of the Netherlands to verify payment date(s) and amount(s). See S0830.725C. for the address and phone number. If the individual has no documentation and the Consulate General of the Netherlands is unable to provide the information, then accept the individual's signed allegation of the amount(s) and the date(s) of receipt.

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b. Obtain a statement as to the date(s) and amount(s) of any account deposits corresponding to the payments; and
c. Document the case record that the individual's resources include unspent WUV payments that are excludable.

D. References

Excluded funds commingled with nonexcluded funds, S1130.700
Income exclusion, Netherlands WUV payments, S0830.725

S1130.610 GERMAN REPARATIONS PAYMENTS

A. Introduction

"German reparations payments" are made to certain survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution, or German Restitution Act. These payments may be made periodically or in a lump sum.

B. Policy

1. The Exclusion

Unspent German reparations payments are excluded from resources. The exclusion applies only if it would affect eligibility for Medicaid.

2. *Interest on Unspent Payments*

Interest earned on unspent German reparations payments prior to July 1, 2004 is not excluded from income or resources. Interest earned on unspent German reparation payments on or after July 1, 2004 is excluded from income and resources.

C. References

Excluded funds have been commingled with other funds, S1130.700.
Interest earned by conserved German reparations payments is not excluded from income by this provision, S0830.260.
The exclusion of German reparations payments from income, S0830.710.

D. Development and Documentation--Initial Application

If an individual alleges that his or her resources include German reparations payments, obtain a statement to:

the date(s) and amount(s) of such payment(s); and
the date(s) and amount(s) of any corresponding account deposit(s).

Absent evidence to the contrary, accept the allegation.

E. Development and Documentation--Posteligibility

The redetermination development for German reparations payments is the same as the initial application development.

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S1130.615 AUSTRIAN SOCIAL INSURANCE PAYMENTS

A. Background

The nationwide class action law suit, Bondy v. Sullivan, involved Austrian social insurance payments which were based, in whole or in part, on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act. These paragraphs grant credits to individuals who suffered a loss (i.e., were imprisoned, unemployed, or forced to flee Austria) during the period of March 1933 to May 1945 for political, religious, or ethnic reasons. Not all Austrian social insurance payments are based on Paragraphs 500-506.

B. Policy

1. The Resource Exclusion

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 are excluded from resources.

Austrian social insurance payments **not** based on wage credits granted under Paragraphs 500-506 are **not** excluded from resources under this provision.

2. Interest On Unspent Payments

Interest earned on unspent Austrian social insurance payments *prior to July 1, 2004 is not excluded from income or resources. Interest earned on unspent* Austrian social insurance payments *on or after July 1, 2004 is excluded from income and resources.*

C. Procedure--Initial Applications and Posteligibility

1. When to Develop

When an individual would otherwise be ineligible due to excess resources, determine if applying this exclusion would permit eligibility. If the exclusion would permit eligibility, develop per 2. below.

If the individual is resources-eligible even without the application of this exclusion, it is not necessary to develop under this section.

2. Development and Documentation

If an individual alleges that his or her resources include unspent Austrian social insurance payments:

a. Determine whether the payments are counted as income, per S0830.715.

   If the payments **are** counted as income, this resource exclusion does **not** apply. If the payments are **not** counted as income, go to b.

b. Obtain a signed statement from the individual as to the date(s) and amount(s) of any account deposits corresponding to the Austrian social insurance payments. Apply the policy in B. above and exclude the unspent payments from the determination of countable resources.

D. References

Excluded funds commingled with nonexcluded funds, S1130.700
Income exclusion, Austrian social insurance payments, S0830.715

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S1130.620 DISASTER ASSISTANCE *(including COVID-19 Relief Payments)*

A. Policy

1. The Exclusion--December 1, 1988 and Continuing

Unspent assistance received from the following sources is permanently excluded from resources:

the Disaster Relief and Emergency Assistance Act (P.L. 100-707);

- **another Federal statute because of a presidentially-declared major disaster;**
- **comparable assistance received from a State or local government; or**
  - **from a disaster assistance organization.**

To be excluded from resources, the funds must be excludable from income per S0830.620.

2. Interest on Excluded Funds

Interest earned on funds excluded under this provision is excluded from income and from resources. (For months prior to December 1988, interest was excluded from income and resources for as long as the funds themselves were excluded.)

B. Procedure

1. When to Develop

Develop this exclusion only when an individual alleges the receipt of assistance excludable under this provision and the exclusion would permit eligibility.

2. Evidence of Excludability

Follow the instructions in S0830.620. If the file contains evidence that the disaster assistance is excluded from income, use the same evidence to establish that the assistance is excluded from resources.

3. Document the Determination

Summarize the basis for the exclusion in the case record. Show the amount excluded and the first month and year that the exclusion applies.

C. References

Payments for repair or replacement of lost, damaged, or stolen excluded resources, S1130.630.

Identifying excluded funds that have been commingled with nonexcluded funds, S1130.700.

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S1130.630 CASH AND IN-KIND ITEMS RECEIVED FOR THE REPAIR OR REPLACEMENT OF LOST, DAMAGED, OR STOLEN EXCLUDED RESOURCES

A. Policy-Time Periods

1. The Policy

Cash and in-kind receipts (ISM or other) from any source for the replacement or repair of lost, damaged, or stolen excluded resources are themselves not treated as resources for 9 months from the date of their receipt.

2. Extension for Good Cause

a. General

For cash receipts, the initial 9 month period can be extended for a reasonable period up to an additional 9 months if the individual shows good cause why repair or replacement was not possible during the first 9 months.

b. Definition-Good Cause

Good cause is present if circumstance beyond the individual's control:

- prevent repair or replacement of the lost, damaged, or stolen property; or
- keep the individual from contracting for such repair or replacement.

c. Victims of Hurricane Andrew

Effective March 17, 1994, for victims of Hurricane Andrew only (which occurred in August 1992 and affected South Florida and Louisiana), the period within which the cash or in-kind replacement is not treated as resources can be extended for up to an additinal 12 months beyond the 9-month extension in a. above if the individual continues to show good cause.

NOTE: The total exclusion period for victims of Hurricane Andrew cannot exceed 30 months (9-month initial period, 9-month good cause extension period, additional 12-month good cause extension).

B. Policy-Funds Not Treated as Resources

1. Funds Subject to Policy

There are no restrictions on where cash and/or in-kind items come from for purpose of this policy (e.g., it may come from an insurance company, a Federal or State agency, a public or private organization, or an individual).

However, funds received from the following sources are to be excluded in accordance with S1130.620 rather than these instruction:

- the Disaster Relief and Emergency Assistance Act;
- some other Federal statute because of a presidentially declared major disaster,
- comparable assistance received from a state or local government; or
- a disaster assistance organization.

(See S0830.620 for income treatment)

2. Interest on Funds Not Treated as Resources

Interest earned by funds not treated as resources under this provision is not treated as income and resources for the period during which the funds themselves are not considered resources.

3. Funds for Temporary Housing

This policy applies to funds received for the purchase of temporary housing.

4. Personal Injury Payments

This policy does not apply to funds received on account of personal injury.

C. Policy-Intended Use

1. During First 9 Months

What the individual intends to do with the funds does not affect their treatment for the first 9 months.

2. Role in Extension for Good Cause

An individual cannot qualify for an extension of the initial 9-month period unless he/she intends to use the funds for their designated purpose, i.e., repair or replacement of excluded resources.

3. Change of Intent During Extension

The good cause extension will terminate as of the date of the change of intent. The funds previously not treated as resources will be taken into account in determining resources for the following month.

D. Procedure

1. When to Develop

When an individual would otherwise be ineligible due to excess resources, determine if applying this policy would permit eligibility. If the policy would permit eligibility, develop per the following instructions.

Note: If the individual is resources-eligible even without the application of this policy, it is not necessary to develop under this section.

2. Evidence

a. General

Make sure the evidence show the source, value, date(s), and intended purpose of the items 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.

b. Individual's Records

Obtain a copy of any evidence the individual has.

c. Verification from Source

If the individual cannot provide evidence that suffices for a determination, obtain the necessary information from the source of the payment(s). Do so by telephone, if possible.



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3. Recontact

a. Initial 9-Month Period

Contact the individual at least 30 days before the initial 9-month period expires to determine if a good cause extension is necessary and if the individual qualifies for the extension.

b. Victims of Hurricane Andrew

For victims of Hurricane Andrew only, recontact the individual at least 30 days before the expiration of the 9-month extension, if applicable, to determine if an additional extension is needed.

If, after the 9-month extension for good cause, you grant an additional extension under the Hurricane Andrew provision and that extension is:.

- for 6 months or less: Review at least 30 days before the extension period expires to determine if continuation of the good cause extension is warranted.
- in excess of 6 months: At the mid-point of the extension period recontact the individual.

4. Recontact Evidence Requirements

a. Obtain evidence of the amount of payment(s) not treated as resources that are still unspent.

b. If payment(s) remain unspent, but the individual alleges:

- good cause (see A.2. above); and
- the intent to use the funds for their designated repairs or replacement;

obtain his/her signed statement regarding intent. Also have the individual submit evidence to substantiate the allegation of good cause, e.g., letters from contractors, etc.)

5. Determination

a. No Extension for Good Cause

If the evidence does not establish good cause, include the unspent payment(s) in determining countable resources as of the first moment of the first month after the month in which the policy is no longer applicable.

b. Extension

If such evidence shows good cause, discuss with the individual how much additional time is needed and why. On the basis of that discussion, extend the initial 9-month period for a reasonable period up to an additional 9 months (plus up to an additional 12 months in the case of victims of Hurricane Andrew), repeating development steps 3. and 4. above, as appropriate.

E. References

- Excluded funds commingled with nonexcluded funds, S1130.700.
- Income treatment of items to replace or repair resources that have been lost, damaged, or stolen, S0815.200.



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S1130.640 BENEFITS EXCLUDED FROM BOTH INCOME AND RESOURCES BY A FEDERAL STATUTE OTHER THAN TITLE XVI

A. Introduction — Many Medicaid income and resource exclusions are specified by Federal statutes other than title XVI.

B. Procedure — See S0830.099 for a list of exclusions and a guide to instructions about exclusions specified by other Federal statutes. Follow those instructions.

C. Reference — Funds excluded by other statutes are commingled with other funds, see S1130.700.

S1130.660 AGENT ORANGE SETTLEMENT PAYMENTS

A. Background — See S0830.730.

B. Policy -The Exclusion — Unspent Agent Orange settlement payments are excluded from resources.

C. Policy-Applicability — The exclusion applies only if it would permit eligibility.

D. Policy - General

1. Income Exclusion — See S0830.730.

2. Interest *on Unspent Payments* — Interest earned *on unspent* Agent Orange settlement payments *prior to July 1, 2004* is not excluded *from income or resources. Interest earned on unspent Agent Orange settlement payments on or after July 1, 2004 is excluded from income and resources.* See S0830.500 for development.

3. Commingled Funds — See S1130.700.

E. Development and Documentation -- Initial Applications — If an individual alleges that his or her resources include unspent Agent Orange settlement payments:

- verify the date(s) and amount(s) of such payment(s) in accordance with S0830.730; and
- obtain a statement as to the date(s) and amount(s) of any account deposits corresponding to the payments.

Absent evidence to the contrary, accept the allegation regarding deposits.

F. Development and Documentation --- Post Eligibility — The redetermination development for Agent Orange payments is the same as the initial applications development.

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S1130.665 VICTIM'S COMPENSATION PAYMENTS

A. Policy

1. The Exclusion

Effective for resource determination made for the month of May 1991 and any subsequent months, unspent payments received from a fund established by a State to aid victims of crime are excluded from resources for 9 months.

To be excluded from resources under this provision, the individual must demonstrate that the payment was compensation for expenses incurred or losses suffered as the result of crime.

2. Interest on Unspent Payments

Interest earned on unspent victim's compensation payments is **not** excluded from income or resources by this provision (S0830.500).

B. Procedure--Initial Claims and Post-Eligibility

1. When to Develop

Develop this exclusion only when an individual alleges the receipt of compensation excludable under this provision and the exclusion would permit eligibility.

2. Development and Documentation

If an individual alleges that his or her resources include unspent victim's compensation payments, ask the individual to submit evidence that:

- verifies the source, date(s), and amount(s) of such payment(s); and
- establishes that the payment 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) or any account deposits corresponding to the victim's compensation payment(s).
Assist the individual as necessary.

3. Acceptable Evidence

Accept the following as evidence establishing that the payment was paid for expenses incurred or losses suffered as the result of a crime:

- a letter or check stub accompanying the payment indicating the reason for the payment;
- a subsequent letter requested by the claimant/recipient to clarify the reason for the payment; or
- any other document indicating the reason for the payment.

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 victims' compensation payment.

C. Reference

Commingled funds, S1130.700.

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S1130.670 RELOCATION ASSISTANCE PAYMENTS

A. Policy --Federal Relocation Assistance

1. The Exclusion

Relocation assistance is provided to persons displaced by projects which acquire real property. Federal relocation assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 (subchapter II, chapter 61, title 42 of the U.S. Code) is excluded from resources. Unlike state or local, there is no time limit on the exclusion for federal relocation assistance (see B.1. below). To be excluded under this provision, the payments must be of the type described in S0830.655B.

2. Interest on Unspent Payments

Interest earned on unspent relocation assistance payments is **not** excluded from income or resources by this provision (S0830.500).

B. Policy -- State or Local Relocation Assistance

1. The Exclusion

Effective for resource determinations made for the month of May 1991 and subsequent months, unspent relocation assistance payments from a State or local government are excluded from resources for 9 months.

To be excluded from resources under this provision, the payments must be of the type described in S0830.655C.

2. Payments Received Prior to May 1991

Payments received in August 1990 through April 1991 also can be excluded from resources under this provision beginning in May 1991. The payments can be excluded only for the number of months that remain in the 9-month period following the month of receipt as of May 1991.

EXAMPLE: The 9-month period for a relocation assistance payment received in January 1991 would be February through October 1991. However, the payment may be excluded from resources only for the months of May through October 1991.

3. Interest on Unspent Payments

Interest earned on unspent relocation assistance payments is **not** excluded from income or resources by this provision (S0830.500).

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C. Procedure -- Initial Applications and Posteligibility

1. When to Develop

When an individual would otherwise be ineligible due to excess resources, determine if applying this exclusion would permit eligibility. If the exclusion would permit eligibility, develop per 2. below.

NOTE: If the individual is resources-eligible even without the application of this exclusion, it is not necessary to develop under this section.

2. Development and Documentation

If an individual alleges that his/her resources include unspent relocation assistance payments:

- follow the procedures in S0830.655D.;
- document the date(s), type(s) and amount(s) of such payments(s); and
- obtain a statement as to the date(s) and amount(s) of any account deposits corresponding to the payments.

D. References

Commingled funds, S1130.700.

M1130.675 TAX ADVANCES, REFUNDS AND REBATES RELATED TO EARNED INCOME TAX CREDITS

A. Policy

1. EITC Related Refunds

Effective with resource determinations made for the month of January 1991, an unspent Federal tax refund or payment made by an employer related to Earned Income Tax Credits (EITC's) is excluded from resources **only for the month following the month** the refund or payment is received.

Interest earned on unspent tax refunds related to EITC's is **not** excluded from income or resources by this provision (S0830.500).

B. Procedure--Initial Claims and Post-Eligibility

1. When to Develop

Develop these exclusion*s* only when an individual alleges the receipt of assistance excludable under this provision and the exclusion would permit eligibility.

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2. Development and Documentation

If an individual alleges that his or her resources include unspent EITC and/or COVID-19 relief refunds or payments:

- verify the source, date(s), and amount(s) of such refund(s) or payment(s) in accordance with S0820.400, and
- obtain a statement as to the date(s) and amount(s) of any account deposits corresponding to the EITC and/or CARES Act refunds or payments.

C. References

Commingled funds, S1130.700.

S1130.678 INDIVIDUAL DEVELOPMENT ACCOUNTS – TANF FUNDED

A. Background

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 authorized states to use money from their Temporary Assistance for Needy Families (TANF) grant to fund Individual Development Accounts (IDAs). The Acts of Assembly of 2020, Special Session I allocated funding for the establishment of IDA accounts for Virginia TANF participants, effective July 1, 2021.

An IDA is a special bank account that helps an individual save for his/her education, the purchase of a first home, or to start a business. The individual uses earnings from their work to set up an approved bank account for an IDA and contributes money from their earnings to the IDA. The TANF program matches the contributions to the IDA. The matching money helps the individual reach his/her goal sooner.

B. Policy

1. Contributions

An individual's contributions that are deposited in a TANF IDA are excluded from resources.

2. Matching Funds

Any matching funds that are deposited in a TANF IDA are excluded from resources.

3. Interest

Any interest earned on the individual's contributions and matching funds that are deposited in a TANF IDA is excluded from resources.

C. Procedures

1. How To Verify TANF IDAs

Whenever possible, verify the individual's TANF IDA through available case records. If the TANF IDA cannot be verified through the case record, obtain verification from the individual that the account is a TANF IDA.

2. After TANF Eligibility Ends

The treatment of an IDA after an individual's TANF eligibility ends or after an individual moves from one state to another can vary from state to state. Check with the TANF Program in the appropriate state regarding whether an account stops being an IDA after TANF eligibility ends or an interstate move occurs, and how to treat funds that remain in the account and withdrawals from the account after TANF eligibility ends or an interstate move occurs.

S1130.679 Resources Funded by Needs-Based Programs such as TANF and Foster Care

Other resources funded by needs-based programs are also exempt resources.

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S1130.680 RADIATION EXPOSURE COMPENSATION TRUST FUND PAYMENTS

A. Background

Fallout emitted during the U.S. Government's atmospheric nuclear testing in Nevada during the 1950's and during a brief period in 1962 exposed some individuals to doses of radiation that put their health at risk. In addition, some individuals employed in uranium mines during the period January 1, 1947 to December 31, 1971 were exposed to large doses of radiation. Public Law 101-426 created the Radiation Exposure Compensation Trust Fund (RECTF) and authorizes the Department of Justice (DOJ) to make compensation payments to individuals (or their survivors) who were found to have contracted certain diseases after exposure. The payments will be made as a one-time lump sum. Generally, the exposure occurred in parts of Arizona, Colorado, Nevada, New Mexico, Utah, and Wyoming.

B. Policy

1. Resource Exclusion

Unspent payments received from the RECTF are excluded from resources.

2. Interest On Unspent RECTF Payments

Interest earned on unspent RECTF payments prior to July 1, 2004 is not excluded from income or resources. Interest earned on unspent RECTF payments on or after July 1, 2004 is excluded from income and resources.

C. Procedure

1. When to Develop

When an individual would otherwise be ineligible due to excess resources, determine if applying this exclusion would permit eligibility.

If the exclusion would permit eligibility, develop per 2. below.

NOTE: If the individual is resources-eligible even without the application of this exclusion, it is not necessary to develop under this section.

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2. Development and Documentation

a. Obtain Documentation

If an individual alleges that his or her resources include unspent RECTF payments:

- document such payments in accordance with S0830.740; and
- obtain a statement as to the date(s) and amount(s) of any financial institution (e.g., checking or savings) account deposits corresponding to the RECTF payments.

b. If Necessary, Contact DOJ

If the individual does not have, and cannot obtain, the documentation in 2.a. above, contact the DOJ. Address correspondence to:

The Radiation Exposure Compensation Program
U.S. Department of Justice
P.O. Box 146
Benjamin Franklin Station
Washington, DC 20044-0146

Provide the DOJ with the individual's name and Social Security number (SSN). When writing on behalf of a survivor, include the survivor's name and SSN.

D. References

- Excluded funds commingled with non-excluded funds, S1130.700.
- Exclusion of RECTF payments from income, S0830.740.

M1130.685 WALKER V. BAYER SETTLEMENT PAYMENTS

A. Policy

Section 4735 of the Balanced Budget Act of 1997 (P.L. 105-33) states that payments described in this subsection from the settlement of the Susan Walker v. Bayer Corp., et.al., class action lawsuit are NOT counted as income in determining eligibility for Medicaid. Payments described in this subsection are:

a. payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corp., et.al., 96-C-5024 (N.D.III.); and

b. payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement of Walker v. Bayer Corp., et.al., and that is signed by all affected parties on or before the later of

- December 31, 1997, or
- the date that is 270 days after the date on which such release is first sent to the persons to whom the payment is to be made.

Any interest earned on these funds *prior to July 1, 2004* is not excluded. *Any interest earned on these funds on or after July 1, 2004 is excluded from income and resources.*

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B. Procedure

Information received by claimants in this lawsuit shows that claimants can choose to receive the payment in one of three ways - in a lump sum, a structured settlement, or a special needs trust. Regardless of which form the individual chooses, the payment(s) are excluded if the above requirements are met.

Verify the source of the funds from a letter from the individual's attorney or a copy of the check which identifies the payor as a Walker v. Bayer settlement account.

OTHER EXCLUDED RESOURCES

S1130.700 IDENTIFYING EXCLUDED FUNDS THAT HAVE BEEN COMMINGLED WITH NONEXCLUDED FUNDS

A. Policy Principle

Otherwise excludable funds must be identifiable in order to be excluded.

B. Operating Policy

1. Identified vs. Segregated

Identifiability does not require that excluded funds be kept physically apart from other funds (e.g., in a separate bank account).

2. Operating Assumption

Always assume, when withdrawals are made from an account with commingled funds in it, that **nonexcludable funds are withdrawn first,** leaving as much of the excluded funds in the account as possible.

3. Effect of Account Transactions

If excluded funds are withdrawn, the excluded funds left in the account can be added to only by:

- deposits of subsequently received funds that are excluded under the same provision; and
- excluded interest (see 4. below).

4. Interest

If interest on the excluded funds is excluded (as with disaster assistance), the percent of an interest payment to be excluded is the same as the percent of funds in the account that is excluded **at the time the interest is posted**. The excluded interest is then added to the excluded funds in the account.

C. Development and Documentation - Initial Application and Posteligibility

1. Evidence

Obtain a **complete** history of account transactions back to the initial deposit of excluded funds. Use the individual's own records if possible.

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2. Determination

a. Accept the individual's allegation as to the date and amount of a deposit of excluded funds if it agrees with the evidence in file on the receipt of the funds.

b. Record in case record:

- each deposit of excluded funds;
- each withdrawal that reduces the amount of excluded funds;
- each computation of excluded interest and its addition to the excluded funds.

D. Examples

1. One Time Receipt and Deposit of Excluded Funds

An individual deposits a $1,000 SSA check ($800 for the preceding 4 months and $200 for the current month) in a checking account. The account already contains $300 in nonexcluded funds.

- Of the new $1,300 balance, $800 is excluded as retroactive SSI benefits.
- The individual withdraws $300. The remaining $1,000 balance still contains the excluded $800.
- The individual withdraws another $300, leaving a balance of $700. All $700 is excluded.
- The individual deposits $500, creating a new balance of $1,200. Only $700 of the new balance is excluded.

2. Periodic Receipt and Deposit of Excluded Funds

An individual deposits $200 in excluded funds in a non-interest bearing checking account that already contains $300 in nonexcluded funds.

- The individual withdraws $400. The remaining $100 is excluded.
- The individual then deposits $100 in nonexcluded funds. Of the
- resulting $200 balance, $100 is excluded.
- The individual next deposits $100 in excludable funds. Of the new $300 balance, $200 is excluded.

3. Interest

A $1,000 savings account includes $800 in excluded disaster assistance when a $10 interest payment is posted. Since 80 percent of the account balance is excluded at the time the interest is posted, 80 percent of the interest ($8) is excluded. The amount of excluded funds now in the account is $808.

M1130.720 Post-PHE Excluded Resources

A. Policy Principle

LTSS recipients with resources accumulated from March of 2020 through the first renewal after the end of the continuous coverage requirements due to the inability to increase patient pay may be exempted for one certification period. This exclusion applies to LTSS recipients at renewal only, not new applications.

B. Operating Policy

1. Identified vs. Segregated

Identifiability does not require that excluded funds be kept physically apart from other funds (e.g., in a separate bank account).

2. Operating Assumption

***Always assume,** when withdrawals are made from an account with commingled funds in it, that **nonexcludable funds are withdrawn first,** leaving as much of the excluded funds in the account as possible.*



3. Effect of Account Transactions *If excluded funds are withdrawn, the excluded funds left in the account can be added to only by excluded interest (see 4. below).*

4. Interest *Interest on the excluded funds is excluded, and the percent of an interest payment to be excluded is the same as the percent of funds in the account that is excluded at the time the interest is posted.*

C. Development and Documentation - Post eligibility

1. Evidence *Bank statements, Patient Fund account statements or other financial documentation.*

2. Determination *If a member who receives LTSS is found to have excess resources at renewal, the state will review the patient pay history,* ***If that history indicates that the member's excess resources are solely due to the state having been unable to increase the patient pay during the pandemic, the amount of the would-be increase will be deducted from the member's excess resources.*** *If the member is under the resource limit after this deduction, and is otherwise eligible, coverage will continue. Record the amount of the excluded resources on the VaCMS screen.*

D. Example

1. Periodic Receipt and Deposit of Excluded Funds *An individual was receiving LTSS in a nursing facility in September 2020. An adjustment was made for a motorized wheelchair (with DMAS approval). Due to PHE provisions the patient pay could not be increased after the cost of the wheelchair was deducted. He or she has accumulated $20,000 in a checking account that would have been owed to a facility as part of the patient pay. The account already contains $300 in non-excluded funds.*

- *Of the new $20,300 balance, $20,000 is excluded.*
- *The individual withdraws $1000 and spends it on a new wardrobe. The remaining $19,300 balance remains excluded.*
- *The individual withdraws another $300, leaving a balance of $19,000. All $19,000 remains excluded until the next renewal.*

An individual was receiving CBC, then entered a nursing facility in June 2022. Due to PHE provisions the patient pay could not be increased. When the renewal comes due in May 2023, he or she has accumulated $5000 in a checking account that would have been owed to a facility as part of the patient pay. The money has been deposited in a non-interest bearing checking account that already contained $500 in nonexcluded funds.

- *The individual withdraws $500. The remaining $5000 is excluded until the May 2024 renewal.*
- *When the May 2024 renewal comes due, the full amount of the account will be countable.*



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M1130.740 ACHIEVING A BETTER LIFE EXPERIENCE (ABLE) ACCOUNTS

A. Policy

The federal Stephen Beck, Jr. Achieving a Better Life Experience Act (ABLE Act), was enacted by Congress on December 19, 2014 and approved by the Virginia General Assembly and Governor in 2015. An ABLE account is a type of tax-advantaged account that an eligible individual can use to save funds for the disability related expenses of the account's designated beneficiary, who must be blind or disabled by a condition that began before the individual's 26th birthday. Funds retained in these accounts are not considered to be resources for Medicaid.

In Virginia, the qualified ABLE program is operated by the Virginia529 program and can be contacted Toll-Free: 1-844-NOW-ABLE (1-844-669-2253).

An eligible individual can be the designated beneficiary/account owner of only one ABLE savings trust account, which must be administered by a qualified ABLE program.

The designated beneficiary is the eligible individual who established and owns the ABLE account. To be an eligible individual, he or she must be:

- Eligible for Supplemental Security Income (SSI) based on disability or blindness that began before age 26;
- Entitled to disability insurance benefits, childhood disability benefits, or disabled widow's or widower's benefits based on disability or blindness that began before age 26; or
- Someone who has certified, or whose parent or guardian has certified, that he or she:
    - Has a medically determinable impairment meeting certain statutorily specified criteria; or is blind; and,
    - The disability or blindness occurred before age 26.

NOTE: A certification that someone meets disability requirements for the ABLE program does not replace a disability determination from either SSA or DDS in determining whether someone meets the Medicaid definition of a disabled individual.

ABLE accounts are not subject to estate recovery.

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B. Procedures

The designated beneficiary, or person acting on the individual's behalf, must provide a copy of the ABLE account documentation for the case record. The documentation should include the designated beneficiary's/account owner's name, address, and the date the ABLE account was established. The eligibility worker must retain the information in the case record.

A copy of the account documentation also must be sent to DMAS at the following address:

Department of Medical Assistance Services
Eligibility & Enrollment Services Division
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

C. Contributions to an ABLE Account

Third party contributions to an ABLE account are not counted as income or included in total resources of the beneficiary. This includes distributions from special needs or pooled trusts. Earnings on an ABLE account (e.g. interest) are part of the account and to be disregarded in determining Medicaid eligibility.

Income contributed into an ABLE account by the designated beneficiary is counted as available income, and not disregarded.

D. Distributions From an ABLE Account

Distributions from an ABLE account are not included in the designated beneficiary's taxable income or counted as income for eligibility determination as long as used for qualified disability expenses, *as determined by the Internal Revenue Service (IRS).*

Examples of Qualified Disability Expenses include, but are not limited to:

- *Education*
- *Housing*
- *Transportation*
- *Employment training and support*
- *Assistive technology and related services*
- *Health*
- *Prevention and wellness*
- *Financial management and administrative services*
- *Legal fees*
- *Expenses for oversight and monitoring*
- *Funeral and burial*
- *Basic living expenses*
- *Other expenses approved by the Secretary of the U.S. Treasury.*

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DETERMINING THE COUNTABLE VALUE OF *HOME & CONTIGUOUS* PROPERTY

Definitions

1. *"Assessed value" means the tax assessed value that a tax assessor's office places on real property for tax purposes; the tax assessed value is the current fair market value (FMV) of real property. In Virginia, all real property is assessed at 100% of its current FMV, so the assessed value of real property is the current FMV of the property.*

2. *"Equity value" means the property's assessed value minus the balance due on the lien (a mortgage or a court-ordered judgment) against the property,* ***when the lien is in the Medicaid applicant's name, when the Medicaid applicant is one of the individuals listed on the lien, or when the Medicaid applicant is one of the owners subject to the lien, meaning that he is responsible for paying the lien. If the Medicaid applicant is not subject to the lien, the balance due on the lien is not subtracted from the value of the property. If the Medicaid applicant is one of two or more individuals subject to the lien, then ONLY the Medicaid applicant's fractional share of the lien balance is deducted from the applicant's share of the property's value.***

3. *"Home property exclusion" means an exclusion for the plot of land on which the home is located. The excluded home lot size may vary according to the locality's building requirements. For localities with a set minimum building lot size, use the lesser of:*
   - *the plat;*
   - *the survey; or*
   - *the locality's minimum size for a building lot.*

   For localities with no minimum building lot requirements, use the lesser of:
   - *the plat;*
   - *the survey; or*
   - *one acre.*

   If the equity value of countable contiguous property causes resources to exceed the maximum limit, re-evaluate the home property applying the definition of the home used in the State Plan for Medical Assistance in Virginia in effect on January 1, 1972. At that time, a "home" meant the house and lot used as the individual's principal residence and all contiguous property ***essential to the operation of the home regardless of value (M1130.100 B.2)****.*

4. *"Life estate interest" is a limited type of ownership in real property. 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 cases, it may be conditional: e.g., for life or until remarriage. The owner of a life estate can sell the life estate interest but does not have title to the property and normally cannot sell the property or pass it on as an inheritance.*

5. *"Remainderman" is the term used when an individual has an ownership interest in the real property, but does not have the right to possess and use the property until termination of the life estate interest.*

A. Procedure #1: Property Owned by One Owner

Step 1 - Determine the *whole* property's assessed value, the assessed value of the excluded house and homesite, and *determine* the balance due on all liens against the property *if the Medicaid applicant is subject to the lien(s).*

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Step 2 - Assessed value of excluded house and homesite
+ $5,000 Exclusion
Excluded property value

Step 3 - *Whole* property assessed value
- Excluded property value
Contiguous property *assessed* value

Step 4 - Contiguous property *assessed* value
÷ *Whole* property assessed value
Portion of *whole* property value represented by the contiguous property
x Balance due on the lien(s) *in applicant's name*
Contiguous property lien amount

Step 5 - Contiguous property *assessed* value
- Contiguous property lien amount
Contiguous property equity value = *Contiguous property countable value*

Step 6 – If the contiguous property's countable value causes excess resources, determine if the contiguous property can be excluded for another reason, such as income-producing. Re-evaluate the home property applying the definition of the home used in the State Plan for Medical Assistance in Virginia in effect on January 1, 1972. At that time, a "home" meant the house and lot used as the principal residence and all contiguous property ***essential to the operation of the home regardless of value****.*

EXAMPLE #1 (one-owner property, *not re-evaluated*):

Example #1, Step 1:
Whole property assessed value = $81,500
Assessed value of homesite (the excluded house, homesite, buildings, etc.) = $64,000
Balance due on property's mortgage *(applicant is the only owner subject to the lien)* = $72,000

Example #1, Step 2:
$64,000 Assessed value of *house &* homesite
+ 5,000 Exclusion
69,000 Excluded property value

Example #1, Step 3:
$81,500 *Whole* property assessed value
- 69,000 Excluded property value
$12,500 Contiguous property *assessed* value

Example #1, Step 4:
$ 12,500.00 Contiguous property *assessed* value
÷ 81,500.00 Total property assessed value
.1533 Portion of *whole* property value represented by the contiguous property
x 72,000.00 Balance due on lien
11,037.60 Contiguous property lien amount

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Example #1, Step 5:

$12,500.00 Contiguous property assessed value
- 11,037.60 Contiguous property lien amount
$ 1,462.40 Contiguous property equity value

Example #1, Step 6:

The property does not produce any income and is not used to produce goods or services that are essential to the operation of the home.

$ 1,462.40 contiguous property countable value

B. Procedure #2: Joint Ownership, Undivided Estate or Unprobated Estate, one owner subject to lien

Step 1 - Determine the whole property's assessed value, the assessed value of the excluded house and homesite, and determine the balance due on all liens against the property if the Medicaid applicant is subject to the lien(s).

Step 2 - **When a partition suit is necessary to liquidate the property** because at least one owner does not agree to sell the contiguous property**:** Determine the shared partition costs for liquidating the property. Use the average cost of partitioning in the locality where the property is located, based on the **assessed** (not equity) value of the whole property. *Use the average cost of partitioning on property not yet partitioned, otherwise use the actual shared cost to partition.*
If a partition suit is NOT necessary to liquidate the property (all the owners agree to sell it), **do not** subtract any partition costs or attorneys' fees; insert zeros in the formula in place of partition costs and attorney's fees.

Step 3 - Assessed value homesite property
+ $5,000 Exclusion
Excluded property value

Step 4 - Whole property assessed value
- Shared partition costs
Countable assessed value
- Excluded property value
Contiguous property assessed value

Step 5 - Contiguous property assessed value
÷ Whole property assessed value
Portion of whole property value represented by the contiguous property
x Balance due on the lien(s)
Contiguous property lien amount
÷ Number of owner's subject to lien
Applicant's share of contiguous property lien amount

Step 6 - Contiguous property assessed value
÷ Applicant's ownership share
Applicant's share of contiguous property assessed value
- Applicant's share of contiguous property lien amount
Applicant's share contiguous property equity value
- Applicant's attorney fees
Contiguous property countable value

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Step 7 – If the contiguous property's countable value causes excess resources, determine if the contiguous property can be excluded for another reason, such as income-producing. Re-evaluate the home property applying the definition of the home used in the State Plan for Medical Assistance in Virginia in effect on January 1, 1972. At that time, a "home" meant the house and lot used as the principal residence and all contiguous property ***essential to the operation of the home regardless of value****.*

EXAMPLE #2 (undivided joint ownership, *one owner subject to lien, not re-evaluated*):

An applicant owns a 1/3 interest in his home, lot, and 4 acres of contiguous property. There is a lien on this property with a balance due of $10,000. *The applicant is the only owner subject to the lien.* The assessed value of the house and homesite lot is *$40,000* and the 4 acres of contiguous property has an assessed value of $60,000 ($100,000 *is the whole property's* assessed value). *One owner, not the applicant, does not agree to sell the contiguous property.* The estimated shared cost of partitioning is $2,000 and the applicant's attorney's fees will be $1,000.

Example #2, Step 1:

Whole property's assessed value = $100,000
Assessed value of homesite (the excluded house, homesite, buildings, etc.) = $40,000
Contiguous property (4 acres) = $60,000
Balance due on *whole* property's mortgage = $10,000

Example #2, Step 2:

Shared partition costs = $2,000
Applicant's attorney's fees = $1,000

Example #2, Step 3:

$ 40,000 Assessed value of homesite
\+ 5,000 Exclusion
45,000 Excluded property value

Example #2, Step 4:

$100,000 *Whole* property assessed value
\- 2,000 Shared partition costs
98,000 Countable assessed value
\- 45,000 Excluded property value
53,000 Contiguous property *assessed* value

Example #2, Step 5:

$ 53,000 Contiguous property *assessed* value
÷ 100,000 *Whole* property assessed value
.53 Portion of *whole* property value represented by the contiguous property
x 10,000 Balance due on the lien(s)
5,300 Contiguous property lien amount
÷ *1* *Number of owners subject to lien*
5,300 *Applicant's share of contiguous property lien amount*

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Example #2, Step 6:

$ 53,000.00 Contiguous property assessed value
÷ 3 Applicant's ownership share
17,666.67 Applicant's share of contiguous property assessed value
- 5,300.00 Applicant's share of contiguous property lien amount
12,366.67 Applicant's share contiguous property equity value
- 1,000.00 Applicant's attorney fees
$11,366.67 Contiguous property equity value

Example #2, Step 7:

The property does not produce any income and is not used to produce goods or services that are essential to the operation of the home.
$11,366.67 contiguous property countable value

C. Procedure #3: Re-evaluated homesite, partition required, multiple owners subject to lien

Step 1 - Determine the whole property's assessed value, the assessed value of the excluded house and homesite, and determine the balance due on all liens against the property if the Medicaid applicant is subject to the lien(s). If another owner is subject to the lien, calculate the applicant's share of the lien balance by dividing the lien balance by the number of owner's subject to the lien. The formula will calculate the applicant's share of the lien balance that is against the contiguous property.

Step 2 - **When a partition suit is necessary to liquidate the property:** Determine the shared partition costs for liquidating the property. Use the average cost of partitioning in the locality where the property is located, based on the **assessed** (not equity) value of the whole property. *Use the average cost of partitioning on property not yet partitioned, otherwise use the actual shared cost to partition.*
If a partition suit is NOT necessary to liquidate the property (all the owners agree to sell it), do not subtract any partition costs or attorney's fees; insert zeros in the formula in place of partition costs and attorney's fees.

Step 3 - Assessed value house & homesite property
+ $5,000 exclusion
Excluded property value

Step 4 - Total property assessed value
- Shared partition costs
Countable assessed value
- Excluded property value
Contiguous property assessed value

Step 5 - Contiguous property assessed value
÷ Whole property assessed value
Portion of whole property value represented by the contiguous property
x Balance due on the lien(s)
Contiguous property lien amount
÷ Number of owner's subject to lien
Applicant's share of contiguous property lien amount

Step 6 - Contiguous property *assessed* value
÷ *Applicant's ownership share*
Applicant's share of contiguous property assessed value
- *Applicant's share of contiguous property lien amount*
Applicant's share contiguous property equity value
- Applicant's attorney fees
Contiguous property countable value

Step 7 – If the applicant's countable equity in the contiguous property causes excess resources, re-evaluate the *property using the 1972 definition of* homesite to determine if the use of the contiguous land would mean more property excluded as the homesite. The $5,000 exclusion is NOT *applied* when the homesite is re-evaluated *using the 1972 definition of home and homesite*.
Determine how much of the contiguous property is actually used by the household as part of the homesite.

Step 8 - Assessed value of house and homesite
+ Value of additional contiguous property used for homesite
Excluded property value

Step 9 - *Whole* property assessed value
- Excluded property value
Contiguous property *assessed* value

Step 10 - Contiguous property *assessed* value
÷ *Whole* property assessed value
Portion of *whole* property value represented by the contiguous property
x Balance due on the lien(s)
Contiguous property lien amount
÷ *Number of owners subject to lien*
Applicant's share of contiguous property lien amount

Step 11 – Contiguous property *assessed* value
÷ *Applicant's ownership share*
Applicant's share of contiguous property assessed value
- *Applicant's share of contiguous property lien amount*
Applicant's share contiguous property equity value
- Applicant's attorney fees
Re-evaluated contiguous property countable value

Use the lesser of the Contiguous Property Countable Value *and the Re-evaluated Contiguous Property Countable Value*.

Step 12: If the individual still has excess resources, evaluate the contiguous property to determine if it can be excluded for another reason or a disregard applied, such as the exclusion or disregard applicable to income-producing property.

EXAMPLE #3 (re-evaluated homesite, *partition required, multiple owners subject to lien*):

Example #3, Step 1:

Applicant owns a 1/3 undivided share in his house, homesite and 10 contiguous acres; the *whole* property is *assessed at* $100,000. A partition suit is necessary to liquidate the contiguous property *because one*



owner does not agree to sell the property. The lien on the property is in the 3 owners' names, so the 3 owners are subject to the lien. The property does not produce any income to the applicant.

Assessed value of *whole* property = $100,000
Assessed value of homesite (the excluded house, homesite, buildings, etc.) = $40,000
Contiguous property assessed value = $60,000
Balance due on entire property's mortgage = *$12,000*

Example #3, Step 2:

Shared partition costs = $2,000
Applicant's attorney's fees = $1,000

Example #3, Step 3:

$ 40,000	Assessed value of homesite
+ 5,000	Exclusion
45,000	Excluded property value

Example #3, Step 4:

$100,000	*Whole* property assessed value
- 2,000	Shared partition costs
98,000	Countable assessed value
- 45,000	Excluded property value
53,000	Contiguous property *assessed* value

Example #3, Step 5:

$ 53,000	Contiguous property *assessed* value
÷ 100,000	*Whole* property assessed value
.53	Portion of *whole* property value represented by the contiguous property
x *12,000*	Balance due on the lien(s)
$ 6,360	Contiguous property lien amount
÷ *3*	*Number of owners subject to lien*
2,120	*Applicant's share of contiguous property lien amount*

Example #3, Step 6:

$53,000.00	Contiguous property *assessed* value
÷ *1/3*	*Applicant's ownership share*
17,666.67	*Applicant's share of contiguous property assessed value*
- *2,120.00*	*Applicant's share of contiguous property lien amount*
15,546.67	*Applicant's share contiguous property equity value*
- 1,000.00	Applicant's attorney fees
14,546.67	Contiguous property countable value

$14,546.67 causes the applicant to have excess resources, so the homesite is re-evaluated for actual use *using the 1972 definition of homesite.*

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Example #3, Step 7:

The applicant says that of the contiguous 10 acres, 1 is used for a garden to grow produce used by the household, 1 acre is used for the livestock raised for home consumption, ½ acre is used for the family cemetery, and 1 acre is used for the septic system; a total of 3.5 additional acres are used as the homesite. *The property does not produce any income.*

Assessed value of *whole* property = $100,000
Assessed value of homesite (the excluded house, homesite, buildings, etc.) = $40,000
Assessed value 10 contiguous acres = $60,000 ÷ 10 = 6,000 per acre
$6,000 value per acre x 3.5 acres = $21,000 additional property value excluded *as homesite*

Example #3, Step 8:

$ 40,000 Assessed value of homesite
+ 21,000 Value of additional property excluded as homesite
$ 61,000 Excluded property value

Example #3, Step 9:

$100,000 *Whole* property assessed value
- 2,000 Shared partition costs
98,000 Countable assessed value
- 61,000 Excluded property value
37,000 Contiguous property *assessed* value

Example #3, Step 10:

$ 37,000.00 Contiguous property *assessed* value
÷ 100,000.00 *Whole* property assessed value
.37 Portion of property value represented by the contiguous property
x *12,000.00* Balance due on the lien(s)
$ *4,440.00* Contiguous property lien amount
÷ *3* *Number of owners subject to lien*
1,480.00 *Applicant's share of contiguous property lien amount*

Example #3, Step 11:

$ 37,000.00 Contiguous property *assessed* value
÷ *1/3* *Applicant's ownership share*
12,333.33 *Applicant's share of contiguous property assessed value*
- *1,480.00* *Applicant's share of contiguous property lien amount*
10,853.33 *Applicant's share contiguous property equity value*
- 1,000.00 Applicant's attorney fees
9,853.33 *Re-evaluated* contiguous property countable value

Because *the $9,853.33 re-evaluated value* is less than *the $14,546.67 value first determined,* the countable value of the applicant's contiguous property is *$9,853.33.* The applicant has excess resources and is not eligible for ABD Medicaid.

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D. Procedure #4: One Owner (Remainderman), One Life Interest Owner, Lien

Step 1 – When the Medicaid applicant is a remainderman and lives on the property in which he owns a remainder interest, determine the age of the life interest owner, determine the whole property's assessed value, the assessed value of the excluded house and homesite, and determine the balance due on all liens against the property if the Medicaid applicant is subject to the lien(s). No estimated costs of selling the remainder interest are deducted from the countable value.

Step 2 – Calculate the assessed value of the contiguous property:
Assessed value of excluded house and homesite
+ $5,000 Exclusion
Excluded property value
Whole property assessed value
- Excluded property value
Contiguous property assessed value

Step 3 – The applicant is the remainderman on this property – determine the value of the remainder interest in the contiguous property which will be countable EVEN IF the life interest holder does NOT agree to sell the life interest.
Contiguous property assessed value
X Remainder interest factor based on life interest owner's age (from table in M1140.120)
Remainder interest value

Step 4 – Calculate the contiguous property lien amount – the portion of the lien that is against the contiguous property:
Contiguous property assessed value
÷ Whole property assessed value
Portion of whole property value represented by the contiguous property
x Balance due on the lien(s) to which applicant is subject
Contiguous property lien amount

Step 5 – Calculate the countable value of the remainder interest in contiguous property:
Remainder interest value
- Contiguous property lien amount
Countable value of remainder interest in contiguous property

Step 6 - If the contiguous property's countable value causes excess resources, determine if the contiguous property can be excluded for another reason, such as income-producing. Re-evaluate the home property applying the definition of the home used in the State Plan for Medical Assistance in Virginia in effect on January 1, 1972. At that time, a "home" meant the house and lot used as the principal residence and all contiguous property ***essential to the operation of the home regardless of value****.*

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Example #4 - One Owner (Remainderman), One Life Estate Owner, Lien:

Example #4, Step 1:

Whole property assessed value = $81,500
Assessed value of homesite (the excluded house, homesite, buildings, etc.) = $64,000
Balance due on property's lien (applicant is the only owner subject to the lien) = $10,000
Life interest owner is 71 years old

Example #4, Step 2:

$64,000 Assessed value of excluded house and homesite
+ 5,000 Exclusion
$69,000 Excluded property value
$81,500 Whole property assessed value
- 69,000 Excluded property value
$12,500 Contiguous property assessed value

Example #4, Step 3:

The life interest owner is 71 years old.

$ 12,500.00 Contiguous property assessed value
X .41086 Remainder interest factor based on life interest owner's age (from table in M1140.120)
$ 5,135.75 Remainder interest value

Example #4, Step 4:

$ 12,500 Contiguous property assessed value
÷ 81,500 Whole property assessed value
.1534 Portion of whole property value represented by the contiguous property
X 10,000 Balance due on the lien(s)
$ 1,534 Contiguous property lien amount

Example #4, Step 5:

$5,135.75 Remainder interest value
- 1,534.00 Contiguous property lien amount
$3,601.75 Countable value of remainder interest in contiguous property

Example #4, Step 6:

The contiguous property's countable value of $3,601.75 causes excess resources. The contiguous property does not produce any income. The home property is re-evaluated for actual use using the 1972 definition of home property.

The applicant says that of the contiguous 5 acres, 1 acre is used for a garden to grow produce used by the household and 1 acre is used for the septic system; a total of 2 additional acres are used as the homesite.

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Assessed value of whole property = $81,500
Assessed value of homesite (the excluded house, homesite, buildings, etc.) = $64,000
Assessed value 5 contiguous acres = $17,500 ÷ 5 = $3,500 per acre
$3,500 value per acre x 2 acres = $7,000 additional property value excluded as essential to homesite

$64,000 Assessed value of home & homesite
+ 7,000 Value of additional property excluded as homesite
$ 71,000 Excluded home property value

$81,500 Assessed value of whole property
-71,000 Excluded home property value
10,500 Contiguous property assessed value

The life interest owner is 71 years old.

$ 10,500.00 Contiguous property assessed value
X .41086 Remainder Interest Factor Based on Life Interest Owner's Age (from table in M1140.120)
$4,314.03 Remainder interest value

$ 10,500 Contiguous property assessed value
÷ 81,500 Whole property assessed value
.1288 Portion of whole property value represented by the contiguous property
X 10,000 Balance due on the lien(s)
$ 1,288 Contiguous property lien amount

$4,314.03 Remainder interest value
-1,288.00 Contiguous property lien amount
$3,026.03 Re-evaluated countable value of remainder interest in contiguous property

Because $3,026.03 is less than $3,601.75, the re-evaluated countable value of the applicant's remainder interest in the contiguous property is used for the contiguous property countable value, and is added to all other resources to determine eligibility.

$3,026.03 contiguous property countable value.

E. Procedure #5: Joint Owners (Remaindermen), One Life Estate Owner, Lien

This is home and contiguous real property that is owned jointly (undivided estate) and is subject to a life interest owner; the Medicaid applicant is one of the owners (remaindermen). The Medicaid applicant lives on the property in which he owns a remainder interest. Because there is a life interest owner of this property and life estate property cannot be divided, ***no*** *estimated partition costs & attorney's fees are deducted from the value of the Medicaid applicant's remainder share.*

Step 1 - Determine the total property assessed value, the assessed value of the excluded house and homesite, the balance due on all liens against the property if the applicant is subject to the lien, and the age of the life interest owner.

Step 2 – Calculate the assessed value of the contiguous property:

Assessed value of excluded house and homesite
+ $5,000 Exclusion
Excluded property value

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Whole property assessed value
- Excluded property value
Contiguous property assessed value

Step 3 – The applicant is one of the remaindermen owners of this property – determine the value of the remainder interest in the contiguous property which will be countable EVEN IF the life interest holder does NOT agree to sell the life interest.
Contiguous property assessed value
X Remainder interest factor based on life interest owner's age (from table in M1140.120)
Remainder interest value

Step 4 – Calculate the contiguous property lien amount – the portion of the lien that is against the contiguous property:
Contiguous property assessed value
÷ Whole property assessed value
Portion of whole property value represented by the contiguous property
x Balance due on the lien(s) to which the applicant is subject
Contiguous property lien amount

Step 5: Calculate the equity value of applicant's share of the remainder interest in contiguous property:
Remainder interest value
÷Number of remaindermen (joint owners of property)
Applicant's share of remainder interest
- Contiguous property lien amount
Equity value of applicant's remainder interest = Countable value of contiguous property

Step 6 - If the countable value of the contiguous property causes excess resources, determine if the contiguous property can be excluded for another reason, such as income-producing. Re-evaluate the home property applying the definition of the home used in the State Plan for Medical Assistance in Virginia in effect on January 1, 1972. At that time, a "home" meant the house and lot used as the principal residence and all contiguous property ***essential to the operation of the home regardless of value****.*

Example #5 Joint Owners (Remaindermen), One Life Estate Owner, Lien

An applicant owns ½ remainder interest (2 owners) in non-home, non-business real property; there is one life interest owner, age 80. There is a lien on this property and the applicant is the only remainderman owner subject to the lien. The lien balance due is $10,000. The assessed value of the property is $181,500. The life interest owner agrees to sell, but the other remainderman owner does not agree to sell. No estimated costs of partitioning or selling the property are deducted.

Example #5, Step 1:

Whole property assessed value = $181,500
Assessed value of homesite (the excluded house, homesite, buildings, etc.) = $64,000
Balance due on property's lien (applicant is the only owner subject to the lien) = $10,000

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***Example #5, Step 2**: – Calculate the assessed value of the contiguous property:*

$64,000 Assessed value of excluded house and homesite
+ 5,000 Exclusion
$69,000 Excluded property value

$181,500 Whole property assessed value
- 69,000 Excluded property value
$112,500 Contiguous property assessed value

***Example #5, Step 3** –Determine the value of the remainder interest in the contiguous property; life interest owner is 80 years old.*

$112,500.00 Contiguous property assessed value
X .56341 Remainder interest factor based on life interest owner's age (from table in M1140.120)
$63,383.63 Remainder interest value

***Example #5, Step 4** – Calculate the contiguous property lien amount – the portion of the lien that is against the contiguous property:*

$112,500 Contiguous property assessed value
÷181,500 Whole property assessed value
.6198 Portion of whole property value represented by the contiguous property
x 10,000 Balance due on the lien(s)
$ 6,198 Contiguous property lien amount

***Example #5, Step 5:** Calculate the equity value of applicant's share of the remainder interest in contiguous property:*

$63,383.63 Remainder interest value
÷ 2 Number of remaindermen (joint owners of property)
$31,691.82 Applicant's share in remainder interest in contiguous property
- 6,198.00 Contiguous property lien amount
$25,493.82 Equity value of applicant's remainder interest

$25,493.82 countable value of contiguous property

Example #5, Step 6:

The $25,493.82 countable value of the contiguous property causes excess resources. The contiguous property cannot be excluded because it does not produce income. The home property must be re-evaluated for actual use using the 1972 home property definition.

The applicant says that of the contiguous 5 acres, 1 acre is used for a garden to grow produce used by the household and 1 acre is used for the septic system; a total of 2 additional acres are used as the homesite. The property does not produce any income.

Assessed value of whole property = $181,500
Assessed value of homesite (the excluded house, homesite, buildings, etc.) = $64,000
Assessed value 5 contiguous acres = $117,500 ÷ 5 = $23,500 per acre
$23,500 value per acre x 2 acres = $47,000 additional property value excluded as essential to homesite



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$ 64,000 Assessed value of home & homesite
+ 47,000 Value of additional property excluded as homesite
$111,000 Excluded home property value

$181,500 Assessed value of whole property
-111,000 Excluded home property value
$ 70,500 Contiguous property assessed value

The life interest owner is 80 years old.

$ 70,500.00 Contiguous property assessed value
X .56341 Remainder interest factor based on life interest owner's age (from table in M1140.120)
$39,720.41 Remainder interest value

$ 70,500 Contiguous property assessed value
÷ 181,500 Whole property assessed value
.3884 Portion of whole property value represented by the contiguous property
X 10,000 Balance due on the lien(s)
$ 3,884 Contiguous property lien amount

$39,720.41 Remainder interest value
- 3,884.00 Contiguous property lien amount
$35,836.41 Re-evaluated countable value of remainder interest in contiguous property

Because the $35,836.41 re-evaluated countable value is less than $39,720.41, the re-evaluated value of the applicant's remainder interest in the contiguous property, $35,836.41, is used for the contiguous property countable value of the property and is added to all other resources to determine eligibility.

$35,836.41 contiguous property countable value

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ABD Home Property Evaluation Worksheet

I. $5,000 Exclusion

1. **Assessed Value (AV)**
   (1a) *House & homesite* _____
   (1b) Contiguous+_____
   (1c) Total AV =_____

2. **Enter Lien *Balance Due*** _____

3. AV *house & homesite (*1a) _____
4. Exclusion +$5,000
5. Excluded Property =_____

6. Total AV (1c) _____
7. *Partition Costs -_____
8. Countable AV =_____

9. Excluded Property (5) -_____

10. Contiguous Property *AV*=_____

11. Total AV (1c) ÷_____
12. % Contiguous Property =_____

13. Lien *Balance* (2) X_____

14. Lien on ***Contiguous*** Property =_____

15. Contiguous Property *AV* (10) _____

16. Lien on Contiguous Property (14) -_____

17. Equity in Contiguous Property =_____

18. Applicant's Share ÷

19. Countable Equity Contiguous Property =_____

20. *Applicant's Attorney Fees -_____

21. Countable Equity *in* Contiguous Property =_____

If countable equity + all other countable resources exceed resource limit, go to Section II.

II. *January 1972* Use of Land *Home* Exclusion

22. #Acres Used/Essential to Home _____
23 Assessed Value Per Acre X_____
24. *Additional* Exclusion =_____

25. AV House *& homesite (1a)* _____

26. *Additional* Exclusion (24) +_____

27. Excluded Property =_____

29. Total AV (1c) _____

30. *Partition Costs -_____

31. Countable AV =_____

32. Excluded Property (27) -_____

33. Contiguous Property *AV*=_____

34. Total AV (1c) ÷_____

35. % Contiguous Property =_____

36. Lien *Balance* (2) X_____

37. Lien on ***Contiguous*** Property =_____

38. Contiguous Property *AV* (33) _____

39. Lien *on* Contiguous Property (37) -

40. Equity in Contiguous Property =_____

41. Applicant's Share ÷_____

42. Countable Equity Contiguous Property =_____

43. *Applicant's Attorney Fees -_____

43. Countable Equity/Contiguous Property =_____

Use if jointly owned, undivided or unprobated estate *and partition is required

Compare line 21 to line 43. Countable resource is the lesser of the two.

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Manual Title	Chapter	Page Revision Date
Virginia Medical Assistance Eligibility	**M11**	**July 2008**
Subchapter Subject	Page ending with	Page
M1130.000 ABD RESOURCE EXCLUSIONS	**M1130, Appendix 3**	**1**

Burial Fund Designation

CASE NAME
CASE NUMBER

I hereby designate the funds described below for burial.

RESOURCE DESIGNATED		**OWNER**	
Description (Include name of financial institution, insurance company, location, account number or policy number, etc.)	**Designated for Whom**	**Date First Considered Designated**	**Value**
RESOURCE DESIGNATED		**OWNER**	
Description (Include name of financial institution, insurance company, location, account number or policy number, etc.)	**Designated for Whom**	**Date First Considered Designated**	**Value**
RESOURCE DESIGNATED		**OWNER**	
Description (Include name of financial institution, insurance company, location, account number or policy number, etc.)	**Designated for Whom**	**Date First Considered Designated**	**Value**

SIGNATURE	DATE

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DETERMINING THE COUNTABLE VALUE OF NON-HOME REAL PROPERTY

Definitions

1. "Assessed value" means the tax assessed value that the tax assessor's office places on the real property for tax purposes; the tax assessed value is the current fair market value (FMV) of the real property. In Virginia, all real property is assessed at 100% of its current FMV, so the assessed value of the real property is the current FMV of the property.

2. "Equity value" means the property's assessed value minus the balance due on the lien (a mortgage or a court-ordered judgment) against the property, **when the lien is in the Medicaid applicant's name, when the Medicaid applicant is one of the individuals listed on the lien, or when the Medicaid applicant is one of the owners subject to the lien, meaning responsible for paying the lien. If the Medicaid applicant is not subject to the lien, the balance due on the lien is not subtracted from the value of the property. If the Medicaid applicant is one of two or more individuals subject to the lien, then ONLY the Medicaid applicant's fractional share of the lien balance is deducted from the applicant's share of the property's value.**

3. "Life estate interest" is a limited type of ownership in real property. 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 cases, it may be conditional: e.g., for life or until remarriage. The owner of a life estate can sell the life estate interest but does not have title to the property and normally cannot sell the property or pass it on as an inheritance.

4. "Remainderman" is the term used when an individual has an ownership interest in the real property, but does not have the right to possess and use the property until termination of the life estate interest.

A. Procedure A: Non-business Real Property Owned by One Owner, Not Producing Income

Step 1 - Determine the total property assessed value and the balance due on all liens against the property that are in the applicant's name.

Step 2 - Property assessed value
- Lien amount balance (when Medicaid applicant is subject to the lien)
Equity value

Example A1 (one-owner non-business, non-income-producing property):

Example #A1, Step 1:

Total property assessed value = $81,500
Balance due on property's mortgage (applicant is subject to the lien) = $72,000

Example #A1, Step 2:

$81,500 Total property assessed value
- 72,000 Lien balance
$ 9,500 Equity value

$9,500 is countable value

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B. Procedure B: Non-business Real Property Owned by One Owner, producing income

Step 1 - Determine the total property assessed value and the balance due on all liens against the property to which the Medicaid applicant is subject.

Step 2 - Property assessed value
- Lien amount balance (the applicant is subject to the lien)
Equity value of property

Step 3 - The real property is not business property, so determine if the $6,000 disregard applies to the property because the property is essential to self-support (S1130.502 and S1130.503):

Ask: Does property produce goods/services essential to the individual's daily activities?

If yes, subtract the $6,000 disregard from the equity value, regardless of how much income the property produces – no rate of return is calculated.

If no, does the property produce net annual income (after all expenses are subtracted from the gross annual income produced by the property) that equals or exceeds 6% of the property's **excluded equity** value?

If yes, subtract the $6,000 disregard from the equity value.

If no, do not subtract the $6,000 disregard.

Example B1 (one-owner non-business, income-producing property, essential to daily living - M1130.502):

Example #B1, Step 1:

Total property assessed value = $81,500
Balance due on property's mortgage (applicant is subject to the lien) = $72,000

Example #B1, Step 2:

$81,500 Total property assessed value
- 72,000 Lien balance
$ 9,500 Equity value

Example #B1, Step 3:

Does property produce goods/services essential to the individual's daily activities?

Yes – property is used as a garden for the individual's household's consumption – only any excess not used by the household is sold, and the individual receives only $100 a year from selling the excess. Rate of return is not calculated because the property is used to produce goods essential to the individual's daily activities.

$ 9,500 Equity value
- 6,000 Disregard
$ 3,500 Countable value of property

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Example #B2 (one-owner non-business, income-producing property, NOT essential to daily living – M1130.503):

Example #B2, Step 1:

Total property assessed value = $90,500
Balance due on property's mortgage (applicant is subject to the lien) = $70,000

Example #B2, Step 2:

$90,500 Total property assessed value
- 70,000 Lien balance
$20,500 Equity value

Example #B2, Step 3:

Does property produce goods/services essential to the individual's daily activities? No.

Does the property produce net annual income (after all expenses are subtracted from the gross annual income produced by the property) that equals or exceeds 6% of the excluded equity value? Because the equity value is over $6,000, the excluded equity value cannot exceed $6,000; the rate of return is calculated on the maximum $6,000 excluded equity value.

Calculate rate of return:

$10,000 Gross annual income from property
- 2,000 Annual expenses to produce income
$ 8,000 Net annual income from property

$6,000 Excluded equity value of property
X .06 6%
$ 360 6% of equity

Because $8,000 net annual income from the property exceeds $360 (6% of the excluded equity value), the property produces the required rate of return and the $6,000 disregard is subtracted from the equity value to determine the countable value of the property:

$ 20,500 Equity value
- 6,000 Disregard
$ 14,500 Countable value of property

Example #B3 (one-owner non-business, income-producing, NOT essential, equity < $6,000 – M1130.503):

Example #B3, Step 1:

Total property assessed value = $12,500
Balance due on property's mortgage (applicant is subject to the lien) = $7,000

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Example #B3, Step 2:

$12,500 Total property assessed value
- 7,000 Lien balance
$ 5,500 Equity value

Example #B3, Step 3:

Does property produce goods/services essential to the individual's daily activities? No.

Does the property produce net annual income (after all expenses are subtracted from the gross annual income produced by the property) that equals or exceeds 6% of the excluded equity value? Yes.

Calculate rate of return:

$2,000 Gross annual income from property
- 100 Annual expenses to produce income
$1,900 Net annual income from property

$5,500 Equity value of property
X .06 6%
$ 330 6% equity

Because the $1,900 net annual income from the property exceeds $330 (6% of the excluded equity value of $5,500), the property produces the required rate of return and the $6,000 disregard is applicable. Because the equity value of the property is less than $6,000, the entire equity value is subtracted from the equity value to determine the countable value of the property:

$ 5,500 Equity value
-5,500 Disregard
$ 0 Countable value of property

C. Procedure C: Real Property Owned by One Owner (Remainderman) and One Life Interest Owner

Step 1 - Determine the age of the life interest owner, the property's assessed value and the balance due on the lien against the property when the applicant is subject to the lien. If there is more than one owner subject to the lien, determine the number of owners subject to the lien.

Step 2 - The applicant is the remainderman on this property – determine the value of the remainder interest in the property which will be countable EVEN IF the life interest holder does NOT agree to sell the life interest. No estimated costs of selling the remainder interest are deducted:

Assessed value of property
X Remainder interest factor based on life interest owner's age (from table in M1140.120)
Remainder interest value
- Lien balance (or portion) if applicant is subject to the lien
Countable value of remainder interest in property

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Example #C1 - Real Property Owned by One Owner (Remainderman) and One Life Interest Owner:

Example #C1, Step 1:

Total property assessed value = $81,500
Balance due on property's mortgage; applicant is NOT subject to the lien = $72,000

Example #C1, Step 2:

The life interest owner's age is 60 years old.

$81,500.00 Assessed value
X .25509 Factor from table for life interest owner 60 years old
$20,789.84 Remainder interest value
- 0 Lien balance (applicant is not subject to the lien)
$20,789.84 Equity value of remainder interest

$20,789.84 countable value of real property

D. Procedure D: Joint Ownership - Undivided Estate or Unprobated Estate

This is non-home real property that is owned jointly (undivided estate).

Step 1 - Determine the total property assessed value and the balance due on all liens against the property to which the applicant is subject. If there is more than one owner subject to the lien, determine the number of owners subject to the lien.

Step 2 - **When a partition suit is necessary to liquidate the property:** Determine the shared partition costs for liquidating the property. Use the average cost of partitioning in the locality where the property is located, based on the **assessed** (not equity) value of the TOTAL property.

If a partition suit is NOT necessary to liquidate the property (all the owners agree to sell it), do not subtract any partition costs or attorneys' fees; insert zeros in the formula in place of partition costs and attorneys fees.

Step 3 - Assessed value of property
- Shared partition costs
Assessed value less shared partition costs

Step 4 - Assessed value less shared partition costs
÷ Applicant's ownership share of property
Applicant's share
- Balance due on the lien(s) (or portion) when applicant is subject to the lien
- Applicant's attorney fees
Applicant's equity value

Step 5 – When the property produces income to the applicant, determine if the $6,000 disregard can be subtracted from the Applicant's Equity Value (S1130.502 and S1130.503):

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Ask: Does property produce goods/services essential to the individual's daily activities?

If yes, subtract the $6,000 from the Applicant's Equity Value, regardless of how much income the property produces to the applicant – no rate of return is calculated.

If no, does the property produce net annual income (after all expenses are subtracted from the gross annual income produced by the property) that equals or exceeds 6% of the property's **excluded equity** value (the excluded equity value cannot exceed $6,000)? If yes, subtract the $6,000 disregard from the Applicant's Equity Value. If no, do not subtract the $6,000 disregard.

Example #D1 (undivided joint ownership, producing income):

Example #D1 - An applicant owns a 1/3 interest in non-home, non-business real property. There is a lien on this property; the applicant and another owner are subject to the lien that has a balance due of $10,000. The assessed value of the property is $100,000. A co-owner does not agree to sell, so a partition suit is required to sell the property. The estimated shared cost of partitioning is $2,000 and the applicant's attorney's fees will be $1,000. The property produces $200 per year gross income to the applicant; there are no expenses to produce the income.

Example #D1, Step 1:

Assessed value of total property = $100,000
Balance due on entire property's mortgage = $10,000
Applicant's one-half share of lien balance = $5,000

Example #D1, Step 2:

Shared partition costs = $2,000
Applicant's attorney's fees = $1,000

Example #D1, Step 3:

$100,000 Total property assessed value
- 2,000 Shared partition costs
98,000 Assessed value less shared partition costs

Example #D1, Step 4:

$98,000 Assessed value less shared partition costs
÷ 3 Applicant's ownership share of property owners
$32,666.67 Applicant's share
- 5,000.00 Applicant's share of balance due on the lien
- 1,000.00 Applicant's attorney fees
$26,666.67 Applicant's equity value

Example #D1, Step 5:

Does property produce goods/services essential to the individual's daily activities? No

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Does the property produce net annual income (after all expenses are subtracted from the gross annual income produced by the property) to the applicant that equals or exceeds 6% of the excluded equity value ($6,000)? If yes, subtract the $6,000 disregard from the Applicant's Equity Value. If no, do not subtract the $6,000 disregard.

Calculate rate of return:

$6,000 Excluded equity value of property
X .06 6%
$ 360 6% Rate of Return

Since the annual net income received from the property is $200, which is **less than** the required rate of return of $360, the $6,000 disregard **is not** subtracted when determining the countable value of the property:

$26,666.67 Applicant's equity value
- 0 Disregard
$26,666.67 Countable value of real property

E. Procedure E: Joint Owners (Remaindermen), One Life Interest Owner, produces income

This is non-home real property that is owned jointly (undivided estate), has one life interest owner, and the property produces income to the applicant who is one of the owners (remaindermen). No $6,000 disregard is applicable to remainder interests in real property. No estimated partition costs & attorney's fees are deducted because the property is subject to a life estate interest.

Step 1 - Determine the total property assessed value and the balance due on all liens against the property to which the applicant is subject. When there is more than one owner subject to the lien, determine the number of owners subject to the lien to determine the Medicaid applicant's share of the lien balance. No estimated partition costs & attorney's fees are deducted.

Step 2 - Determine value of the remainder interest in the property (M1140.120) regardless of whether the life interest owner agrees to sell the life interest, using the age of the life interest owner:

Assessed value of property
X Remainder interest factor based on life interest owner's age (from table in M1140.120)
Remainder interest value

Step 3: Remainder interest value
÷Applicant's ownership share of remaindermen (joint owners of property)
Applicant's share of remainder interest
- Lien balance (or portion) when applicant is subject to lien
Countable value of property

Example #E1 - Joint Owners (Remaindermen),1 Life Interest Owner, produces income:

An applicant owns ½ remainder interest in non-home, non-business real property; there is one life interest owner, aged 80 years. There is a lien on this property; the applicant is the only owner who is subject to the lien. The balance due on the lien is $10,000. The assessed value of the property is $81,500. The life interest owner agrees to sell, but the other remainder owner does not agree to sell. No estimated costs of partitioning or selling the property are deducted. No $6,000 disregard for income-producing property is allowed on a remainder interest.



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Example #E1, Step 1:

Total property assessed value = $81,500
Balance due on property's mortgage (applicant is only owner subject to lien) = $10,000

Example #E1, Step 2:

The life interest owner's age is 80 years old.

$81,500.00 Total property assessed value
X .56341 Factor from table for life interest owner's Age (80 years old)
$45,917.92 Value of remainder interest

Example #E1, Step 3:

$45,917.92 Value of remainder interest
÷ 1/2 Applicant's ownership share of remainder interest (joint owners of property)
$22,958.96 Applicant's share of remainder interest
- 10,000.00 Lien balance (applicant is the only owner subject to lien)
$12,958.96 Countable value of property

$12,958.96 countable value of property

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CHAPTER M11
RESOURCES
SUBCHAPTER 40
TYPES OF COUNTABLE RESOURCES

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M1140 Changes

Updated With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Pages 1, 3 and 4
TN #DMAS-23	4/1/22	Table of Contents, page i Page 16 Table of Contents, page ii was added as a runover page. Pages 16a-16e were added. Page 16e is a runover page.
TN #DMAS-21	10/1/21	Page 26 Page 26a is a runover page.
TN #DMAS-20	7/1/21	Pages 18, 26a Page 19 is a runover page.
TN #DMAS-11	1/1/19	Page 17
TN #DMAS-7	1/1/18	Page 30
TN #DMAS-5	7/1/17	Page 7
UP #9	4/1/13	pages 2, 17
TN #97	9/1/12	Table of Contents, page i Table of Contents page ii was removed. pages 2, 16-19, 26, 26a
TN #96	10/1/11	pages 12-12a, 24
TN #93	1/1/10	pages 13-15 pages 24, 25
TN #91	5/15/09	pages 11-12a

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TYPES OF COUNTABLE RESOURCES

*M*1140.001 PURPOSE OF SUBCHAPTER PER POMS S1140.001

Introduction

This subchapter contains instructions for the development of resources whose value ordinarily will count toward the resource limit. Use these instructions only after you have made certain that the property at issue:

- is a resource, based on instructions in the S1110 and S1120 subchapters; and
- is not an excluded resource, based on instructions in the S1130 subchapter.
- *The reported values of the resources are not reasonably compatible with electronic sources AND below the resource limit. See M1110.600.*

M1140.010 GENERAL VERIFICATION REQUIREMENTS -- INITIAL APPLICATIONS

A. Development and Documentation-- Any Resources

1. General Rule: Verify

Except as indicated in 2. and B. below, always verify the value of resources for any month for which you must determine eligibility.

If an applicant appeals a denial related to a particular resource, the evidence in the file must clearly establish the value of that resource. It must do so even if the issue under appeal is not the value itself (e.g., when the issue under appeal is ownership). This requirement ensures that at each level in the appeals process, the file contains complete documentation of the resource in question.

2. Exceptions to the General Rule

You do not have to verify the value of resources for a given month if:

- the resource is **totally** excluded, regardless of its value; or
- the individual is ineligible for that month for a nonfinancial reason.

3. Values That Apply to Resources

See S1140.042 and M1110.400 for detailed instructions on "current market value (CMV) and "equity value" (EV).

Develop the EV of a resource whenever:

- the CMV of all countable resources exceeds the applicable limit; and
- the individual alleges a debt against the resource.

You do **not** have to develop the EV for a resource if the CMV of all countable resources does not exceed the applicable limit.

See S1110.510 for developing the value of a resource when there is a **shared ownership**.

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B. Development and Documentation-Exceptions for Liquid Resources Only

1. Cash on Hand

Accept an allegation of cash on hand, regardless of amount. Never ask to see or count cash.

2. Government-Issued Debit Cards

Government-administered benefits may be issued via government-sponsored debit cards, such as the Direct Express Debit MasterCard used for Social Security, Supplemental Security Income, Railroad Retirement and other government benefits. If the debit card account is funded solely by deposits from a government program, the money in the debit card account, minus any income deposited to the account for the month, is considered cash on hand and is countable unless otherwise excluded. See subchapter S1130 for information about benefits that are excluded as resources.

Debit cards that are *not government-sponsored* (e.g. the Green Dot pre-paid Visa or MasterCard) are considered bank accounts *even if the individual's government benefits are deposited into the debit account*. See S1140.200.

C. Development and Documentation--Photocopying Restrictions

U.S. Government Securities and Obligations

It is legal to photocopy checks issued by the Federal Government, U.S. Savings Bonds, Treasury notes, and other securities and obligations of the U.S. Government **only if** the photocopies are:

- in black and white; and
- of a size less than three-fourths or more than one and one-half, in linear dimension, of each part of the item illustrated.

Photocopying Not Legal

If equipment limitations or restrictions imposed by State or Federal law do not permit legal photocopying of a document, make a certification from the original document involved. If the document appears to have been altered in some way, certify it "as is" with a notation as to the apparent alteration.

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*M*1140.020 GENERAL VERIFICATION REQUIREMENTS -- POSTELIGIBILITY

A. Development and Documentation-- Any Resources

Evaluation of continued eligibility is required for redetermination and changes. Different types of Medicaid coverage may require additional months to be evaluated, i.e., QMB and SLMB reevaluation may require retroactive and ongoing medically needy evaluation. The following instructions apply to any period of review.

1. Value During Past Months

a. Reasonable Compatibility
You do not have to verify the value of resources for a period of review if the reported values of the resources are reasonably compatible with electronic sources AND below the resource limit (resource eligible), or both values are over the resource limit (resource ineligible). See M1110.600.

b. **Ineligibility for Entire Period**
You do not have to verify the value of resources for a period of review, **if** for the **entire** period, the individual is ineligible because of a nonfinancial reason.

c. **Eligibility for One or More Months**
Verify the value of resources for any month being reviewed for which the individual is not ineligible based on a. above.

2. Value in Current Month

As at initial application, always verify the value of resources for any month for which you must determine eligibility.

You do not have to verify the current value of resources if the individual is ineligible for a nonfinancial reason.

3. Developing Value When An Appeal is Filed

See S1140.010A.1. if an individual appeals a termination of Medicaid coverage due to the value of particular resource.

B. Development and Documentation--Non-Liquid Resources

1. General Rule-Apply Current Value

Use the current value of a nonliquid resource in determining resources for any months evaluated due to redetermination or change unless:

- the specific instructions for developing that resource say not to; or
- evidence indicates that it would be inappropriate to do so, as may be the case with a resource that continually appreciates in value.

2. Exception Chart

If the resource is...	then see...	regarding
real property	S1140.100 D.2	use of the tax-assessed value.
foreign property	S1140.100 G.3	the retroactive application of current foreign exchange rates
an automobile	M1130.200 C.4	use of the current N.A.D.A Guide.



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C. Development and Documentation-Liquid Resources

1. General Rule--Verify Verify the value of liquid resources for each month covered by an application unless 2 *or 3* below applies.

2. Exception--Cash As in initial, accept the individual's allegation.

3. Reasonable Compatibility *If the reported values of the resources are reasonably compatible with electronic sources AND below the resource limit (resource eligible), or both values are over the resource limit (resource ineligible) no additional development is required. See M1110.600.*

D. Related Policy

1. Photo-copying Restrictions See M1140.010 D. for photocopying restrictions imposed by Federal or State law.

2. Current Market Value/Equity Value See M1110.400 for detailed instructions on CMV and EV.

See M1140.010 A.3. for what values to apply to resources.

3. Shared Ownership See S1110.510 for developing the value of a resource when there is shared ownership.

4. Determining Equity Value See S1140.042.

S1140.030 OWNERSHIP

A. Operating Policy--Liquid Resources

1. Assumption For presumably liquid resources (S1110.305), assume that the person whose name is shown as owner owns the entire resource. If more than one owner is shown, assume that each has equal ownership interest.

2. Exceptions: Checking/ Savings Accounts and Time Deposits See S1140.200 and S1140.205 for checking and savings accounts. See S1140.210 for time deposits.

B. Operating Policy-Nonliquid Resources For presumably nonliquid resources (S1110.310), assume, absent some indication to the contrary, that an individual's allegation of sole ownership is correct.

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S1140.042 DETERMINING EQUITY VALUE

A. Operating Policy

Develop the equity value of a resource (liquid or nonliquid) when an individual alleges a debt against it and the difference between equity and CMV could mean the difference between eligibility and ineligibility.

B. Development and Documentation

1. Statement

If an individual alleges a debt against the resource in question, obtain his or her signed description of the debt.

2. Verification

a. **Verify,** at a minimum:

- the outstanding principal balance of any month for which a determination must be made; and
- **Obtain** a copy of the agreement or note that establishes the debt. If this does not provide all the information needed, you may use other records of the individual, the creditor, or both.

3. Determining the Countable Value of Real Property

The procedures for determining the countable value of real property are found in Appendix 1 to subchapter S1130.

C. Example-Equity Value Permits Eligibility for Limited Time

The Rounds, an aged couple, file for Medicaid in January 1994. Their countable liquid resources total $1,500. They also own nonhome real property with a CMV of $2,000, which would cause their total resources to exceed the $3,00 limit.

However, there is a mortgage on the land with an outstanding principal balance of $800. Thus, the property's equity value ($1,200) currently permits eligibility.

Payments on the mortgage reduce the outstanding principal balance by $80 a month. At that rate, the property's equity value will reach $1,520 in May 1994, and resources will exceed the limit.

S1140.044 RESOURCES WITH ZERO VALUE

A. Policy Principal

Property that meets the definition of a resource (S1110.100 B.1.) is a resource even if it has no value to count; i.e., has a CMV of zero (S1110.100 B.2.).

B. Operating Policy

An unsuccessful attempt to sell property at its estimated CMV may suggest that the property has a lesser CMV than estimated, but does not necessarily mean that the property has no CMV at all.

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C. Related Policies

1. Reasonable Efforts to Sell For the effect of reasonable but unsuccessful efforts to sell real property see M1130.140.

2. Conversion of a Resource Should property that has been determined to have no CMV be sold, the proceeds of the sale represent the conversion of a resource, not income (S1110.600 B.4.).

REAL PROPERTY

S1140.100 NON-HOME REAL PROPERTY

A. Definition Non-home real property consists of land and buildings or immovable objects (including some mobile homes) that are attached permanently to the land and that do not meet the definition of a home (M1130.100).

B. Operating Policy--Assumptions

1. Sole Ownership Absent evidence to the contrary, accept an individual's allegation of sole ownership of property.

2. Marketability Absent evidence to the contrary, assume that an individual can sell the property at its estimated CMV.

C. Development and Documentation Shared Ownership Document an allegation of shared ownership with any of the following evidence:

- a tax assessment notice or bill;
- a current mortgage statement;
- a deed;
- a report of title search;
- wills, court records, or other documentation of inheritance.

If the individual alleges owning other than an equal share of the property (e.g., alleges having a 25 percent ownership interest where there are only two owners), the evidence must support that allegation, as well.

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D. Development and Documentation Current Market Value

1. Tax Assessment Notice

a. When to Use

Obtain a copy of the most recently issued tax assessment notice for the property . Base the CMV on this assessment.

b. How to Use

To determine CMV based on a tax assessment notice, divide the assessed value by the assessment ratio. For example, an assessed value of $2,000 divided by an assessment ratio of 50 percent equals a CMV of $4,000.

2. Certified Real Property Assessment

a. When to Use

Effective 10/4/16, the certified value of real property as determined by an appraiser licensed in the state in which the real property is located, is accepted as the property's CMV.

b. How to Use

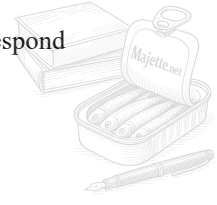
The use of an appraisal is applicable only to non-commercial real property. A certified appraisal documenting the value of the property must contain the name and license number of the individual conducting the appraisal. A copy of the appraisal must be scanned into the VaCMS case record or placed in the paper case record. See M0110.400.

***3.* Knowledge-able Source Estimate**

a. **When to Use**
If an individual owns property which does not have a tax assessment, in order to establish CMV, have the individual obtain an estimate of the property's CMV from a knowledgeable source.

b. What The Estimate Must Show
The estimate must show, in addition to the estimate itself:

- the name of the person providing the estimate;
- the name, address and telephone number of the business or agency for whom the person providing the estimate works;
- the basis for the estimate, to include such things as a description of the property and its condition and, where appropriate, the value of similar property in the same area; and
- the period to which the estimate applies (which should correspond to the period for which it is being request).



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c. Knowledgeable Sources Knowledgeable sources include but **are** not limited to:

- real estate brokers;
- the local office of the Farmer's Home Administration (for rural land);
- banks, savings and loan associations, mortgage companies, and similar lending institutions;
- an official of the local property tax jurisdiction (be sure to obtain the individual's estimate rather than the office's assessment); and
- the County Agricultural Extension Service.

d. **Assisting The Individual**
If the individual is incapable of obtaining an estimate, lend assistance. If you obtain an estimate by phone, be sure to record all pertinent facts in file.

If you cannot obtain an estimate by phone, you can contact a knowledgeable source for an estimate by mail.

e. **Obtaining More Than One Estimate**
If you doubt the validity of an estimate furnished by the individual, obtain an estimate from an additional knowledgeable source.

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E. Development and Documentation Equity Value

1. When to Develop

See S1140.042.

2. Evidence

a. The allegation of an encumbrance (any legal debt, such as a mortgage, lien, loan, purchase contract, security interest, etc.) must be supported with evidence of:

- the original amount owed;
- the outstanding principal balance; and
- the schedule and amount of payments due on the principal balance.

b. Have the individual submit a copy of the **note or agreement** establishing the encumbrance.

c. Verify with the creditor (by phone, if possible) any required information that the note or agreement does not show (normally, this will be the outstanding principal balance).

3. Special Review

If, because of scheduled payments on the debt, the equity value of the property may cause the individual's resources to exceed the resource limit before the next scheduled redetermination, establish a special review.

4. Exempt and Nonexempt Property with Single Encumbrance

If there is an encumbrance on the property only the prorated share of the encumbrance on the countable assessed value will be used to determine the countable equity value.

Example: An applicant owns a home, lot and four acres of contiguous property. The contiguous property is assessed at $15,000, but the equity is only $3,000. $5,000 of the assessed value of $15,000, would be exempt as home property. The portion of the equity value of $3,000 relating to the countable $10,000 portion of the land would then be included as a countable resource.

The portion of the equity value, $10,000 divided by $15,000 is .666. Therefore, .666 of $3,000 equity or $1,998 is countable**.**

5. Determine the Countable Value

The procedures and an example for determining the countable value of real property with an encumbrance are found in Appendix 1 to subchapter S1130.

F. Development and Documentation Foreign Property

1. General

Foreign property is subject to the same rules as domestic property.

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2. Obtaining Evidence of Legal Bars

a. **General**
Evidence of a legal bar to the sale of property, or to removing the proceeds of a sale from the country, makes CMV development unnecessary. If the individual alleges such a bar, try to verify it by phone before going through the development in 3. below. Document the information you obtain.

b. **Acceptable Source of Information**
Acceptable sources of information are a consulate, mission, or embassy of the country, or our own Department of State. The number of the General Information Desk at State is (202) 647-4000. Contact your regional office if you need help.

3. Obtaining Evidence General

If an individual does not have the documents necessary to support a determination of ownership and CMV or equity value, he or she may be able to write for them, directly or with the aid of a local nationality organization.

- a detailed description of the property, its location, and any other background information the individual can provide;
- the specific information needed, e.g., CMV, the details of any restrictions on removing the proceeds of a sale from the country, etc., and
- the source(s) of the necessary documents or information, to the extent known.

4. CMV Estimate in Foreign Currency

If the CMV estimate is in foreign currency, contact a local bank for the current exchange rate. Apply the current rate retroactively and prospectively unless the individual provides reliable evidence of a different rate.

5. Effect of Partial Restrictions

a. If a legal restriction limits the **amount** an individual can remove from the country, that limit is the maximum value the property can have as a resource.

b. If a legal restriction affects **when** the proceeds of a sale can be removed from the country (e.g., once a year), such proceeds are income when they can be removed, and are not resources before then.

c. If the individual has already sold property and can remove a portion of the proceeds before the next scheduled redetermination:

- document the appropriate amount as unearned income for the expected month of receipt; and
- if, in your judgement, the amount to be received is likely to affect eligibility based on resources for the month after receipt, set a special review for the month after receipt to make a resource determination.

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M1140.110 OTHER PROPERTY RIGHTS

A. Introduction

1. Mineral Rights

Mineral rights represent ownership interest in natural resources such as coal, oil, or natural gas, which normally are extracted from the ground.

2. Timber Rights

Timber rights permit one party to cut and remove free standing trees from the property of another property.

3. Easements

An easement gives one party the right to use the land of another party for a special purpose.

4. 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. See M1140.110A.6 for life estates.

5. Water Rights

Water rights usually confer upon the owner for riverfront or storefront property the right to access and use the adjacent water.

6. Life Estates

a. General

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 cases, it may be conditional: e.g., for life or until remarriage.

The owner of a life estate can sell the life estate but does not have title to the property and thus normally cannot sell it or pass it on as an inheritance.

b. Life Estate Created Prior to August 28, 2008

The value of a life estate created prior to August 28, 2008 is not counted as a resource. Exception: The value of a life estate owned by a QDWI enrollee is countable, regardless of the date on which it was created.

c.* Life Estate Created On or After August 28, 2008 *but Before February 24, 2009

The value of a life estate created on or after August 28, 2008 *but before February 24, 2009* is a countable resource to the owner of the life estate unless the life estate is excluded under one of the real property exclusions contained in Chapter S1l. Exception: The value of a life estate owned by a QDWI enrollee is countable, regardless of the date on which it was created.

The value of a life estate in real property on which the individual resides and considers to be his home is excluded. If the individual leaves the property but retains a life estate, and the property is not occupied by a spouse or dependent child, the value of the life estate becomes a countable resource unless it is excluded under one of the real property exclusions contained in Chapter S11.

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d. Life Estate Created on or after February 24, 2009

The value of a life estate created on or after February 24, 2009 is not counted as a resource. Exception: The value of a life estate owned by a QDWI enrollee is countable, regardless of the date on which it was created.

7. Remainder Interests

When the owner of 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.

B. Development and Documentation

1. General

Treat the items in A. above as real property and develop ownership and value per S1140.100. See 4. below for additional instructions regarding life estates and remainder interests.

2. Mineral Rights

a. Ownership of Land and Mineral 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.

b. Ownership of Mineral Rights Only

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, in addition to those listed in S1140.100 D.2.c.:

- the Bureau of Land Management;
- the U.S. Geological Survey;
- any mining company that holds leases.

3. Lease for Life

Refer any "lease for life" agreement and related information to the regional coordinator for a determination of whether it creates a life estate under State law.

4. Value of Life Estate

a. General

The value of a life estate created on or after August 28, 2008 but before February 24, 2009 is a countable resource to the owner of the life estate unless the life estate is excluded under one of the real property exclusions contained in Chapter S1l.

b. **Calculate Value of Life Estate**

To determine the countable value of a life estate, use the table in S1140.120, *Life Estate and Remainder Interest Tables.* Multiply the CMV of the property by the “life estate” decimal that corresponds to the *applicant’s or enrollee’s* age. Record the result *in the case record*.



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If there is more than one life estate owner, divide the *CMV* of the real property by the number of people *owning* a life estate interest. Multiply the prorated *CMV* of the property by the life estate decimal that corresponds to the *applicant's or enrollee's* age. Record the result *in the case record*.

c. **Life Estate *Interest Owned by Another Person* Affects Property Value**

Any countable equity value of real property *is* affected if it is:

- subject to someone else having life estate interest, or
- the applicant/recipient transfers real property *and retains* a life estate interest, thus affecting the *real property* value *used to calculate the uncompensated value of the* asset transfer.

See S1140.120, Life Estate and Remainder Interest Tables to determine *the value* of *the life estate interest*.

5. Value of Remainder Interest

a. General

A "remainder" interest in real property is the term used when an individual has an ownership interest in the real property, but usually does not have the right to possess and use the property until termination of the life estate interest. The individual who owns a remainder interest in real property is called the "remainderman." An individual's ownership of a remainder interest in real property must be evaluated to determine the real property's countable value.

b. Calculate Value of Remainder Interest – One Remainderman

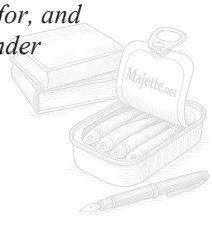
To determine the countable value of a remainder interest when only one individual owns the remainder interest, use the table in S1140.120, Life Estate and Remainder Interest Tables. Multiply the CMV of the real property by the "Remainder" decimal that corresponds to the ***life estate owner's age.*** *The result is the value of the remainder interest. Record the result in the case record.*

c. Calculate Value of Remainder Interest – Two or More Remaindermen

*To determine the countable value of a remainder interest when more than one individual owns a remainder interest in the property, divide the CMV of the real property by the number of remainder interests owned. Multiply the prorated CMV of the property by the "****Remainder"*** *decimal that corresponds to the* ***life estate owner's age****. If a remainderman is subject to a lien against the property, subtract the remaining balance or portion of the balance from the CMV value. The result is the countable value of the remainder interest. Record the countable value calculation and result in the case record.*

6. Examples in S1130 Appendix 1 and Appendix 4

See Appendix 1 and Appendix 4 to subchapter S1130 for instructions for, and examples of, determining the countable value of life estate and remainder interests in real property.

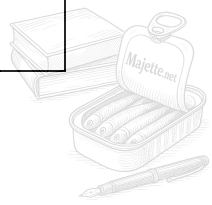


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S1140.120 LIFE ESTATE AND REMAINDER INTEREST TABLES

EXHIBIT--TABLE -UNISEX LIFE ESTATE OR REMAINDER 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*



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EXHIBIT--TABLE -UNISEX LIFE ESTATE OR REMAINDER TABLE

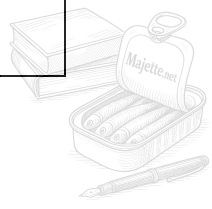
AGE	LIFE ESTATE	REMAINDER
36	*.93460*	*.06540*
37	*.93026*	*.06974*
38	*.92567*	*.07433*
39	*.92083*	*.07917*
40	*.91571*	*.08429*
41	*.91030*	*.08970*
42	*.90457*	*.09543*
43	*.89855*	*.10145*
44	*.89221*	*.10779*
45	*.88558*	*.11442*
46	*.87863*	*.12137*
47	*.87137*	*.12863*
48	*.86374*	*.13626*
49	*.85578*	*.14422*
50	*.84743*	*.15257*
51	*.83674*	*.16126*
52	*.82969*	*.17031*
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*

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EXHIBIT--TABLE -UNISEX LIFE ESTATE OR REMAINDER TABLE

AGE	LIFE ESTATE	REMAINDER
71	*.58914*	*.41086*
72	*.57261*	*.42739*
73	*.55571*	*.44429*
74	*.53862*	*.46138*
75	*.52149*	*.47851*
76	*.50441*	*.49559*
77	*.48742*	*.51258*
78	*.47049*	*.52951*
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	*.32262*	*.67738*
88	*.30859*	*.69141*
89	*.29526*	*.70474*
90	*.28221*	*.71779*
91	*.26955*	*.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*



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FINANCIAL INSTITUTION ACCOUNTS

M1140.150 QUALIFIED TUITION PROGRAMS (QTPS)

A. Operating Policies

Qualified Tuition Programs (QTPs), also referred to as Section 529 Plans, allow individuals to prepay or contribute to an account established for paying a designated beneficiary's education expenses at an eligible educational institution. QTPs can be established and maintained by states, agencies, instrumentalities of states, and eligible educational institutions. Individuals may contribute to a QTP regardless of the amount of their income.

There are two types of QTPs (529 Plans): savings plans and pre-paid plans.

Savings plans:

- *are accounts that provide investment options such as mutual funds or money market funds (similar to a retirement account (e.g. 401K)).*
- *are not guaranteed by the State and the value is subject to fluctuations in financial markets (e.g. the stock market).*
- *can be established for a beneficiary of any age.*

Prepaid plans

- *allow individuals to purchase units or credits at participating colleges and universities for tuition.*
- *allow individuals to lock-in future tuition rates at current prices.*
- *States may guarantee investments in plans that they sponsor.*
- *Most plans must be established for a beneficiary by a certain age or grade.*

B. Definitions

1. Account Owner

An account owner, also referred to as a donor, is the individual who has ownership of the account and directs use of the funds. Most plans allow the account owner to reclaim the funds deposited into a QTP at any time.

2. Designated Beneficiary

A designated beneficiary is the individual (i.e. a student or future student) who is to receive the benefit of the funds in the account. The designated beneficiary can be changed to a member of the beneficiary's family.

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3. Beneficiary's Family

The beneficiary's family includes the beneficiary's spouse and the following other relatives of the beneficiary:

- *son, daughter, stepchild, foster child, adopted child, or a descendant of any of them;*
- *brother, sister, stepbrother, or stepsister;*
- *father, mother, or ancestor of either;*
- *stepfather or stepmother;*
- *son or daughter of a brother or sister;*
- *brother or sister of father or mother;*
- *son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law*
- *the spouse of any individual listed above; or*
- *first cousin.*

4. Eligible Educational Institutions

Eligible educational institutions include any college, university, or vocational school eligible to participate in a student aid program administered by the U.S. Department of Education. This includes virtually all accredited public, non-profit, and proprietary (i.e. privately owned profit making) institutions. It also includes certain educational institutions located outside the U.S.

Effective January 1, 2018, eligible educational institutions also include elementary or secondary public, private, or religious schools, but distributions are limited to $10,000 towards tuition per beneficiary per year.

5. Withdrawals or Distributions

Withdrawals or distributions are the issuance of funds from the account. Distributions are payable to an eligible educational institution, the QTP account owner, the designated beneficiary or the estate of the beneficiary, as directed by the account owner. The account owner determines when distributions are made from the account and for what purpose.

6. Gift

Distributions from a QTP meet the definition of a gift provided:

- *they are not repayment for goods or services provided by the designated beneficiary;*
- *they are not given because of a legal obligation on the donor's part; and*
- *they are given irrevocably (i.e. the donor relinquishes all control). For additional information on gifts, see S0830.520.*

7. Rollover Contribution

A rollover contribution is any amount "rolled over" or transferred to another QTP for the benefit of the same beneficiary or a member of the beneficiary's family. Effective December 22, 2017, rollovers can also include transfers from a QTP to the beneficiary's or another family member's Achieving a Better Life Experience (ABLE) account. For more information about ABLE accounts, see M1130.740.

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8. Educational Expenses

Educational expenses are tuition, fees, and other necessary educational expenses at any educational institution. Examples of educational expenses include:

- *tuition and fees*
- *books*
- *laboratory fees*
- *student activity fees*
- *transportation*
- *stationary supplies*
- *technology fees*
- *impairment-related expenses necessary to attend school or perform schoolwork (e.g. special prosthetic devices necessary to operate school machines or equipment).*

***NOTE:** Educational expenses do not include the cost of food and shelter.*

C. QTP as a Countable Resource

Funds in a QTP are a countable resource to the individual who owns the account (e.g. a parent or grandparent). Normally, the owner is the person who established the account. In most instances, the individual who establishes a QTP retains the ability to withdraw any or all of the funds in the account for his or her own benefit.

NOTE: In most cases, the designated beneficiary (i.e. the student or future student) is not the owner of the account and does not have any rights to the funds in the account.

1. Value of a QTP

The value of the QTP is the current market value minus any applicable penalties, but not minus taxes. In addition, any maintenance fees associated with the account, whether scheduled or collected, do not reduce its value.

2. Dividends and Interest Earned on a QTP

Dividends and interest are returns on capital investments such as stocks, bonds, or savings accounts. Exclude dividends and interest earned on QTPs from income.

3. Rule for Withdrawals or Distributions From a QTP

Withdrawals or distributions to the account owner are not income but a conversion of a resource (i.e. the resource in a different form). The distribution is a countable resource to the account owner.

Assume that any distribution the designated beneficiary receives from a QTP is a gift, unless there is evidence to the contrary (e.g. there is an allegation that the distribution must be repaid). Distributions, which meet the definition of a gift and are used for educational expenses of the designated beneficiary, are excluded as income in the month of receipt. If an excluded distribution is retained into the month following the month of receipt, it is an excluded resource of the designated beneficiary for 9 months beginning with the month after the month of receipt. For information on educational gifts, see M0830.520 and S1130.455.

If the designated beneficiary spends any portion of a QTP distribution for a purpose other than his or her educational expenses or no longer intends to



use the funds for his or her educational expenses, the funds are income at the earlier of two points:

- *in the month the funds are spent; or*
- *in the month the individual no longer intends to use the funds for educational expenses.*

If a countable distribution is retained into the month following the month of receipt, it is a countable resource.

4. Examples of QTP Distributions

EXAMPLE 1—Distributions excluded as income and resources

A disabled adult, age 19, is the designated beneficiary of a QTP. On January 10, the disabled adult receives $3,000 from the QTP. The disabled adult spends $2,800 for tuition and fees in January. As of February 1, $200 of the distribution remains. The disabled adult tells the eligibility worker (EW) they will use the rest of the money for future educational expenses.

The EW determines:

- *The disabled adult is not the owner of the QTP; therefore, it is not a resource to the individual.*
- *The distribution meets the definition of a gift for educational purposes and is excluded from income in the month of January.*
- *The remaining amount of $200 is excluded from resources for the months of February through October. As of November 1, any portion that remains is a countable resource of the disabled adult.*

EXAMPLE 2—Distributions counted as income and resources

A disabled adult, age 21, is the designated beneficiary of a QTP. On August 5, the disabled adult receives $1,500 from the QTP. During the month of August, the individual spends $1,350 on books. The individual spends $75 on groceries in August and saves $75. The disabled adult tells the EW that they intends to add the rest of the money to their "emergency fund" that they have set aside for non-educational expenses.

The EW determines:

- *The disabled adult is not the owner of the QTP; therefore, it is not a resource to the individual.*
- *That $1,350 of the distribution meets the definition of a gift for educational purposes and is excluded from income in the month of August.*

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- *That $150 of the distribution is countable income to the individual for the month of August because the disabled adult spent $75 on non-educational expenses and intends to use $75 for non-educational expenses. As of September 1, any portion of the $75 that remains is a countable resource of the disabled adult.*

5. Rollover or Transfer of QTP Funds

Funds in a QTP may be transferred or "rolled over" to a member of the beneficiary's family. A transfer or "rollover" of QTP funds from a beneficiary to a family member does not necessarily indicate a transfer of account ownership. When there is a valid transfer, the original account owner no longer owns the property.

M1140.200 CHECKING, SAVINGS AND DEBIT CARD ACCOUNTS

A. Operating Policies

1. Ownership

Assume that the person designated as owner in the account title owns all the funds in the account (see S1140.205 regarding joint accounts).

2. Right to Withdraw Funds

Absent evidence to the contrary, assume that the person shown as owner in the account title has the legal right to withdraw funds from the account.

3. Fiduciaries

A fiduciary's right to withdraw funds is the same as the owner's right to withdraw them.

4. Right to Withdraw - Examples of Evidence to the Contrary

a. Right to Withdraw Funds Restricted to a Specified Account Holder

An account is titled, "In trust for John Jones and Mary Smith, subject to sole order of John Jones, balance at death of either to belong to survivor." Since John alone has unrestricted access, none of the funds in the account could be considered Mary's resources unless John were her fiduciary or his resources were deemed available to her.

b. Withdrawals Require Authorization of Third Party

An account is title, "George Dahey, restricted Individual Indian Money Account." Mr. Dahey cannot withdraw funds from the account without Bureau of Indian Affairs (BIA) authorization. Therefore, the account is not his resource.

c. "Blocked" Accounts

If State law specifically requires the funds be made available for the care and maintenance of an individual, assume, absent evidence to the contrary, that they are that individual's resource. This is true despite the fact that the individual or his/her agent is required to petition the court to withdraw funds for the individual's care. Refer to regional coordinator any questions regarding State law on "blocked accounts."

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5. Right to Use for Support and Maintenance

Absent evidence to the contrary, assume that an individual who owns and has the legal right to withdraw funds from a bank account also has the legal right to use them for his or her own support and maintenance.

6. Right to Use - Examples of Evidence to the Contrary

a. Use Restricted by Court Order

Even with ownership interest and the legal ability to access property, a legal restriction against the property's use for the owner's own support and maintenance means the property is not the owner's resources (S1110.100).

6. Examples of Evidence to the Contrary

a. Use Restricted by Court Order
Even with ownership interest and the legal ability to access property, a legal restriction against the property's use for the owner's own support and maintenance means the property is not the owner's resources (S1110.100).

EXAMPLE: An account is titled, "Aristotle Iris by Hester Pry, Representative Payee," where Ms. Pry is an officer of the institution in which Mr. Iris lives. A statewide court order prohibits such officers from using the funds of an institutionalized person for support and maintenance provided by the State. Therefore, the funds in the account are not a resource while Mr. Iris is in the institution.

b. Special Purpose Accounts
An account is titled, "Thomas Green, Kiwanis Club Fund for Heart Surgery." While Mr. Green has unrestricted access to funds, development shows that their use is restricted to the expenses of his surgery. Therefore, they are not a resource.

7. Debit Card Accounts

Debit cards that are not government-sponsored (e.g. the Green Dot pre-paid Visa or MasterCard) are considered bank accounts even if the individual's government benefits are deposited into the debit account. *Some debit card accounts may allow other monies to be deposited. In addition, joint owners may be able to access funds in the account.*

If the debit card is sponsored by a government program such as the Social Security Administration and the individual cannot deposit other money into the account, the money in the debit card account, minus any income deposited to the account for the month, is considered cash on hand and is verified by the client's statement of the balance in the account. See M1140.010.

B. Development and Documentation Initial Applications and Post-eligibility

1. Informing the Individual of Reporting Responsibilities

Be sure the individual understands that:

- he must report any bank account on which his or her name appears, regardless of any special purpose for which the account may have been established or whose money is in it;
- DSS may use other statements or forms to obtain information from any bank account or financial institution to verify the allegations.

2. Curtailing Development

Do not verify account balances under any of the following circumstances:

a. the individual alleges that his name does not appear on any accounts, and there is no evidence to the contrary;

b. the individual is ineligible for a non-financial reason.

3. Minimum Documentation - Account Balances Must Be Verified

Document, in addition to the balances themselves;

- the name and address of the financial institution;
- the account number(s); and
- the exact account designation.

4. Verification

Use the Asset Verification System whenever possible to verify the bank account. If the balance of the account when combined with other countable resources is within the resource limit for the individual's assistance unit size, no further development is necessary.

If the balance of the bank account places the individual's resources over the limit, any deposits for the month of the AVS results must be accounted for using the policy in M1140.200 B.6 below. Obtain deposit information from the individual.

5. Requesting Information from Financial Institutions

When it is necessary to request account information from a financial institution (FI), have the individual sign an authorization for release of the information.

If a financial institution refuses to provide the information needed for a determination, try to obtain its cooperation by explaining why assistance is required. If the institution still refuses to provide the information, inform the individual and ask him or her to try to get the information from the institution

a. Acceptable Forms of FI Records

1. FI original records that appear to be complete and unaltered;
2. FI records other than bank statements issued by the FI, when individual:
   - alleges that no transactions have occurred that the records do not show; or
   - alleges that such transactions have occurred and provides appropriate evidence of them; **and**
   - the records, the allegation regarding additional transactions, and the alleged current account balance (on the application or renewal form) reflect a complete and consistent picture of the account;
3. Records verified by telephone contact with the FI and documented in the case record.

b. Examples of Acceptable FI Records Other than Bank Statements

- passbooks,
- the individual's check register,
- bank statements or account activity information printed from the FI's website and submitted by the individual,
- account ledgers,
- ATM transaction receipts, and
- deposit or withdrawal slips.

Accept an FI document in the format in which it is provided by the FI or the individual if it meets the criteria in *M1140.200 B.5* above.

***6.* Determining the Value of a Bank Account**

There is no single method for determining the countable value of a bank account. The countable value is the lower of:

- the balance before income is added, or
- the ending balance minus any income added during the month.

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Funds cannot be both income and a resource in the same month. Income that has been added to a bank account during the month must be subtracted from the ending balance to ensure that the income is not also counted as a resource.

c. Balance Information

The financial institution may show the opening balance for the first day of a given month or the closing balance for the last business day of the previous month. Accept either, the amount will be the same. See M1110.001 for monthly determinations of resource eligibility.

C. Development and Documentation--Posteligibility Only

If you discover a previously undeveloped checking or savings account after eligibility has been established, develop account balances and interest for the period that a determination can cover.

S1140.205 JOINT CHECKING AND SAVINGS ACCOUNTS

A. Introduction

The instructions in S1140.200, except for A.1. (ownership), apply to all checking and savings accounts. The instructions in this section, which apply to joint accounts only, supplement those in S1140.200.

B. Operating Policy--Rebuttable Ownership Assumptions

1. Account Holders Include One Or More Applicants or Recipients and No Deemors

Assume that all the funds in the account belong to the applicant(s)/ recipient(s), in equal shares if there is more than one applicant or recipient.

2. Account Holders Include One or More Deemors

Provided that none of the account holders is an applicant or recipient (in which case the assumption in 1. above would apply), assume that all the funds in the account belong to the deemor(s), in equal shares if there is more than one deemor.

C. Development and Documentation--Initial Applications and Posteligibility

1. Informing the Individual

Inform the individual:

- of the applicable ownership assumption;
- of the corresponding income implications (S0810.130); and
- of his or her right to provide evidence rebutting the ownership assumption, if he or she disagrees with it.

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2. Individual Wishes to Rebut

a. Rebuttal Statement

If an individual wishes to rebut the applicable ownership assumption, obtain his or her statement, regarding:

- who owns the funds;
- why there is a joint account;
- who has made deposits to and withdrawals from the account; and
- how withdrawals have been spent.

b. Required Evidence

In addition, inform the individual that he or she must submit the following evidence:

- a corroborating statement from each other account holder (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);
- account records showing deposits, withdrawals and interest in the months for which ownership is at issue;
- if the individual owns *none* of the funds, evidence showing that he or she can no longer withdraw funds 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 holder(s), and redesignation of the account.

c. Determination

Any funds that the evidence establishes were owned by the other account holder(s), and that the individual can no longer withdraw from the account, were not and are not the individual's resources. However, such funds can be deemed available to the individual if the account holder to whom they belong is a deemor. Document the determination in file.

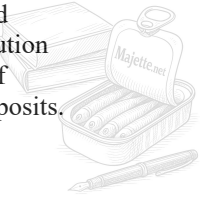
NOTE: You must verify joint account balances if an individual rebuts ownership of any of the funds in an account.

S1140.210 TIME DEPOSITS

A. Introduction

1. Time Deposits

A time deposit is a contract between an individual and a financial institution whereby the individual agrees to leave funds on deposit for a specified period (six months, two years, five years, etc.) and the financial institution agrees to pay interest at a specified rate for that period. Certificates of deposit (C.D.s) and savings certificates are common forms of time deposits.



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2. Penalties for Early Withdrawal

Withdrawal of a time deposit before the specified period expires incurs a penalty, which usually is imposed against the principal. This penalty does not prevent the time deposit from being a resource, but does reduce its value as a resource.

3. Early Withdrawal Prohibited

On rare occasions, the terms of a time deposit will prohibit early withdrawal altogether.

B. Operating Policy

1. Ownership

The assumptions regarding ownership of bank accounts (S1140,200 and S1140.205) apply to time deposits.

2. Early Withdrawal Prohibited

a. **Principal**
If the owner of a time deposit cannot under any circumstances withdraw it before it matures, it is not a resource. It becomes a resource (not income) on the date it matures, and may affect countable resources for the following month.

b. **Interest**
If the owner has no access to the interest before the deposit matures, accrued interest is not a resource and is income in the month the deposit matures (not before then).

3. Value as a Resource

The resource value of a time deposit at any given time is the amount the owner would receive upon withdrawing it at that time, excluding interest paid that month. Generally, this is:

- the amount originally deposited;
- plus accrued interest for all but the current month;
- minus any penalty specified on the certificate for early withdrawal.

C. Related Policy--Interest

See S0830.425 regarding the treatment of interest for income purposes.

D. Development and Documentation

Verify the original amount deposited, interest accrued, and what penalty applies for early withdrawal. If the individual alleges that the deposit cannot be withdrawn prior to maturity under any circumstances, verify that. Obtain this information from the individual's copies of account records to the extent possible. Contact the financial institution only to obtain information the individual's records do not provide.

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S1140.215 CONSERVATORSHIP ACCOUNTS

A. Definitions

1. Conservator-ship Account

The term "conservatorship account" refers to a financial account in which a person or institution has been appointed by a court to manage and preserve the assets of an individual which are held in the account.

2. "Individual"

For Medicaid purposes the "individual" for whom a conservatorship account is held may be a applicant, recipient, or other person whose resources are deemable to the applicant or recipient.

B. Policy

The following policy does not apply to trusts, which are discussed in S1120.200.

1. Assumption of Availability for Support and Maintenance

If State law requires that funds in a conservatorship account be made available for the care and maintenance of an individual, we assume, absent evidence to the contrary, that funds in such an account are available for the individual's support and maintenance and are, therefore, that individual's resource.

A State statute may not specifically address the issue of whether funds in a conservatorship account must be made available for the care and maintenance of the individual. Other State statutes or case law may specifically prohibit the use of funds held in the conservatorship account for general support of the individual in certain circumstances. Eligibility Workers (EW) should follow regional instructions regarding availability presumptions that apply in those States.

2. Examples of "Evidence to the Contrary"

Examples of evidence of the contrary include (but are not limited to):

- restrictive language in the court order that established the account or in a subsequent court order;
- State or local procedural rules for the withdrawal of funds from the account; and
- local court practices regarding withdrawal of funds.

3. Requirement to Petition Court for Release of Funds

The fact that an individual or his/her agent must petition the court for withdrawal of funds does not mean that the funds may be assumed to be unavailable for the individual's support and maintenance (and, therefore, not a resource for Medicaid purposes).

Denial by the court of a request for withdrawal of funds does not necessarily mean that funds in the account are unavailable for the individual's support and maintenance. If the court approves requests to withdraw funds in order to provide support and maintenance, and only disapproves requests for non-essential items, the funds are considered available and a resource for Medicaid purposes. The EW should review the

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history of petitions for (and approvals and denials of) withdrawal of funds. If a denial by the court appears to be an exception rather than the rule, the funds may be determined to be a resource for Medicaid purposes.

C. Procedure

1. Follow Regional Instructions

Refer to regional instructions regarding State law, State or local rules, or local court practices regarding the conditions under which funds held in conservatorship accounts may be withdrawn.

2. Obtain the Individual's Allegation

Obtain over the individual's signature an allegation regarding:

- who can withdrawn the funds;
- the method for withdrawing funds (e.g., petition the court or unlimited ability to withdraw by the individual or his/her agent);
- uses to which funds may or must be put; and
- any restrictions on availability or use of funds.

If the court has restricted use of funds in the account **at the individual's or his/her agent's request**, obtain the individual's allegation as to whether the restriction(s) can be removed by request or petition.

3. Obtain Evidence as Necessary

If you must verify the value of the funds (see S1140.010 or S1140.020 for general verification requirements) or if the individual's allegations suggest that funds in the conservatorship account are not a resource for Medicaid purposes, ask the individual to submit evidence regarding the account. Obtain evidence to document the issues which must be addressed. This evidence may include:

- the court order establishing the conservatorship and the account;
- any account records showing withdrawals, deposits, and balances;
- prior applications or petitions for withdrawal of funds (if applicable), including any correspondence or notices from the court responding to the applications or petitions; and
- any other doucments or evidence in the individual's possession pertaining to the conservatorship account.

4. Make Resource Determination

Document in the case record your determination as to whether the funds in the account are a resource for Medicaid purposes. Refer to regional instructions, as applicable.

If the court has restricted use of funds in the account at the individual's or his/her agent's request and the registration(s) can be removed at the individual's or agent's request or petition, determine that the funds are a resource for Medicaid purposes.

If due to the complexity of the conservatorship account or the history of petitions for funds, you are unable to determine the status of the account for Medicaid resource purposes, refer to the case to the Regional Specialist.

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D. Examples

The following examples illustrate policy and procedures for conservatorship accounts.

1. Funds Assumed to Be Available for Support and Maintenance

The claimant, a disabled 28-year-old individual, received a $20,000 court-ordered personal injury award as a result of an accident on a city bus. The court order stipulates that the claimant's legal guardian must petition the court for withdrawal of funds as needed. The order does not place any restrictions on how the funds may be used on behalf of the claimant.

The EW consults the regional specialist on conservatorship or "blocked" accounts and determines that, under State law, the funds in an account such as this may be assumed to be available for the individual's support and maintenance. Therefore, the EW determines that the funds in the account are a resource for Medicaid purposes.

2. Funds Not Available for Support and Maintenance

Same situation as above. However, regional instructions indicate that State law restricts the use of personal injury funds held in conservatorship accounts to medical expenses only. Since the funds are not available for food, clothing, or shelter, the EW determines the funds are not a resource.

3. Petition for Withdrawal of Funds Denied

The Medicaid recipient, a 2-year-old child, has received a $100,000 medical malpractice award. The court order requires that the child's parents petition the court for withdrawal of funds. The parent/payee alleged that a recent petition for withdrawal of funds was denied.

The EW asks the payee to submit evidence of the petition in question and all prior petitions. Examining the evidence, the EW concludes that all but one petition for withdrawal of funds were approved for the general support and maintenance of the child. The court denied one petition, citing the intended use of the funds. The court characterized the intended use as "nonessential for the child's care."

Since the one denied petition does not negate the presumption that the funds are available for the child's support and maintenance, the EW concluded that the funds are a resource for Medicaid purposes.

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OTHER COMMON INVESTMENT VEHICLES

S1140.220 STOCKS

A. Introduction

Shares of stock represent ownership in a business corporation. Their value shifts with demand and may fluctuate widely. The following guidelines apply to all stocks, including preferred stocks, warrants and rights, and options to purchase stocks.

B. Operating Policy

1. Co-Ownership

Absent evidence to the contrary, assume that each owner owns an equal share of the value of the stock.

2. Salability

Absent evidence to the contrary, assume that the owner of shares of stock can sell them at will at current value.

3. Broker Fees

Broker fees do not reduce the value that stocks have as resources.

D. Development and Documentation

1. Ownership

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 file with a photocopy. If the individual does not have this documentation, have him or her obtain a statement from the firm. Provide assistance as needed.

2. Value--Publicly Traded Stocks

a. **Which Value to Use**

The CMV of a stock is its closing price on the previous business day. The values of over-the-counter stocks are shown on a "bid" and "asked" basis. For example, "18 bid, 19 asked." 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.

b. **Sources of Information**

The closing price of a stock on a given day can usually be found in the next day's regular or financial **newspaper.**

As a last resort, contact a local **securities firm.** Record the appropriate closing price and the source of the information.

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3. Value--Stock That Is Not Publicly Traded

a. **Traded**

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

b. **Evidence**

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

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

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

S1140.230 MUTUAL FUND SHARES

A. Introduction

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

B. Development and Documentation

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

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S1140.240 U.S. SAVINGS BONDS

A. Introduction

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

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

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

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

B. Operating Policy

1. Sole Ownership

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

2. Co-Ownership

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

3. Status as Resources

a. General

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

b. Co-ownership Without Access

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

C. Development and Documentation

1. Ownership

***a.* Paper Bonds**

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

***b.* Electronic Bonds**

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

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2. Status as Resources

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

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

3. Value

a. Series E, EE, and I paper bonds

- **On-line Verification** at: http://www.publicdebt.treas.gov/sav/savcalc.htm
- Current copy of the Table of Redemption Values for US Savings Bonds
- **Bank Verification** As a last alternative, obtain the value by telephone from a local bank and record it. The bank will need the series, denomination, date of purchase and/or date.

b. Series E, EE, and I electronic bonds

- Ask individual to obtain his "Current Holdings" list from the Treasury web site at: http://www.savingsbonds.gov/
- Use Current Holding Summary to verify number of bonds, face value, issue dates, confirmation numbers and value.

c. Series H and HH Bond After Maturity

After maturity, the redemption value of a series H or HH bond is its face value. Verification of value per a. or b. above is unnecessary.

4. Photocopy

Document the file with a photocopy or certification of the bond(s). See **S1140.010 C**. on photocopying U.S. Government obligations.

5. Follow-up, if Appropriate

If an individual owns a U.S. Savings Bond which, upon maturity, may cause countable resources to exceed the limit, recontact the recipient shortly before the bond matures in order to redevelop the value of countable resources.

S1140.250 MUNICIPAL, CORPORATE, AND GOVERNMENT BONDS

A. Introduction

1. Bond

A bond is a written obligation to pay a sum of money at a specified future date. Bonds are negotiable and transferable.

2. Municipal Bond

A municipal bond is the obligation of a State or a locality (county, city, town, villages or special purpose authority such as a school district).

3. Corporate Bond

A corporate bond is the obligation of a private corporation.

4. Government Bond

A government bond, as distinct from a U.S. Savings Bond (see S1140.240), is a **transferable** obligation issued or backed by the Federal Government.

B. Operating Policy

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

C. Documentation

Documentation instructions for stocks (S1140.220) also apply to bonds.

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M1140.260 ANNUITIES

A. Introduction

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

B. Operating Policy

1. Revocable Annuity

An annuity that names revocable beneficiaries is considered to be an available resource because it can be surrendered, cashed in, assigned, transferred or have the beneficiary changed. Annuities are presumed to be revocable when the annuity contract does not state that it is irrevocable. The countable value of the revocable annuity is the amount of the funds in the annuity minus any fees required for surrender.

2. Annuities Purchased with Assets of a Third Party

Annuities purchased with the assets of a third party such as those received through a legal settlement are not considered to be countable resources.

3. Annuity Purchased Prior to February 8, 2006

An annuity purchased prior to February 8, 2006, is considered a countable resource if the annuity can be surrendered. The countable value of the annuity is the amount of the funds in the annuity minus any fees required for surrender.

4. *Irrevocable* Annuity Purchased on or after February 8, 2006

A non-employment related annuity purchased by or for an individual *using that individual's assets* on or after February 8, 2006, *is no*t considered an available resource *if it is irrevocable.*

Prior to receiving long-term *services and supports (LTSS)* paid by Medicaid, all annuities purchased by the institutionalized individual or the community spouse on or after February 8, 2006, must name the Commonwealth of Virginia as the primary beneficiary for at least the total amount of medical assistance paid on behalf of the institutionalized individual. If there is a community spouse or minor or disabled child, the Commonwealth must be named as the remainder beneficiary behind the spouse or minor or disabled child.

For individuals applying for *LTSS*, annuities owned by either the applicant or the applicant's spouse must also be evaluated using the policy in M1450.200 to determine whether an uncompensated asset transfer has occurred.

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S1140.300 PROMISSORY NOTES, LOANS, AND PROPERTY AGREEMENTS

A. Introduction

1. General

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

For cash loans, see S1120.220.

2. Promissory Note

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

3. Loan

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

4. Property Agreement

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

B. Operating Policy

1. Real Estate Contracts Prior to Settlement

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

2. Value as a Resource Assumption

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

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C. Development and Documentation – Written Agreement

1. Copy of Agreement

Obtain a copy of the agreement for the file. Cease development if including the original balance in countable resources does not cause ineligibility.

2. Principal Balance

If including the original balance in countable resources causes ineligibility and payments have been made, obtain evidence of the outstanding principal balance.

Cease development if including the outstanding principal balance in countable resources does not cause ineligibility.

3. Rebuttal Rights

If including the outstanding principal balance in countable resources causes ineligibility, **inform the individual** that we will use the outstanding principal balance in determining resources unless he or she submits:

- evidence of a legal bar to the sale of the agreement ; or
- an estimate from a knowledgeable source, showing that the CMV of the agreement is less than its outstanding principal balance.

4. Knowledgeable Sources

Knowledgeable sources include anyone regularly engaged in the business of making such evaluations: e.g., banks or other financial institutions, private investors or real estate brokers. The estimate must show the name, title, and address of the source.

D. Related Policy

1. Loans and the Borrower

See S1120.220 on how to determine whether the proceeds of a loan are income or a resource to the borrower.

2. Home Replacement Funds Exclusion

See S1130.110 when a contract is from the sale of an excluded home.

3. Individuals Requesting Long-term Care

For individuals requesting Medicaid payment for long-term care who have purchased promissory notes, loans, or mortgages on or after February 8, 2006, see M1450.540.

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M1140.305 CONTINUING-CARE RETIREMENT COMMUNITY ENTRANCE FEES

A. Introduction

Continuing-care or life-care retirement communities generally provide guaranteed care for the life of the individual in return for a set entrance fee as well as monthly maintenance fees. If the applicant has entered into a continuing-care contract or agreement with a retirement community, the entrance fee paid by the individual to the retirement community must be evaluated.

B. Operating Policy

An individual's entrance fee paid to a continuing-care retirement or life-care retirement community that collects an entrance fee upon admission shall be considered an available resource if:

- *the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;*
- *the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing-care or life-care contract and leaves the retirement community; and*
- *the entrance fee does not confer an ownership interest in the continuing-care retirement community or life-care community.*

C. Development and Documentation

1. Copy of Contract/ Agreement

Obtain a copy of the contract or agreement. If one or more of the conditions in B. above is not met in the terms of the contract, do not develop the contract further as a resource..

2. Countable Value of Entrance Fee

If all of the conditions in B. above are met in the terms of the contract or agreement, determine the countable value of the entrance fee. Contact the retirement community to determine:

- *the amount of the entrance fee actually paid if the contract or agreement stipulates installment payments, and*
- *whether any amount has been refunded to the applicant.*

Subtract any amount that the retirement community has refunded from the amount paid. Document the resulting balance in the case record as a countable resource.

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M1140.310 LIFE INSURANCE

A. Introduction

This section provides broad policy principles concerning the treatment of life insurance policies for Medicaid purposes. Detailed instructions on the development and, where applicable, the exclusion of life insurance are contained in M1130.300.

B. Policy Principles

1. Countability Based on Total Face Value

If the combined face values of all the life insurance policies an individual, owns on a given insured age 21 or older, exceed $1,500, the cash surrender value of any such policy is a resource to the individual.

2. Policies Whose Face Values Are Not Taken into Account

For purposes of determining whether the combined face values of all the life insurance policies an individual owns on a given insured age 21 or older, exceed $1,500, the face values of the following are not taken into account:

- term insurance that does not have a cash surrender value; and
- burial insurance; i.e., insurance whose terms preclude the use of policy proceeds (proceeds include any cash surrender value) for any purpose other than payment of the insured's burial expenses.

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TRUSTS

M1140.400 TRUSTS ESTABLISHED BY A WILL

A. Policy

If a Medicaid applicant or recipient is the named beneficiary in a trust established by a will, determine from the terms of the trusts, what income or principal is available to the applicant or recipient. If the trust is "discretionary" determine what part of the corpus or income the trustee is making available to the applicant or recipient. Any corpus or income which the trustee does not make available cannot be counted in determining Medicaid eligibility.

M1140.401 TRUSTS WHICH WERE NOT CREATED BY A WILL

A. Policy

This section deals with the countable value of trusts or similar legal devices which were not established by a will. The trust may be revocable or irrevocable. The date the trust was established will affect how the trust is evaluated for Medicaid eligibility.

For detailed instructions on Trust Property, see:

- M1120.200, Trust Property
- M1120.201, Trust Established on or After August 11, 1993
- M1120.202, Trust Established for Disabled Individual on or After August 11, 1993
- M1130.520, Trust Established Between July 1, 1993 and August 10, 1993
- M1140.402, Medicaid Qualifying Trust (Created Prior to August 11, 1993)
- M1140.403, Trust(s) Created After July 1, 1993 and Before August 11, 1993 With Corpus in Excess of $25,000

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M1140.402 MEDICAID QUALIFYING TRUSTS (CREATED PRIOR TO AUGUST 11, 1993)

A. Introduction

A "Medicaid qualifying trust" is a trust, or similar legal device, established (other than by a will) by an individual or an individual's spouse prior to August 11, 1993. Under this trust the individual may be beneficiary to *all/or* part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.

EXCEPTION: A trust or initial trust decree established **prior** to April 7, 1986, solely for the benefit of an *intellectually disabled* individual who resides in an intermediate care facility for the *intellectually disabled* is not "Medicaid Qualifying Trust."

B. Trust Restrictions Not Recognized

The requirements of this section shall apply without regard to:

- whether or not the Medicaid qualifying trust is irrevocable or
- is established for purposes other than to enable a grantor to qualify for Medicaid; or
- whether or not the trustee(s) exercises his discretion to distribute any payments to the individual.

C. Development

1. Countable Value

The **maximum** amount of payments permitted under the terms of a "Medicaid Qualifying Trust" to be distributed to the grantor, **if** the trustee exercised his discretion to the **fullest** extent possible, shall be considered available in determining the grantor's eligibility for Medicaid.

D. Exception

A trust or initial trust decree established prior to April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded is not a "Medicaid Qualifying Trust."

E. References

M1120.200, Trust Property
M1120.201, Trusts Established on or after August 11, 1993.

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M1140.403 TRUST(S) CREATED AFTER JULY 1, 1993 AND BEFORE AUGUST 11, 1993 WITH CORPUS IN EXCESS OF $25,000

A. Policy

Single or multiple trusts created after July 1, 1993 and before August 11, 1993, with corpus or corpora in excess of $25,000, will have the excess over $25,000 evaluated for countable resources for Medicaid eligibility.

B. Trust Restrictions Not Recognized

The following will not affect the evaluation of the countable value, regardless of whether or not the trust:

- is irrevocable; or
- established for purposes other than to make the individual eligible for Medicaid; or
- the trustee exercises his discretion to distribute trust payments to the applicant/recipient.

C. Development/ Documentation

1. Countable Value

a. Verify the current value of the corpus or corpora of the trust(s).

b. Prorate $25,000 by the number of trusts.

c. Subtract the amount in b. above from the corpus or corpora of the trust(s).

d. The remainder of the corpus or corpora of the trust(s)

- that may be paid under the terms of the trust,
- without any limits imposed by any void restrictive clauses within the trust

is counted as an available resource.

e. The maximum amount of income payable from the trust according to its terms is considered available income whether or not it is actually paid to the applicant/recipient.

D. References

Trusts Established Between July 1, 1993 and August 11, 1993, M1130.520

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M1140.404 TRUSTS ESTABLISHED ON OR AFTER AUGUST 11, 1993

A. Introduction

The enactment of OBRA 93 affects the treatment of trusts. For purposes of determining the countable value of a trust for an individual's eligibility for Medicaid, the rules specified in this section shall apply to a trust established by such individual on or after August 11, 1993.

For the purposes of determining an individual's eligibility for Medicaid, the rules specified below shall apply to a trust established by such individual.

EXCEPTION: Certain trusts established for disabled individuals
See M1120.202.

B. Policy

1. Who Establishes Trust

a. Individual Establishes Trust

An individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:

- the individual,
- the individual's spouse,
- a person, including a court or administrative body (i.e., Power of Attorney, etc.), acting at the direction or upon the request of the individual or the individual's spouse.

b. Funeral Director Establishes Trust

A funeral home director who operates his business in Virginia can legally establish an irrevocable trust for an individual for the purpose of paying for funeral and burial expenses. Under a "two-step" process, funds transferred from the individual to the funeral home are deemed a compensated transfer for value when the amount of the funds transferred does not exceed the value of the goods and services purchased. The entire amount of the trust is exempt when placed in an irrevocable trust by the funeral director.

The "two step" process occurs when:

1) the individual signs a preneed contract with a funeral home director promising prepayment in return for specific funeral merchandise and services and pays the agreed upon amount in the form of a direct cash payment or purchase of a life insurance policy or annuity to the

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funeral director;

2) then, the funeral home director in turn places the money, life insurance policy or annuity into a trust, established by a person other than the individual.

2. Treatment of Assets in Trust

In the case of a trust, the corpus of which includes assets of an individual and assets of any other person or persons, the provisions of this section shall apply to the portion of the trust attributable to the assets of the individual.

This section shall apply without regard to:

- the purpose for which a trust is established,
- **whether the trustee has or exercises any discretion under the trust,**
- any restrictions on when or whether distributions may be made from the trust, or
- any restriction on the use of distributions from the trust.

3. Revocable Trust

In the case of a revocable trust:

a. the corpus of the trust shall be considered resources available to the individual.

b. Payments from the trust to or for the benefit of the individual shall be considered income of the individual.

c. Any other payments from the trust shall be considered assets disposed of by the individual.

4. Irrevocable Trust

a. Payment Can Be Made To Individual

When there are any circumstances under which payment from the trust corpus or income could be made to or for the benefit of the individual, the following rules apply:

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- payments from the trust corpus or income which are made to or for the benefit of the individual shall be considered **income** to the individual;

- income from the trust corpus that could be paid to the individual is considered a **resource** to the individual;

- the portion of the trust corpus that could be paid to the individual is considered a **resource** to the individual;

- a payment from the trust that is NOT made to or for the benefit of the individual shall be considered a transfer of assets by the individual.

NOTE: An irrevocable trust for burial is a trust from which payment will be made for the benefit of the individual.

b. Payment CANNOT Be Made To Individual

1) When all or any portion of the corpus of the trust cannot be paid under any circumstances to the individual, all (or any such portion) of the trust corpus shall be considered a transfer of assets. The effective date of the transfer of assets is the date the trust was established.

2) Any income earned by the corpus of the trust, from which no payment could be made (under any circumstances) to the individual, shall be considered a transfer of income.

c. Under the provisions of Section 55-19.5 of the Code of Virginia, clauses in a trust which foreclose or prohibit payments to an individual if he requires nursing home or medical care, or if he applies for Medicaid, are void. However, if a trust has been written in another state in which such clauses are legally enforceable, the date payment is foreclosed by such a clause is a transfer of assets that occurs on the date the payment is foreclosed.

d. In determining the value of the trust assets transferred, include all payments made from the trust after the date the trust was established or, if later, the date payment to the individual was foreclosed.

If the individual adds funds to the trust after these dates, the addition of those funds is considered to be a new transfer and effective on the date the funds are added.

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M1140.500 WORKERS' COMPENSATION MEDICARE SET-ASIDE ARRANGEMENT ACCOUNTS

A. Introduction

A Workers' Compensation Medicare Set-aside Arrangement (WCMSA) is an arrangement which allocates a portion of a Workers' Compensation settlement for future medical expenses. The initial amounts of any set asides are determined on a case-by-case basis and are reviewed by the Centers for Medicare and Medicaid Services (CMS). Most WCMSAs will be placed in interest bearing accounts and are self-administered by applicants/enrollees, or by a competent administrator.

Funds authorized by a WCMSA are unearned income in the month of receipt, and any amount retained following the month of receipt is a countable resource. Section S0830.235 contains information on Workers' Compensation payments.

B. Operating Policy

1. Ownership

Assume that the person designated as owner in the account title owns all the funds in the account.

2. Right to Withdraw Funds

Absent evidence to the contrary, assume that the person shown as owner in the account title has the legal right to withdraw funds from the account.

3. Fiduciaries

A fiduciary's right to withdraw funds is the same as the owner's right to withdraw them.

4. Right to Use for Support and Maintenance

Although funds are intended for specific medical expenses, there are no legal restrictions as to how an individual uses the funds. Assume that an individual who owns and has the legal right to withdraw funds from a WCMSA also has the legal right to use them for his own support and maintenance.

C. Development and Documentation

The development and documentation instructions for checking and savings accounts contained in section S1140.200 apply to WCMSA accounts.

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S1140.990 RESOURCES GUIDE -- OPTIONAL DESK AID

A. Introduction This section provides:

- general information about various investment vehicles encountered; and
- serves as a guide to appropriate instructions which follow this table.

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Term	See	Cross Reference
Balanced Fund	E.4.	See Mutual Fund below.
Bond	C.	Interest, Capital Gains, Security Trades
CATS (Certificate of Accrual on Treasury Securities)	D.3.	See U. S. Government Security below.
CD (Certificate of Deposit)	B.4.	Disqualified Interest, Forfeit Interest, Interest
Checking Account	B.	Interest
Common Stock	F.1.	Dividends, Co-op Dividends, In-kind Dividends, Capital Gains
Convertible Bond	C.1.c.	See Corporate Bond below.
Corporate Bond	C.1.	Interest, Capital gains, Security Trades
Federal Agency Security	D.4.	See U.S. Government Security below.
FREDDIE MAC	D.4.	See U.S. Government Security below.
GINNIE MAE	D.4.	See U.S. Government Security below.
Growth Fund	E.2.	See Mutual Fund below.
Income Fund	E.3.	See Mutual Fund below.
IRA (Individual Retirement Account)	H.	Varies with type of investment
Junk Bond	C.1.d.	See Corporate Bond above.
Keogh Account	H.	See Indiv. Retirement Account below.
MMDA (Money Market Deposit Account)	B.3.	Interest
Money Market Fund	E.6.	See Mutual Fund below.
Municipal Bond	C.2.	Interest, Capital Gains, Security Trades

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Term	See	Cross Reference
Municipal Bond Fund	E.5.	See Mutual Fund below.
Mutual Fund	E.	Disqualified Interest, Dividends, In-Kind Dividends, Interest
NOW Account	B.2.	Interest
Option	G.	Security Trades, Capital Gains
Passbook Account	B.1.	See Savings Account below.
Preferred Stock	F.2.	Dividends, In-kind Dividends
Savings Account	B.1.	Interest
Savings Bond	D.5.	See U.S. Savings Bond below.
Savings Certificate	B.4.	See Certificate of Deposit above.
Stock	F.	See Common and Preferred Stock above.
Super NOW Account	B.2.	See NOW Account above.
Tax-exempt Bond	C.2.	See Municipal Bond above.
Term Account	B.4.	See Certificate of Deposit above.
TIGER (Treasury Investment Growth Receipts)	D.3.	See U.S. Government Security below.
Time Account	B.4.	See Certificate of Deposit above.
Treasury Bill (T-Bill)	D.1.	See U.S. Government Security below.
Treasury Bond	D.2.	See U.S. Government Security below.
Treasury Note	D.2.	See U.S. Government Security below.
UIT (Unit Investment Trust)	C.3.	Interest, Security Trades
U.S. Government Security	D.	Interest, Security Trades, Capital Gains
U.S. Savings Bond	D.5.	Interest
Zero Coupon Bond	C.4.	Interest, Capital Gains, Security Trades

B. Description of Checking and Savings Accounts

1. Savings Accounts

Savings accounts pay interest unless the financial institution has a minimum balance requirement and the account does not meet this requirement. Account owners can make deposits and withdrawals at any time in any amount. Develop per S1140.200 - .205.

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2. Now and Super Now Accounts

NOW (Negotiable Order of Withdrawal) accounts are interest-bearing checking accounts. Super NOW accounts are money market checking accounts. They have higher interest rates than NOW accounts. Develop per S1140.200 -.205.

3. MMDA (Money Market Deposit Accounts)

MMDA's allow banks to compete with mutual fund money markets. They are interest-bearing checking accounts. Develop per S1140.200 -.205.

4. CD (Certifi-cate of Deposit)

A CD is a bank deposit that cannot be withdrawn for a certain period of time or that can be withdrawn early only with a penalty. Develop per S1140.210.

C. Description of Bonds

1. Corporate Bonds

Develop corporate bonds in accordance with the instructions in S1140.250.

a. General Type
Corporations sell corporate bonds to raise capital. There are two types:

- **debentures**, which are backed by the issuer's full faith and credit and
- **mortgage backed bonds**, which are backed by a lien on the company's assets.

b. Two Forms of Each Type
Corporate bonds are issued in two forms:

- **registered,** which pay interest to their registered owner; and
- **bearer** or **coupon** bonds, which pay it to whomever holds the bond.

c. Convertible Bonds
Convertible bonds are debentures that can be exchanged for a specified number of shares of a company's common stock.

d. Junk Bonds
High risk bonds are called junk bonds.

e. Interest
Corporate bonds usually pay a fixed rate of interest for a fixed period of time--annually, semi-annually, or quarterly.

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2. Municipal or Tax Exempt Bonds

Municipal bonds are to city, county and State governments and authorities what corporate bonds are to corporations. They are exempt from Federal taxes and often are exempt from State and local taxes as well. Most municipal bonds are one of two general types:

- general obligation bonds, which are backed by the full faith and credit of the issuing municipality and supported by the taxing power; and
- revenue bonds, which are backed by the project being financed and the revenue or user fees it generates.

Other types of municipals are: limited-tax bonds, anticipation notes, industrial development bonds, and life-care bonds.

Develop municipal bonds in accordance with the instructions in S1140.250.

3. UIT (Unit Investment Trust)

A UIT is a package of bonds in a portfolio. One can buy share of the package for $1 to $1,000 per share with a minimum investment of $750 to $5,000, depending on the trust. The interest rate usually is fixed at purchase and does not change. Units usually are sold or redeemed through the trust sponsor.

4. Zero Coupon Bonds

Zero coupon bonds usually are issued by corporations. They do not pay current interest; accrued interest is paid at maturity. The U.S. Government does not issue zero coupon bonds directly. However, see TIGER and CATS.

5. Buying and Selling Bonds

Bonds usually are bought and sold through brokers, securities dealers, or other investors. They may sell for more or less than their face value or purchase price, depending on a variety of factors.

6. Reading Bond Quotations

The following is a typical bond quotation, showing from left to right:

- the name and the issuer (AT&T);
- the bond's nominal or coupon rate (3 7/8 percent);
- the last two digits of the year in which the bond matures (1990);
- the current yield (5.6 percent);
- the number of bonds traded during the year (54,000);
- the highest, lowest, and last price of the bond for the period covered by the quotation (bond prices are quoted on a par of 100, so the last price of 69 1/4 equals $692.50).
- the net change in the bond price.

	CURRENT	SALES				
ISSUE	YIELD	1000's	HIGH	LOW	CLOSE	CHANGE
AT&T 3 7/8	5.6	54	69 3/4	69 1/4	69 1/4	-3/8

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D. Description of U.S. Government Securities

1. Treasury Bills (T-Bills)

T-Bills are short-term obligations that require a minimum investment of $10,000. Certificates are not issued for T-Bills; they are registered in book form at the Treasury Department and receipts are provided as proof of purchase. T-Bills can be sold before maturity. Develop in accordance with S1140.250.

2. Treasury Notes and Bonds

Treasury notes and bonds are similar to T-Bills but have longer maturities and a lower minimum investment requirement. They have been registered in book entry form since July 1986 but were sometimes issued as bearer bonds before then. Develop per S1140.250.

3. Tiger and Cats

These are Government securities issued with a zero coupon concept. The broker removes the interest coupons from the security and sells it at a big discount with a long maturity. Accrued interest is then paid at maturity. These bonds can be sold before maturity. Develop in accordance with S1140.250.

4. Federal Agency Securities

Some of the Federal agencies with charters to issue securities are:

- the Federal Home Loan Bank Board;
- the Federal Home Loan Mortgage Corporation (FREDDIE MAC);
- the Export-Import Bank; and
- the Government National Mortgage Association (GINNIE MAE).

Minimum investment requirements range from $1,000 to $25,000. Develop per S1140.250.

5. U.S. Savings Bonds

U.S. Savings Bonds are registered, nontransferable Treasury securities Develop per S1140.240.

E. Description of Mutual Funds

1. General

"Mutual fund" is a term that encompasses a wide range of investments. Basically, it is a pool of assets (stocks, bonds, etc.) managed by an investment company. A mutual fund share represents ownership interest in this pool as opposed to a particular stock or bond. Develop mutual funds per S1140.230.

2. Growth Funds

The primary objective of these funds, also known as performance funds and hedge funds, is aggressive long term growth of investment rather than current income. Dividends typically are low.

3. Income Funds

The objective is current income through high dividends and interest, as opposed to capital gains.

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4. Balanced Funds

The objective is a balance of growth and income.

5. Municipal Bond (Tax Exempt Fund)

The fund invests in tax-exempt bonds and the interest is passed along to holders on a tax-exempt basis.

6. Money Market Funds

The fund invests in conservative vehicles such as T-Bills and bank certificates. The minimum investment usually is $1,000, but may be less. Income may fluctuate daily based on interest rates. Money market funds often have a check-writing feature.

7. Buying and Selling Mutual Funds

"Load" funds are sold through a broker who collects a commission. "Noload" funds usually are purchased directly from the fund (no commission) and often are advertised in newspapers and magazines.

8. Reading Mutual Fund Quotations

The format of the following table is typical of those shown in newspapers and financial publications, showing from left to right:

- the names of the funds available for each management group (in this case, four funds managed by the Fund Founders Group);
- the high and low values for the preceding 52-week period;
- the most recent closing price;
- the change over the previous week; and
- the fund's income and capital gains totals for the previous 12 months.

Fund Founders Group	52 Weeks H	L	Close	Week's Change	Income*	Capital Gains
Growth n.	8.77	6.28	6.37	-0.08	0.157	2.505
Income n.	15.18	13.72	13.87	+ 0.01	1.273	0.232
Mutual	11.56	9.74	9.98	- 0.07	0.426	0.706
Special n.	37.11	22.88	23.54	- 0.13	1.900	1.395

n = no-load
*= last 12 months

F. Description of Stocks

1. Common Stocks

Common stock usually is held in the form of a certificate registered in the owner's name. Dividends usually are paid quarterly and may vary with company earnings.

- "Listed" stocks are those listed on the NYSE, AMEX, or on one of the regional exchanges such as Boston, Philadelphia, or Chicago.
- Over-the-counter (OTC) stocks, which include "penny" stocks, are not listed on the major exchanges. They usually are reported in the National Association of Security Dealers Automated Quotations (NASDAQ) system.

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2. Preferred Stock

Preferred stock receives preference with respect to dividends and, in case of bankruptcy, the distribution of assets. Preferred stock dividends:

- are paid at a fixed rate;
- must be paid before common stock dividends can be paid; and
- must be made up later, when not paid timely, whereas common stock dividends may be skipped.

3. Reading Stock Quotations

Stock tables vary little from publication to publication. The following quote is typical, showing from left to right:

- the standard abbreviations of the name of the company (Philadelphia Electric in this case), followed by "pf" for preferred stock on the second line;
- the dividend amount;
- the price-to-earnings ratio;
- sales volume, in thousands;
- the day's high, low, and closing prices (22 3/4 = $22.75); and
- the change in price from the previous day.

NAME	DIV	PE	SALES	HIGH	LOW	LAST	CHG
Phi El	2.20	9	4323	22 7/8	22 5/8	22 3/4	- 1/8
Phil E pf	4.30	-	50	42 3/4	42 3/4	42 3/4	-

G. Description of Options

1. General

An option is the right to sell or buy something at a specified price by a specified date. The "something" is usually stock, but there are options on interest rates, stock market indexes, commodity futures, and other items as well. An option to sell is called a "put." An option to buy is a "call." The value of an option depends on:

- the length of the contract (3, 6, or 9 months);
- the difference between the CMV of the item and the price at which the put permits it to be sold or the call permits it to be bought; and
- the volatility of the item (how much its CMV is expected to fluctuate).

2. Buying and Selling Options

Options can be sold through a broker. If the CMV of an item goes up in relation to a call price, the value of the option increases. If it goes down, the value of the option decreases. The reverse is true for a put.

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3. Reading Option Quotations

There are several exchanges across the country that list option prices for about 300 stocks: the Chicago Board of options Exchanges (CBOE), AMEX, the Philadelphia Stock Exchange, and the Pacific Stock Exchange. Transactions on these exchanges are listed in financial publications and many newspapers.

Although a stock option contract controls 100 shares of stock, options are quoted on the price per share. If a contract sells for $300, the cost per share is $3. Options come due and are quoted for each January, April, July and October.

The following example is a typical options quotation and shows, from left to right:

- the name of the stock (Tandy), the expiration month (April) and per-share price of the option ($30 for put option on line 2);
- the number of contracts sold (996 on line 2);
- the high, low, and closing prices for a contract ($56.25, $25, and $37.50, respectively, on line 2); and
- the net change in the value of the contract ($6.25).

Name, Expiration Date, and Price	Sales	High	Week's Low	Last	Net Change
Tandy Apr.30	1317	4 3/4	2 3/4	3 1/8	- 1/8
Apr. 30p	996	9/16	1/4	3/8	-1/16

H. Description of IRA (Individual Retirement Account) and Keogh Account

The terms IRA and Keogh account refer to retirement plans. They do not identify the underlying investment vehicle, which can be a bank account, CD, mutual fund, etc. Develop IRA's and Keogh accounts in accordance with the section(s) that deal with the underlying investment vehicle.

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Update (UP) #9	4/1//13	Appendix 1, page 6 Appendix 2, page 5

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QDWI *(*QUALIFIED DISABLED AND WORKING INDIVIDUALS*)*

A. Introduction

This appendix contains the policy regarding resources that are treated differently for the QDWI covered group. The resource policy for QDWI individuals is identical to SSI resource policy. The policy in this appendix applies to QDWI evaluations only.

B. QDWI Resource Evaluation

Resource treatment and evaluations used in QDWI evaluations are listed in:

- S1110 Resources, General;
- S1120 Identifying Resources;
- S1130 Resource Exclusions; and
- S1140 Countable Resources.

C. Resources Treated Differently

The following types of resources are treated differently for QDWI individuals. The differences are:

- automobiles*
- burial fund exclusions - maximum amount of $1,500
- burial plots - only one space per individual and immediate family members
- home property*
- household goods and personal effects*
- inheritances and unprobated estates*
- life estates*
- real property whose sale would cause undue hardship, due to loss of housing, to a co-owner*
- real property following reasonable but unsuccessful efforts to sell

The policy for counting resource*s* marked with *an asterisk is contained* in this appendix.

D. References

Information on how to treat other types of resources of a QDWI individual is found within each of the following sections:

M1130.400 Burial Spaces
S1130.410 Burial Fund Exclusions
M1140.110 Countable Life Estate Interest

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DETERMINING *QDWI* ELIGIBILITY BASED ON RESOURCES

S1110.600 FIRST-OF-THE-MONTH (FOM) RULE FOR MAKING DETERMINATIONS

A. Policy Principle -- the FOM Rule

We make all resources determinations as of the first moment of a calendar month.

B. Policy Principle -- Significance of the FOM Rule

1. Increase in Value of Resources

We consider any increase in the value of an individual's resources in the resources determination as of the first moment of the month following the month in which:

- the value of an existing resource increases (e.g., the value of a share of stock goes up or installment payments increase a property's equity value);
- an individual acquires an additional resource (e.g., inherits property); or
- an individual replaces an excluded resource with one that is not excluded (e.g., sells an excluded automobile for nonexcluded cash).

2. Decrease in Value of Resources

We consider any decrease in the value of an individual's resources in the resources determination as of the first moment of the month following the month in which:

- the value of an existing resource decreases (e.g., the value of a share of stock goes down);
- an individual spends a resource (e.g., withdraws $150 from a savings account to pay bills); or
- an individual replaces a countable resource with one that is not countable (e.g., trades a countable piece of real property for an excluded automobile).

3. Treatment of Assets Under Income and Resources Counting Rules

When an individual receives something in cash or in kind during a month, we evaluate it under the appropriate income-counting rules in that month. If the individual retains the item into the month following that of receipt, we evaluate it under the resource-counting rules. Thus, we do not evaluate the same asset under two sets of counting rules for the same month.

4. Receipts from the Sale, Exchange, or Replacement of a Resource

If an individual sells, exchanges, or replaces a resource, what he/she receives in return is not income. It is a different form of resource. This includes assets which have never been subject to resources counting because the owner sold, exchanged, or replaced them in the same month in which he/she received them.

The concept of such transactions not producing income does not apply to receipts from the sale of timber, minerals, or other like items which are part



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of the land.

C. Example--Receipt of a Resource Considered as Income and Exchanged in Same Month

Miss Laramie, a disabled individual, received a $350 unemployment insurance benefit on January 10 at which time it was unearned income. On January 18, she used the $350 to purchase several shares of stock; i.e., she exchanged one resource (cash) for another resource (stock). We never counted the $350 cash payment as a resource because Miss Laramie exchanged it for stock in the month of receipt. The stock is not income; it is a different form of resource. Since a resource is not countable until the first moment of the month following the receipt, we first count the stock in the resources determination made as of February 1.

S1120.215 INHERITANCES AND UNPROBATED ESTATES

A. Introduction

An ownership interest in an unprobated estate may be a resource if an individual:

- *is an heir or relative of the deceased; or*
- *receives any income from the property; or*
- *under State intestacy laws, has acquired rights in the property due to the death of the deceased.*

B. Operating Policy

1. When to Develop

We develop for this type of resource only if:

- *the property in question is not excludable under any of the provisions in S1110.210 B.; and*
- *counting the property's value would result in excess resources.*

2. Ownership Interest

There is an ownership interest in an unprobated estate if:

- *documents (e.g., a will or court records) indicate an individual is an heir to property of a deceased; or*
- *an individual has use of a deceased's property or receives income from it; or*
- *documents establish, or the individual alleges, a relationship between himself and the deceased which, under State intestacy laws, awards the individual a share in the distribution of the deceased's property; and*
- *the inheritance, use of income, and distribution are uncontested.*

3. When Unprobated Estate Can Be a Resource

We do not consider that an inheritance is a resource until the month following the month in which it meets the definition of income. See S0830.550 for the income rules on inheritances. Thereafter, if retained, we evaluate the property as a resource.

C. Development and Documentation

1. Ownership Interest

Document the file, as applicable, with a copy of:

- *an inheritance or relationship document (or a signed statement alleging a relationship);*
- *evidence of income from the property;*
- *individual's signed statement concerning his/her use of the property and whether there is contest of any factor; or*
- *other evidence showing that the situation meets the criteria in B.*

2. Sole vs. Shared *Follow S1110.510 and S1140.030 to determine and document whether there are other owners and, if so, whether the individual needs their consent to sell his/her share of the property.*

3. Status as a Resource

- *If the individual is the sole owner or if other owners give needed consent to sell, the property is the individual's resource. Some States do not require the consent of other heirs in order for a co-owner to sell property.*

- *If other owners withhold consent and that consent is necessary to sell, the property is not a resource until the estate has been through probate. It is subject to the resource counting rules the month following the month it meets the definition of income.*

4. Value of Resource

a. *CMV - Develop the property's CMV (and EV, if appropriate) following guidelines in S1140 for the particular type of property involved.*

b. *Shared Ownership*

- *For real property, and most personal property, see S1140.030 B.*
- *For checking/savings accounts and time deposits, see S1140.205 and S1140.210.*

REAL PROPERTY

S1130.100 THE HOME

A. Policy Principles

1. Exclusion of the Home *An individual's home, regardless of value, is an excluded resource.*

2. Definition of the Home *An individual's home is property in which he or she has an ownership interest and that serves as his or her principal place of residence. It can include:*

- *the shelter in which he or she lives;*
- *the land on which the shelter is located; and*
- *related buildings on such land.*

3. Principal Place of Residence *An individual's principal place of residence is the dwelling the individual considers his or her established or principal home and to which, if absent, he or she intends to return. It can be real or personal property, fixed or mobile, and located on land or water.*



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4. Individual Owns The Land

For purposes of excluding "the land on which the shelter is located" (A.2. above), it is not necessary that the individual own the shelter itself.

EXAMPLE: *If an individual lives on his or her own land in someone else's trailer, the land meets the definition of home and is excluded.*

5. Extent of Property To Which The Exclusion Applies

a. Land

The home exclusion applies not only to the plot of land on which the home is located, but to any land that adjoins it.

Land adjoins the home plot if not completely separated from it by land in which neither the individual nor his or her spouse has an ownership interest.

Easements and public rights of way (utility lines, roads, etc.) do not separate other land from the home plot.

b. Buildings

The home exclusion applies to all buildings on land excluded per a. above.

6. Property That No Longer Serves As The Principal Place of Residence

a. General Rule

Property ceases to be the principal place of residence - and, therefore, to be excludable as the home - as of the date that the individual, having left it, does not intend to return to it.

Such property, if not excluded under another provision, will be included in determining countable resources as of the first moment of the first day of the following month.

b. Exceptions to General Rule

Even if the individual leaves the home without the intent to return, the property remains an excluded resource for as long as:

- *a spouse or dependent relative of the individual continues to live there while the individual is institutionalized; or*
- *its sale would cause undue hardship, due to loss of housing, to a co-owner of the property.*

7. Dependent Relative Defined

a. ***Dependency*** *may be of any kind (financial, medical, etc.).*

b. ***Relative*** *means:*

- *child, stepchild, or grandchild;*
- *parent, stepparent, or grandparent;*
- *aunt, uncle, niece, or nephew;*
- *brother or sister, stepbrother or stepsister, half brother or half sister;*
- *cousin; or*
- *in-law.*

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B. Development and Documentation - Initial Claims

1. Ownership

a. Use of Allegation
Accept an individual's allegation of home ownership unless the file raises a question about it (e.g., a life estate is involved, the individual is under age 18, does not live with a parent, and does not live with someone else). If there is a question, have the individual submit one of the items of evidence listed in b. - d., below.

b. Evidence of Real Property Ownership

- tax assessment notice;
- recent tax bill;
- current mortgage statement;
- deed;
- report of title search;
- evidence of heirship in an unprobated estate (e.g., receipt of income from the property, a will, or evidence of relationship recognizable under State intestate laws in cases where the home is unprobated property).

c. Evidence of Personal Property Ownership (e.q., a Mobile Home)

- **title;**
- **current registration.**

d. **Evidence of Life Estate or Similar Property Rights**

- deed;
- will;
- other legal document**.**

e. Equitable Ownership

Virginia does not recognize equitable ownership of real property.

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2. Principal Place of Residence -- Operating Assumption

*Absent ownership in more than one residence or evidence that raises a question about the matter, **assume** that the alleged home is the individual's principal place of residence.*

3. Indication of More than One Residence

*If an individual alleges or other evidence indicates ownership of more than one residence, **obtain** his or her signed statement concerning such points as:*

- *how much time is spent at each residence;*
- *where he or she is registered to vote;*
- *which address he or she uses as a mailing address or for tax purposes.*

***Determine** the principal place of residence accordingly and document the determination in file.*

4. Evidence Indicates Nonadjoining Property

a. Individual Agrees With Evidence

If evidence indicates that land the individual owns does not adjoin the home plot, and the individual agrees that it does not:

- ***obtain** his or her statement to that effect; and*
- ***develop** the nonadjoining portion per S1140.100 (Nonhome Real Property) or S1130.500 (Property Essential to Self-Support), as applicable.*

b. Individual Disagrees With Evidence

If the individual maintains that all the land adjoins the home plot, document the file with:

- *a sketch of the land showing the boundaries of the various plots and the location of the shelter used as the home; and*
- *evidence of how the land is treated for tax assessment purposes.*

The sketch may be by the individual, from public records, or by the Eligibility Worker (from direct observation).

The tax assessment information may be in the form of a tax assessment notice or obtained from the appropriate tax jurisdiction and recorded in case record

c. Combined or Single Holding for Tax Assessment

Assume that the land is a single piece of property in which all the land adjoins the home plot if:

- *it is recorded and treated as a single holding for tax assessment purposes; or*
- *the original holding has been subdivided, but still is treated as a single holding for tax assessment purposes.*

d. More Than Single Holding for Tax Assessment

If the land is recorded and treated as two or more holdings for tax assessment purposes, use the sketch to determine whether other holdings adjoin the home plot.



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5. Absences From The Home

a. Summary of Development

If the individual is in an institution, determine whether a spouse or dependent relative is living in the home (see b. below).

If no spouse or dependent relative is living the home, or if the absence is for a reason other than institutionalization, determine:

- *whether the individual intends to return to the home (see c. below); and*
- *if not, whether the sale of the home would cause undue hardship, due to loss of housing, to a co-owner (see D.1. below).*

NOTE: *If a previously undeveloped absence from the home has ended, assume that the individual always intend to return. The absence, regardless of duration, will not affect the home exclusion.*

b. Spouse or Dependent Relative Development

Obtain a signed statement from the individual as to:

- *whether anyone is living in the home while the individual is in the institution;*
- *if so, how that person is related to the individual, if at all; and*
- *if related (except for the individual's spouse), how that person is dependent on the individual, if at all.*

Absent evidence to the contrary, accept the allegations.

c. "Intent to Return" Development

If the individual has left his or her home but intends to return to it, see D. below for the necessary development.

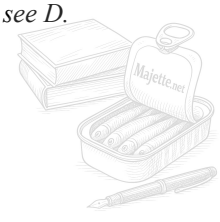
NOTE: *"Intent to return" development applies only to the* ***continued*** *exclusion of property which met the definition of the individual's* ***home*** *prior to the time the individual left the property. See A.2. above for the definition of "home."*

C. Procedure – Post-eligibility

If, after Medicaid eligibility is established, an individual receives real property - for example, as an inheritance or gift - which may be excludable as his/her home, apply the policy and procedures in A. and B. above to determine whether the home exclusion applies.

Redevelop the exclusion from resources of an individual's home only if something raises a question about the correctness of the original determination or indicates that the exclusion may no longer apply (e.g., a change of address).

If the individual has left his or her home but intends to return to it, see D. below.



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D. Procedure -- "Intent to Return Home" Development

1. Obtain Statement

Obtain a signed statement from the individual as to:

- *when and why he or she left the home;*
- *whether he or she intends to return; and*
- *if he or she does not intend to return, when that decision was made.*

NOTE: *If the individual has a representative payee, obtain the "intent" statement from the payee.*

This statement governs the "intent to return" determination unless the statement is self-contradictory (see 2. through 4. below).

2. Self-Contradictory Statement

Consider a statement to be self-contradictory if it contains conflicting or unclear expressions of intent.

Examples of self-contradictory statements:

"Sometimes I want to go home and sometimes I don't."

"I intend to go home but I also want to stay here."

"Yes, I want to go home, but I really don't know if I should."

3. Factors Not to Consider

Do not consider other factors, such as the individual's age, physical condition, or other circumstances when determining intent to return home. Assuming the individual is mentally competent, age, mental capacity, and physical condition are ***not*** *factors in evaluating the individual's statement of intent.*

Example: *The recipient is 93 years old and in the intensive care unit of a hospital. She tells the Eligibility Worker that her doctor believes she may not be able to leave the hospital and return home. However, she states that she intends to return to her former residence as soon as she is well enough to leave the hospital. Based on her statement, "intent to return home" is established.*

Example: *The recipient's home was partially destroyed by fire. He does not know when the necessary repairs will be completed. In the meantime, he is living with his sister. He states he intends to return to the former residence as soon as possible. Based on his statement, "intent to return home" is established.*

4. Obtaining More Information If Needed

If the individual's statement of intent is self-contradictory, contact someone who knows the situation, such as a physician, family member, or close friend or relative, to clarify the situation.



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S1130.130 REAL PROPERTY WHOSE SALE WOULD CAUSE UNDUE HARDSHIP, DUE TO LOSS OF HOUSING, TO A CO-OWNER

A. Policy Principles

1. Exclusion

*The value of an individual's ownership interest in jointly owned real property is an excluded resource **for as long as** sale of the property would cause undue hardship, due to loss of housing, to a co-owner.*

2. Undue Hardship

Undue hardship would result if such co-owner:

- *uses the property as his or her principal place of residence;*
- *would have to move if the property were sold; and*
- *has no other readily available housing.*

B. Development and Documentation-- Initial Applications and Post-Eligibility

1. Allegations of Loss of Housing for Co-Owner

If someone alleges that the sale of certain real property would force a co-owner living on it to move, obtain:

- *the individual's signed statement to that effect, and*
- *evidence of joint ownership (see S1130.100 B.1.b.-d.).*

If co-ownership is not proven, skip to 3. below. Otherwise, obtain the statement in 2. below.

2. Required Statement from Resident Co-Owner

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; and*
- *has other living quarters readily available.*

Apply the policy principle in A. above to determine whether, on the basis of the statements of the individual and the co-owner, the sale of the property would cause undue hardship to the co-owner.

Accept any reasonable allegation from the co-owner that there is no readily available housing (e.g., no other affordable housing available or no other housing with necessary physical modifications for a handicapped individual).

3. Determination-Not Undue Hardship

If the property cannot be excluded on the basis of undue hardship:

- *document the file to that effect;*
- *issue appropriate notice.*

4. Determination-Undue Hardship

If the property can be excluded on the basis of undue hardship:

- *document the file to that effect;*
- *issue appropriate notice.*

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S1130.140 REAL PROPERTY FOLLOWING REASONABLE BUT UNSUCCESSFUL EFFORTS TO SELL

A. Policy Principles

Real property that an individual has made reasonable but unsuccessful efforts to sell will be excluded from resource evaluation for as long as:

- the individual continues to make reasonable efforts to sell it; and
- including the property as a countable resource would result in a determination of excess resources.

B. Policy Reasonable Efforts to Sell/Buy

1. Reasonable Efforts to Sell -

The individual must make reasonable efforts to sell excess nonliquid property by taking all necessary steps to sell it through media serving the geographic area in which the person lives or, if different, where the property is located.

2. Reasonable Efforts to Sell Real Property

a. The individual/couple agrees in writing to:

- sell excess nonliquid resources at their current market value (CMV); and

b. Within 30 days of signing an agreement, the owner must:

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

NOTE: Reasonable efforts must be evaluated in consideration of the individual's circumstances and must not be restricted to "traditional" sales methods such as employing a real estate agent.

c. Except for gaps of no more than 1 week, the owner must maintain efforts of the type listed in a. above; and

d. The owner must not reject any reasonable offer to buy the property and must accept the burden of demonstrating to DSS's satisfaction that he rejected an offer because it was not reasonable.

3. Reasonable Offer to Buy Real Property

We assume that an offer to buy real property is reasonable if it is at least two-thirds of the estimated CMV unless the owner proves otherwise.

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a. Definition

Good cause exists when circumstances beyond an individual's control prevent his/her taking the required actions to accomplish reasonable efforts to sell.

b. Significance of Good Cause

- Without good cause, failure to meet the criteria outlined in 1. or 2. above, as applicable, means that the individual is not making reasonable efforts to sell the property. Therefore, his/her countable resources include the value of the excess property.

- With good cause, failure to meet the criteria in 1. or 2. above means that the exclusion continues.

C. Examples - Good Cause

1. No Offer to Buy	The individual makes good faith efforts to sell excess nonliquid resources (or is prevented from doing so by circumstances beyond his/her control) but receives no offer to buy them.
2. Reliance on an Offer That Does Not Result in a Sale	A legitimate or apparently legitimate offer to buy an excess nonliquid resource halts further efforts to sell it for a prolonged period of time, and the prospective buyer subsequently cannot or will not complete the purchase.
3. Escrow Begins But Closing Does Not Take Place Within Disposal Period	The individual accepts an offer to buy real property, and escrow begins, which precludes acceptance of another offer. Closing (at which full or partial payment and transfer of title are exchanged) does not take place within the disposal period.
4. Incapacitating Illness Or Injury	The individual becomes homebound or hospitalized for a prolonged period, due to illness or injury, and cannot take the steps necessary to sell the resource or to arrange for someone to sell it on his/her behalf.
5. Part-Owner Dies	A part-owner of a resource dies, and administration or probate of the estate delays efforts to sell the resource (assuming that the property continues to be a resource.)

PERSONAL PROPERTY

S1130.200 AUTOMOBILES

A. Policy Principles

1. Automobile Defined	For Medicaid purposes, "automobiles" means any vehicle used for transportation. It thus can include, in addition to cars and trucks: boats, snowmobiles, animal-drawn vehicles, and even animals.



2. Current Market Value Defined

The CMV of an automobile is the average price an automobile of that particular year, make, model and condition will sell for on the open market (to a private individual) in the particular geographic area involved.

3. Exclusion Regardless of Value

One automobile is excluded regardless of value if, for the individual or a member of the individual's household, it is:

- necessary for employment;
- necessary for the treatment of a specific or regular medical problem;
- modified for operation by, or the transportation of, a handicapped person; or
- necessary, because of climate, terrain, distance or similar factors, for the

4. Alternate Exclusion--Up to $4,500 Of CMV

If **no** automobile is excluded per 3. above, up to $4,500 of the **CMV** of **one** automobile is excluded. If the CMV exceeds $4,500, the excess counts as a resource unless the automobile can be excluded under some other provision. Equity value is not a consideration for purposes of this exclusion.

5. Other Automobiles

Any automobile an individual owns in addition to the one wholly or partly excluded per 3. or 4., and which cannot be excluded under another provision is a resource in the amount of its equity value.

B. Operating Policy--More Than One Automobile Owned

1. General Rule

The exclusion applies in the manner most advantageous to the individual.

2. Example--One of Two Cars is Totally Excluded

If one of two cars can be excluded as necessary for medical treatment, and the other will be a countable resource, the exclusion applies to the car with the greater equity value regardless of which car is used to obtain medical treatment.

3. Example--Neither of Two Cars is Totally Excluded, One Is Excluded to $4,500 of CMV

Mr. Smith owns two cars. One has a CMV of $8,000 and an equity value of $500. The other, which has been paid off, has a CMV and equity value of $2,500. Neither can be excluded based on use.

Applying the $4,500 exclusion to the car with the $8,000 CMV would leave $3,500 of the CMV of that car as a countable resource. It also would leave the $2,500 equity value of the other car as a countable resource.

Applying the $4,500 exclusion to the car with the $2,500 CMV excludes that car entirely, leaving only the $500 equity value of the other car to be included among countable resources. Therefore, the exclusion applies to the car with the $2,500 CMV.

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C. Development and Documentation-- Initial Applications

1. Status as Automobile

a. Use of Allegation
For the purpose of determining whether a vehicle is used for transportation (i.e., whether it is an automobile for Medicaid purposes), accept the individual's account of its use unless a question arises. If a vehicle is not being used for transportation, find out why.

b. Vehicle Not Used for Transportation

- A temporarily broken down vehicle normally used for transportation still qualifies as an automobile. One that has been junked or that is used only as a recreational vehicle (such as a boat used weekends on the lake) does not.

Vehicles that do not meet the definition of an automobile are personal property. The value they have as a resource is their equity value, and the personal effects exclusion does not apply to them.

2. Ownership

Absent evidence to the contrary, accept the individual's allegation as to sole or joint ownership and his or her proportionate share of joint ownership. Resolve any questions by examining the title, the current year's registration, or the bill of sale. Place in file a photocopy of the document examined or record the relevant facts in case record.

3. Exclusion Regardless of Value

Absent evidence to the contrary, accept the individual's allegation as to the presence of a factor that would qualify the automobile for exclusion regardless of value.

4. CMV Based On N.A.D.A. Guides

a. Description of Vehicle
When the value of an automobile must be developed, get a description complete enough to enable you to find it in one of the N.A.D.A. guides discussed below, e.g.: 1982 Chevrolet Caprice, V-6, 2-door.

b. N.A.D.A. Official Used Car Guide
This publication gives values for popular foreign and domestic cars and light trucks up to 8 years old. Use as the automobile's CMV the average **trade-in** value shown for it in the most recently published of these two issues, regardless of the period of time covered by the determination.

c. N.A.D.A. Older Car Guide
This publication gives values for popular cars and trucks from 8 to 18 years old. Use the average trade-in value shown in the most recently published January-April issue.

If the automobile is more than 18 but less than 25 years old, use the value shown for it at 18 years old.



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d. Other N.A.D.A. Guides
N.A.D.A. also publishes guides on mobile homes, recreational vehicles, boats, motorcycles, and mopeds.

5. Rebuttal of N.A.D.A. Value

a. When Rebuttal Applies
If the N.A.D.A. guide value affects eligibility and the individual disagrees with it, give him or her the opportunity to rebut it.

b. Rebuttal Evidence
Rebuttal evidence can consist of N.A.D.A. guides and/or of a written appraisal of the automobile's CMV obtained by the individual at his or her own cost from a disinterested knowledgeable source, such as a used car of truck dealer or an automobile insurance company.

c. Determination
Document a rebuttal determination in case record.

6. Exceptions To Use of N.A.D.A. Guide Values

The following circumstances preclude use of the N.A.D.A. guides:

- The guides do not list the make and/or model of the vehicle.
- The guides list but do not show a value for the make and/or model of the vehicle.
- The vehicle is a car or truck 25 or more years old.
- The vehicle is any motorized vehicle other than a car or truck, or is a nonmotorized vehicle (e.g., an animal or animal-drawn vehicle).

7. Knowledgeable Source Estimate

When one of the exceptions in 6. above applies, or other circumstances make use of the N.A.D.A. guides inappropriate, get a CMV estimate from a disinterested knowledgeable source.

Provide the contact with a complete description of the vehicle, including year, make, model, number of doors, equipment, etc. Absent evidence to the contrary, such as that the vehicle is damaged or is in "mint" condition, assume it to be in average condition.

Inform the contact that the estimate should show what the vehicle would sell for on the open market in the geographic area covered by local media. If the estimate is obtained by telephone, document the file with all the pertinent facts.

D. Development and Documentation-Posteligibility

1. Exclusion Regardless Of Value

If an automobile has been excluded regardless of value, it is not necessary to redevelop the exclusion or the value.

2. Exclusion To $4,500 of CMV

a. General
It is not necessary to redevelop the CMV of a vehicle that has been excluded to $4,500 of its CMV unless the CMV in excess of $4,500 affects eligibility.



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b. Exception
Always redevelop the collector value of an antique or other collectible

E. Related Policy

If a vehicle cannot be excluded under this provision, consider the possibility of its exclusion as property essential to self-support (S1130.500), or as part of a plan for achieving self-support.

S1130.430 HOUSEHOLD GOODS AND PERSONAL EFFECTS

A. Policy Principles

1. Items Excluded Regardless Of Value

a. One wedding ring and one engagement ring per individual are excluded regardless of value.

b. 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.

2. Exclusion Of Up To $2,000 Equity Of Other Items

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.

B. Definitions

1. 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, but are not limited to: furniture, appliances, televisions sets, carpets, cooking and eating utensils, dishes, etc.

2. 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 or her. They include, but are not limited to: clothing, jewelry, personal care items, prosthetic devices, and educational or recreational items such as books, musical instruments, or hobby materials.

3. Items Of Unusual Value

An item of unusual value is one whose CMV exceeds $500.

4. 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.

Durable items do **not** include:

- anything treated as an item of unusual value;
- ordinary cooking and eating utensils;
- small appliances;
- linens;

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- clothing; or
- household furnishings of little value.

C. Development and Documentation--Initial Claims

1. Wedding And Engagement Rings

If only one wedding and/or engagement ring per individual is alleged, exclude it without further development. Treat additional such rings in accordance with the instructions below.

2. Allegation Of No Items Of Unusual Value, Or Of Only One Such Item With A CMV of $1,000 Or Less

Absent evidence to the contrary, accept the allegation. Assume that the total equity value of all household goods and personal effects is $2,000 or less. No further development is required.

3. Allegation Of Items Of Unusual Value Whose Total CMV Exceeds $1,000

a. Ask if the individual's physical condition requires any of the items. If the answer is "No," record it in the *case record* and skip to c. below for the additional development required.

If the answer is "Yes," record it in the case record with the following information:

- 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; and
- the extent to which any other member of the household uses the item.

b. **Determine,** based on the allegations, whether any of these items is excluded per A.1.b. above.

If, after exclusion of appropriate items per A.1.b., the alleged total CMV of the remaining items of unusual value does not exceed $1,000, **discontinue development.** Otherwise, proceed according to c. below.

c. 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 nonexcluded items of unusual value does not exceed $2,000, **cease development.** If it does exceed $2,000, proceed according to d. below.

d. **Verify** the CMV of any item of unusual value not excluded per A.1.b. Use any reliable evidence of CMV 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 (the amount it would cost to purchase a



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similar item new) rather than CMV. Do not use replacement value in lieu of CMV.

If the verified CMV of all nonexcluded items of unusual value and the alleged CMV of all durable items totals $2,000 or less, **cease development.** Otherwise, proceed according to e. below.

e. **Determine** whether any of the durable items (i.e., that are not items of unusual value) can be excluded per A.1.b. above. If they can, and if the verified CMV of all nonexcluded items of unusual value and the alleged CMV of the remaining durable items then totals $2,000 or less, **cease development.** Otherwise, proceed according to f. below.

f. **Verify** the CMV of the nonexcluded durable items. If the verified total CMV of all nonexcluded items of unusual value and nonexcluded durable items is $2,000 or less, **cease development.** Otherwise, proceed according to g. below.

g. 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.

S1140.110 OTHER PROPERTY RIGHTS

A. Introduction

For resources other than a life estate, apply development and documentation located in S1140.110 to QDWI evaluations.

B. 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 cases, it may be conditional: e.g., for life or until remarriage. The owner of a life estate can sell the life estate but does not have title to the property and thus, normally cannot sell it or pass it on as an inheritance.

For QDWI evaluations, a life estate in real property, other than the home property, is counted as a resource ***regardless of when the life estate was established.*** *Follow the policy in M1140.110 for determining the countable value of a life estate.*

A life estate in home property does not need to be developed as the home is an excluded resource.

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QMB, SLMB, QI AND ABD 80% FPL

A. Introduction

This section contains information regarding the resources that are treated differently for *QMB, SLMB, QI and ABD 80% FPL covered groups. The differences are:*

- home property,
- inheritances and unprobated estates, and
- real property whose sale would cause undue hardship, due to loss of housing, to a co-owner.

B. Resource Evaluation

Resource treatment and evaluation used *for QMB, SLMB, QI and ABD 80% FPL determinations are listed in:*

- S1110 Resources, General,
- S1120 Identifying Resources,
- S1130 Resource Exclusions and
- S1140 Countable Resources

C. Resource Policy Exceptions

Sections of policy that apply only to QMB, SLMB, QI and ABD 80% FPL evaluations are:

- S1120.215 Inheritances and Unprobated Estates
- S1130.100 The Home
- S1130.130 Real Property Whose Sale Would Cause Undue Hardship, Due to Loss of Housing to a Co-owner

The detailed information on these resources is below.

S1120.215 INHERITANCES AND UNPROBATED ESTATES

A. Introduction

An ownership interest in an unprobated estate may be a resource if an individual:

- is an heir or relative of the deceased; or
- receives any income from the property; or
- under State intestacy laws, has acquired rights in the property due to the death of the deceased.

B. Operating Policy

1. When to Develop

We develop for this type of resource only if:

- the property in question is not excludable under any of the provisions in S1110.210 B.; and
- counting the property's value would result in excess resources.

2. Ownership Interest

There is an ownership interest in an unprobated estate if:

- documents (e.g., a will or court records) indicate an individual is an heir to property of a deceased; or

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- an individual has use of a deceased's property or receives income from it; or
- documents establish, or the individual alleges, a relationship between himself and the deceased which, under State intestacy laws, awards the individual a share in the distribution of the deceased's property; and
- the inheritance, use of income, and distribution are uncontested.

3. When Unprobated Estate Can Be a Resource

We do not consider that an inheritance is a resource until the month following the month in which it meets the definition of income. See *S0830.550* for the income rules on inheritances. Thereafter, if retained, we evaluate the property as a resource.

C. Development and Documentation

1. Ownership Interest

Document the file, as applicable, with a copy of:

- an inheritance or relationship document (or a signed statement alleging a relationship);
- evidence of income from the property;
- individual's signed statement concerning his/her use of the property and whether there is contest of any factor; or
- other evidence showing that the situation meets the criteria in B.

2. Sole vs. Shared Ownership

Follow S1110.510 and S1140.030 to determine and document whether there are other owners and, if so, whether the individual needs their consent to sell his/her share of the property.

3. Status as a Resource

- If the individual is the sole owner or if other owners give needed consent to sell, the property is the individual's resource. Some States do not require the consent of other heirs in order for a co-owner to sell property.

- If other owners withhold consent and that consent is necessary to sell, the property is not a resource until the estate has been through probate. It is subject to the resource counting rules the month following the month it meets the definition of income.

4. Value of Resource

a. CMV - Develop the property's CMV (and EV, if appropriate) following guidelines in S1140 for the particular type of property involved.

b. Shared Ownership

- For real property, and most personal property, see S1140.030 B.
- For checking/savings accounts and time deposits, see S1140.205 and S1140.210.

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REAL PROPERTY

S1130.100 THE HOME

A. Policy Principles

1. Exclusion of the Home

An individual's home, regardless of value, is an excluded resource.

2. Definition of the Home

An individual's home is property in which he or she has an ownership interest and that serves as his or her principal place of residence. It can include:

- the shelter in which he or she lives;
- the land on which the shelter is located; and
- related buildings on such land.

3. Principal Place of Residence

An individual's principal place of residence is the dwelling the individual considers his or her established or principal home and to which, if absent, he or she intends to return. It can be real or personal property, fixed or mobile, and located on land or water.

4. Individual Owns The Land But Not The Shelter

For purposes of excluding "the land on which the shelter is located" (A.2. above), it is not necessary that the individual own the shelter itself.

EXAMPLE: If an individual lives on his or her own land in someone else's trailer, the land meets the definition of home and is excluded.

5. Extent of Property To Which The Exclusion Applies

a. Land

The home exclusion applies not only to the plot of land on which the home is located, but to any land that adjoins it.

Land adjoins the home plot if not completely separated from it by land in which neither the individual nor his or her spouse has an ownership interest.

Easements and public rights of way (utility lines, roads, etc.) do not separate other land from the home plot.

b. Buildings

The home exclusion applies to all buildings on land excluded per a. above.

6. Property That No Longer Serves As The Principal Place of Residence

a. General Rule

Property ceases to be the principal place of residence - and, therefore, to be excludable as the home - as of the date that the individual, having left it, does not intend to return to it.

Such property, if not excluded under another provision, will be included in determining countable resources as of the first moment of the first day of the following month..



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b. Exceptions to General Rule
Even if the individual leaves the home without the intent to return, the property remains an excluded resource for as long as:

- a spouse or dependent relative of the individual continues to live there while the individual is institutionalized; or
- its sale would cause undue hardship, due to loss of housing, to a co-owner of the property

7. Dependent Relative Defined

a. Dependency may be of any kind (financial, medical, etc.).

b. Relative means:

- child, stepchild, or grandchild;
- parent, stepparent, or grandparent;
- aunt, uncle, niece, or nephew;
- brother or sister, stepbrother or stepsister, half brother or half sister;
- cousin; or
- in-law.

B. Development and Documentation-- Initial Claims

1. Ownership

a. Use of Allegation
Accept an individual's allegation of home ownership unless the file raises a question about it (e.g., a life estate is involved, the individual is under age 18, does not live with a parent, and does live with someone else). If there is a question, have the individual submit one of the items of evidence listed in b. - d. below.

b. Evidence of Real Property Ownership:

- tax assessment notice;
- recent tax bill;
- current mortgage statement;
- deed;
- report of title search;

evidence of heirship in an unprobated estate (e.g., receipt of income from the property, a will, or evidence of relationship recognizable under State intestate distribution laws in cases where the home is unprobated property).

c. Evidence of Personal Property Ownership (e.g., a Mobile Home):

- title;
- current registration.

d. Evidence of Life Estate or Similar Property Rights

- deed;
- will

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- other legal document**.**

e. Equitable Ownership

Virginia does not recognize equitable ownership of real property.

2. Principal Place of Residence -- Operating Assumption

Absent ownership in more than one residence or evidence that raises a question about the matter, **assume** that the alleged home is the individual's principal place of residence.

3. Indication of More than One Residence

If an individual alleges or other evidence indicates ownership of more than one residence, **obtain** his or her signed statement concerning such points as:

- how much time is spent at each residence;
- where he or she is registered to vote;
- which address he or she uses as a mailing address or for tax purposes.

Determine the principal place of residence accordingly and document the determination in file.

4. Evidence Indicates Nonadjoining Property

a. Individuals Agrees With Evidence
If evidence indicates that land the individual owns does not adjoin the home plot, and the individual agrees that it does not;

- **obtain** his or her statement to that effect and
- **develop** the nonadjoining portion per S1140.100 (Nonhome Real Property) or S1130.500 (Property Essential to Self-Support), as applicable.

b. Individual Disagrees With Evidence
If the individual maintains that all the land adjoins the home plot, document the file with:

- a sketch of the land showing the boundaries of the various plots and the location of the shelter used as the home; and
- evidence of how the land is treated for tax assessment purposes.

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The sketch may be by the individual, from public records, or by the Eligibility Worker (from direct observation).

The tax assessment information may be in the form of a tax assessment notice or obtained from the appropriate tax jurisdiction and recorded in the case record.

c. Combined or Single Holding for Tax Assessment

Assume that the land is a single piece of property in which all the land adjoins the home plot if:

- it is recorded and treated as a single holding for tax assessment purposes; or
- the original holding has been subdivided, but still is treated as a single holding for tax assessment purposes.

d. More Than Single Holding for Tax Assessment

If the land is recorded and treated as two or more holdings for tax assessment purposes, use the sketch to determine whether other holdings adjoin the home plot.

5. Absences From The Home

a. Summary of Development

If the individual is in an institution, determine whether a spouse or dependent relative is living in the home (see b. below).

If no spouse or dependent relative is living in the home, determine:

- whether the individual intends to return to the home (see c. below); and
- if not, whether the sale of the home would cause undue hardship, due to loss of housing, to a co-owner (see D.1. below).

NOTE: If a previously undeveloped absence from the home has ended, assume that the individual always intend to return. The absence, regardless of duration, will not affect the home exclusion.

b. Spouse or Dependent Relative Development

Obtain a signed statement from the individual as to:

- whether anyone is living in the home while the individual is in the institution;
- if so, how that person is related to the individual, if at all; and
- if related (except for the individual's spouse), how that person is dependent on the individual, if at all.

Absent evidence to the contrary, accept the allegations.

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c. "Intent to Return" Development

If the individual has left his or her home but intends to return to it, see D. below for the necessary development.

NOTE: "Intent to return" development applies only to the **continued** exclusion of property which met the definition of the individual's **home** prior to the time the individual left the property. See A.2. above for the definition of "home."

C. Procedure – Post-eligibility

If, after Medicaid eligibility is established, an individual receives real property - for example, as an inheritance or gift - which may be excludable as his/her home, apply the policy and procedures in A. and B. above to determine whether the home exclusion applies.

Redevelop the exclusion from resources of an individual's home only if something raises a question about the correctness of the original determination or indicates that the exclusion may no longer apply (e.g., a change of address).

If the individual has left his or her home but intends to return to it, see D. below.

D. Procedure -- "Intent to Return Home" Development

1. Obtain Statement

Obtain a signed statement from the individual as to:

- when and why he or she left the home;
- whether he or she intends to return; and
- if he or she does not intend to return, when that decision was made.

NOTE: If the individual has a representative payee, obtain the "intent" statement from the payee.

This statement governs the "intent to return" determination unless the statement is self-contradictory (see 2. through 4. below).

2. Self-Contradictory Statement

Consider a statement to be self-contradictory if it contains conflicting or unclear expressions of intent.

Examples of self-contradictory statements:

"Sometimes I want to go home and sometimes I don't."

"I intend to go home but I also want to stay here."

"Yes, I want to go home, but I really don't know if I should."

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3. Factors Not to Consider

Do not consider other factors, such as the individual's ages, physical condition, or other circumstances when determining intent to return home. Assuming the individual is mentally competent, age, mental capacity, and physical condition are **not** factors in evaluating the individual's statement of intent.

Example: The recipient is 93 years old and in the intensive care unit of a hospital. She tells the Eligibility Worker that her doctor believes she may not be able to leave the hospital and return home. However, she states that she intends to return to her former residence as soon as she is well enough to leave the hospital. Based on her statement, "intent to return home" is established.

Example: The recipient's home was partially destroyed by fire. He does not know when the necessary repairs will be completed. In the meantime, he is living with his sister. He states he intends to return to the former residence as soon as possible. Based on his statement, "intent to return home" is established.

4. Obtaining More Information If Needed

If the individual's statement of intent is self-contradictory, contact someone who knows the situation, such as a physician, family member, or close friend or relative, to clarify the situation.

S1130.130 REAL PROPERTY WHOSE SALE WOULD CAUSE UNDUE HARDSHIP, DUE TO LOSS OF HOUSING, TO A CO-OWNER

A. Policy Principles

1. Exclusion

The value of an individual's ownership interest in jointly owned real property is an excluded resource **for as long as** sale of the property would cause undue hardship, due to loss of housing, to a co-owner.

2. Undue Hardship

Undue hardship would result if such co-owner:

- uses the property as his or her principal place of residence;
- would have to move if the property were sold; and
- has no other readily available housing.

B. Development and Documentation--Initial Applications and Post-Eligibility

1. Allegations of Loss of Housing for Co-Owner

If someone alleges that the sale of certain real property would force a co-owner living on it to move, obtain:

- the individual's signed statement to that effect, and
- evidence of joint ownership (see S1130.100 B.1.b.-d.).

If co-ownership is not proven, skip to 3. below. Otherwise, obtain the statement in 2. below.



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2. Required Statement from Resident Co-Owner

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; and
- has other living quarters readily available.

Apply the policy principle in A. above to determine whether, on the basis of the statements of the individual and the co-owner, the sale of the property would cause undue hardship to the co-owner.

Accept any reasonable allegation from the co-owner that there is no readily available housing (e.g., no other affordable housing available or no other housing with necessary physical modifications for a handicapped individual).

3. Determination-Not Undue Hardship

If the property cannot be excluded on the basis of undue hardship:

- document the file to that effect;
- issue appropriate notice.

4. Determination-Undue Hardship

If the property can be excluded on the basis of undue hardship:

- document the file to that effect;
- issue appropriate notice.

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CHAPTER M13

SPENDDOWN

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CHAPTER M13
SPENDDOWN
SUBCHAPTER 10

SPENDDOWN GENERAL PRINCIPLES AND DEFINITIONS

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M1310 Changes

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TN #DMAS-30	1/1/24	Page 2
TN #DMAS-27	4/1/23	Pages 1, 3
TN #DMAS-14	10/1/19	Page 1
TN #DMAS-10	10/1/18	Page 1 Pages 2 and 3 are runover pages.
TN #DMAS-2	10/1/16	Pages 1-6 On pages 1 and 4-6, corrected the subchapter number in the headers. Neither the dates nor the policies were changed.
UP #9	4/1/13	Pages 1-3
UP #7	7/1/12	Table of Contents Pages 1-5 Page 6 was added.
TN #95	3/1/11	Page 4

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M1310.000 SPENDDOWN GENERAL PRINCIPLES AND DEFINITIONS

M1310.100 GENERAL PRINCIPLES OF MEDICAID SPENDDOWN

A. Introduction

Individuals and families who otherwise meet the medically needy non-financial and resource eligibility requirements, but whose countable income exceeds the medically needy income limits, are not eligible for Medicaid unless:

- the excess income is insufficient to meet the cost of needed medical care, and
- the cost of incurred medical or remedial care recognized under state law has been deducted from excess income.

This section contains the policy and procedures for determining a family's or a non-institutionalized individual's medically needy income eligibility when their income exceeds the medically needy income limit.

B. Applicability

Spenddown applies only to the medically needy (MN) covered groups listed in M0320 and M0330. There are no MN covered groups for Low-income Families with Children (LIFC) parents, Modified Adjusted Gross Income (MAGI) Adults, or children between age 18 and 19 years who do not meet the definition of an Individual Under Age 21 in M0330.804.

Individuals and families who meet a MN covered group must meet the MN nonfinancial and resource requirements in order to be placed on a spenddown. *If information requested for the Categorically Needy evaluation has not been returned, information for the MN evaluation should not be requested and a spenddown cannot be calculated.*

An individual or family is income eligible when countable income after deducting specified medical or remedial care expenses is equal to or less than the medically needy income limit (MNIL) for the budget period.

For a spenddown which involves an incarcerated person, see M1350.850.

C. Opportunity to Receive Full Medicaid Coverage

Individuals who are eligible for only a limited package of Medicaid services must be evaluated to determine if they could become eligible for full Medicaid coverage as medically needy (MN) by meeting a spenddown. To be evaluated for a spenddown, the individual must meet a MN covered group listed in M0330.001 and meet all of the requirements for the MN covered group.

1. Aged, Blind or Disabled (ABD) Medically Indigent (MI) Enrollees

Individuals in the following limited-benefit ABD covered groups also meet a MN covered group:

- Qualified Medicare Beneficiaries (QMBs),
  - Special Low-income Medicare Beneficiaries (SLMBs),
  - Qualified Individuals (QIs), and
  - Qualified Disabled Working Individuals (QDWIs).

Information specific to processing spenddown for these individuals is contained in M1370.

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2. Plan First Enrollees Individuals enrolled in Plan First do not necessarily meet a MN covered group. Plan First enrollees who meet a MN covered group and its requirements in M0330 are placed on two six-month spenddown budget periods within the 12 month renewal period. They may also be eligible for a retroactive MN spenddown determination.

3. MN Children Under Age 18 With $0 Spenddown Liability Due to differences in income counting methodology applicable to Categorically Needy (CN) and MN covered groups, a child under age 18 may be ineligible for coverage in a CN covered group but have countable income under the income limit for MN coverage. The child's spenddown liability is $0.00 (zero dollars); therefore, his spenddown is met on the first day of the spenddown period. Enroll the child in *a 12 month* period of coverage, without the need for a new application, and complete an annual renewal. Continue to enroll the child in *12 month* periods of coverage *each* year as long as he continues to be eligible as MN at renewal. See M0330.803.

M1310.200 INSTITUTIONALIZED INDIVIDUALS IN MEDICAL FACILITIES OR RECEIVING MEDICAID CBC

A. General Principle Do not use this subchapter for institutionalized Medically Needy individuals in long-term care [medical facilities or Medicaid Community-based Care (CBC)] who have income over the MNIL.

Go to subchapter M1460 when the individual is institutionalized in a medical facility or when the individual receives Medicaid Community-based Care (CBC) waiver services. Subchapter M1460 contains the policy and procedures for determining the eligibility and spenddown liability for individuals in long-term care.

M1310.300 SPENDDOWN DEFINITIONS

A. Introduction This section contains the definitions of terms used in the spenddown chapter, Chapter M13.

B. Definitions

1. Applicable Exclusions Applicable exclusions are the amounts that are deducted from income in determining an individual's income eligibility as identified under the July 16, 1996, AFDC State Plan for Families & Children covered groups, and under the SSI program for aged, blind or disabled individuals.

2. Assistance Unit The Medicaid assistance unit is the individual or family who applies for Medicaid and whose financial eligibility is determined. The assistance unit for the Families & Children (F&C) covered groups is called the "family unit" or the "budget unit." The assistance unit for an ABD individual is just the individual, unless the individual is married, living with his/her spouse and the spouse is also ABD or the spouse is NABD and has deemable income. In this situation, the assistance unit is the married ABD couple.

3. Available Income Available income means the earned and unearned income before exclusions used in determining the income eligibility of a medically needy individual.



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4. Break in Spenddown Eligibility

A break in spenddown eligibility only occurs after an individual has, at least once, established eligibility by meeting a spenddown in a prior budget period. A break in spenddown eligibility occurs when:

- there is a break between spenddown budget periods;
- the individual establishes Medicaid eligibility in the ABD 80% F
- PL covered group or a CN F&C covered group; or the individual does not meet the spenddown liability in a spenddown budget period.

Note: during the first renewal after the end of the Public Health Emergency there will be considered to be NO BREAK since the prior spenddown.

5. Budget Period

Budget period means a period of time during which an individual's income is calculated to determine Medicaid eligibility.

6. Carry-over Expenses

Carry-over expenses are the balance due on medical, dental, and remedial care expenses incurred in the retroactive or prospective budget periods prior to the current budget period which were not used in establishing eligibility and which may be deducted in consecutive budget periods when there has been no break in spenddown eligibility.

7. Consecutive Budget Period

A consecutive budget period is any spenddown budget period that immediately follows a spenddown budget period in which eligibility was established.

8. Countable Income

Countable income means, for the medically needy, the amount of the individual's gross income after deducting allowable exclusions that is measured against the medically needy income limit (MNIL).

9. Covered Expenses

Covered expenses means expenses for services that are included in the State Plan for Medical Assistance (Medicaid State Plan).

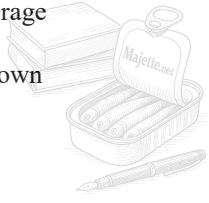
10. Current Payments

Current payments are payments made in the current spenddown budget period on expenses incurred before the current spenddown budget period, which were not used in establishing eligibility in a previous spenddown budget period and when there has been a break in spenddown eligibility. The payment amount allowed is the actual payment amount paid to the provider and is deducted from the spenddown liability on the date the payment is actually made.

11. First Prospective Budget Period

The first prospective budget period is the spenddown budget period that begins:

- the first day of the month the individual first applied for Medicaid and is placed on spenddown, or
- the first day of the month after the cancellation of Medicaid coverage due to excess income, or
- when a new Medicaid application is filed after a break in spenddown eligibility.



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12. Incurred Expenses

Incurred expenses means expenses for medical, dental**,** or remedial care services:

- which are recognized under state law;
- which are rendered to an individual, family, or legally responsible relative;
- which the individual is liable for in the current budget period or was liable for in the three-month retroactive period; and
- which are not subject to payment by any liable third party.

An expense for a medical or remedial service is an incurred expense from the date the liability arises until the end of the budget period in which the expense is fully used to meet a spenddown.

13. Initial Application

An initial application is the individual's first Medicaid MN spenddown application. There are two ways an individual can have an initial application:

- this is the individual's first application for Virginia Medicaid, or
- this is the first time the individual has been placed on a spenddown.

14. Legally Responsible Relative

A legally responsible relative is the individual's spouse and/or, when the individual is under age 21, a parent who is responsible by law to support the individual. The legally responsible relative's resources and income may be used in determining the individual's Medicaid eligibility.

15. Liable Third Party

Liable third party means any individual, entity or program that is or may be liable to pay all or part of the cost of medical or remedial treatment for injury, disease or disability of a Medicaid applicant or recipient.

16. Medical Expense Record Form

The "Medical Expense Record-Medicaid" (#032-03-023) is a form provided to the client for keeping a chronological record of his medical expenses. It is used by the eligibility worker to determine if the spenddown has been met.

17. Medically Needy Income Limit (MNIL)

MNIL means the medically needy income limit. This is the income standard established to determine the financial eligibility of medically needy individuals and families.

18. Noncovered Expenses

Noncovered expenses are expenses for necessary medical and remedial services recognized under state law but not covered under the Medicaid State Plan, including those that exceed the Medicaid limitation on amount, duration, or scope of the service covered under the State Plan.

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19. Old Bills

Old bills are unpaid medical, dental, or remedial care expenses which:

- were incurred prior to the Medicaid application's retroactive period or
- were incurred during the retroactive period if the individual either did not meet the retroactive spenddown or was not eligible for Medicaid in the retroactive period (for example, due to excess resources), and
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and
- remain a liability to the individual.

Old bills that are based on previous applications do not meet the definition of "old bills" when there has been a break in spenddown eligibility.

EXCEPTION: Bills paid by a state or local program are treated as old bills even though they are not the individual's liability.

20. Prospective Budget Period

A prospective budget period is the prospective period of time during which income is projected for the purpose of determining spenddown eligibility.

21. Re-application

Re-application means any Medicaid medically needy spenddown application which is filed after the initial application.

22. Retroactive Spenddown Budget Period

The retroactive spenddown budget period is the retroactive period in which the individual is on a spenddown. The retroactive spenddown budget period is the 3 months immediately prior to the application month, when none of the months overlap (was included in) a previous MN spenddown budget period in which spenddown eligibility was established.

When some of the months overlap a previous MN spenddown budget period in which spenddown eligibility was established, the retroactive spenddown budget period is shortened (prorated) to include only the month(s) which were not included in the previous MN spenddown budget period in which spenddown eligibility was established.

23. Spenddown

Spenddown is the process through which countable income is compared to the MNIL for the budget period and incurred expenses are deducted from excess countable income.

24. Spenddown Budget Period

A spenddown budget period is the budget period during which the individual's or family's countable income exceeds the MNIL for the budget period and during which the individual or family is placed on a spenddown.

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25. **Spenddown Eligibility**

Spenddown eligibility means the individual established eligibility by meeting a spenddown within a spenddown budget period.

26. **Spenddown Liability**

The spenddown liability is the amount by which the individual's or family's countable income exceeds the MNIL for the budget period.

27. **State or Territorial Public Program**

A state or territorial public program is a public health program that is wholly or partially funded and administered by a state or territory, including a political subdivision thereof (i.e., SLH, GR, AG and CSB services).

28. **State or Territorially-Financed Program**

A state or territorially-financed program is a state or territorial public program whose funding, except for deductibles and coinsurance amounts required from program beneficiaries, is either:

- appropriated by the state or territory directly to the administering agency, or
- transferred from another state or territorial public agency to the administering agency.

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M1320 Changes

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TN #DMAS-33	10/1/24	Page 2
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TN #DMAS-6	10/1/17	Page 2
TN #DMAS-2	10/1/16	Page 2 Page 3 is a run over page.
TN #95	3/1/11	Page 1

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M1320.000 SPENDDOWN INFORMATION

M1320.100 INFORMING THE APPLICANT

A. Introduction

An individual applicant who meets all the medically needy Medicaid eligibility requirements except income, because his countable income exceeds the Medicaid income limits, must be told about spenddown and what he can do to become eligible for Medicaid coverage for a limited time period.

This section lists the items of which the EW must inform the applicant.

B. Allowable Expenses

The worker must inform the applicant about the incurred medical, dental, or remedial care expenses, either paid or unpaid, that can be deducted from the spenddown liability.

1. Covered By State or Local Public Program

Expenses for incurred medical services received on or after December 22, 1987, which were provided, covered, or paid for by a state or local government program can be deducted even though the applicant does not owe anything for the service.

Expenses covered by Medicare and Medicaid (which are federal programs) CANNOT be deducted.

2. Old Bills

Expenses incurred for medical services received prior to the initial application's retroactive period or *during the retroactive period if the individual either did not meet the retroactive spenddown or was not eligible for Medicaid in the retroactive period (for example, due to excess resources)* may be deducted if:

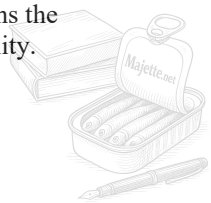
- the applicant is legally liable to pay the expense;
- the applicant still owes a balance to the medical service provider for the service;
- the expense was not deducted from (counted in) any previous spenddown budget period in which the spenddown was met, and
- a claim for the expense was submitted to the liable third party(ies), if any.

3. Third Party Payment

An allowable medical expense cannot be deducted until the individual's insurance or other third party, if applicable, has taken action on the claim and the applicant provides evidence documenting:

- the claim was denied, or
- the amount of the claim paid by the third party.

Only the amount not covered by the third party(ies) and which remains the liability of the individual may be deducted from the spenddown liability.



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C. Incur Noncovered Expenses First

The worker must inform the applicant that it is to his advantage to use the spenddown liability (excess income) for medical and dental services not covered by the Medicaid program before he uses the spenddown liability for covered services. Medicaid will not pay for noncovered medical services even after the spenddown is met.

D. Estimate When Spenddown Liability Will Be Met

The worker can help the applicant estimate the approximate time when the spenddown liability will be met if:

- the individual has already spent or owes for medical services received prior to, on, or after the first day of the month of application, and
- the individual anticipates medical expenditures in the near future.

E. Reapplying at the End of the Spenddown Period

The worker must inform the individual of the spenddown period and the need to file a reapplication if additional coverage is needed. If the individual is enrolled in the QMB, SLMB, or QDWI covered groups; *opted in and* is enrolled in Plan First and also meets a Medically Needy (MN) covered group; or is an MN Child Under Age 18 with $0 spenddown liability (see M0330.803), the system-generated Medicaid/FAMIS Renewal form may be used to establish new spenddown budget periods.

An individual on a spenddown who is living with Medicaid and/or FAMIS enrollees can use their Medicaid/FAMIS Renewal form to reapply; the reapplication is entered into VaCMS as a new application.

For all others, the Application for Health Insurance & Help Paying Costs is required to establish additional spenddown budget periods.

M1320.200 PROCESSING TIME STANDARDS

A. Applications

1. Processing Standards

The time standards for Medicaid eligibility determination must be met when determining spenddown. The processing time standards are:

- 90 days for applicants whose disability must be determined and
- 45 days for all other applicants

from the date the signed Medicaid application is received by the local agency.

2. Third Party Payment Verifications

The standards shall also apply to receipt of third party payment or verification of third party intent to pay in order to determine allowable expenses deductible from the spenddown liability. Efforts to determine the third party liability shall continue through the last day of the processing standard period of time. If information regarding third party liability for an incurred expense is not received by this date, eligibility must be determined without deducting the expense.

B. Changes

The time standard for evaluating a reported change is 30 days from the date the worker receives notice of a change in circumstances or a medical or dental expense submitted by the individual.



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Efforts to determine the third party liability shall continue through the last day of the processing time standard. If information regarding third party liability for an incurred expense is not received by this date, eligibility must be determined without deducting the expense.

M1320.300 ACTION ON APPLICATIONS

A. Case Action

When an applicant meets all the MN eligibility requirements except income, the application is denied and the applicant is placed on a spenddown.

B. Retroactive Period

When an applicant has old bills, the worker will determine the retroactive budget period and retroactive spenddown liability. Determination of the retroactive budget period is necessary in order to correctly deduct the old bills from the spenddown liability in the first prospective and consecutive budget periods. If there is no Medicaid-covered service in the retroactive budget period, do not evaluate retroactive Medicaid eligibility.

C. Notice to Applicant

A "Notice of Action on Medicaid..." (#032-03-008) is sent to the applicant. *Generate the notice from VaCMS, or print the form and* check the block in the third section, which states "Denied full coverage because income exceeds the income level". Enter the spenddown liability and the spenddown budget period begin and end dates in the appropriate section. Send a copy of the "Medical Expense Record - Medicaid" (#032-03-023) to the applicant for recording his medical expenses. See Appendix 1 to subchapter M1340.

M1320.400 SPENDDOWN CASE REVIEW REQUIREMENTS

A. Introduction

The individual must notify the worker when medical or dental expenses are incurred. The individual does NOT have to formally request a re-evaluation of his spenddown.

The individual should submit the "Medical Expense Record - Medicaid" together with bills or receipts for medical services either paid or incurred. Evidence of third party payment or denial of payment must be provided, if applicable.

B. *Submission of* Expenses

When the individual o*r a third party* submits medical expenses for re-evaluating the spenddown, a new application form is NOT completed.

Contact the individual and ask if his living situation, resources or income have changed since he signed the application form. If the individual reports any changes, request verification, evaluate accordingly, and record the changes in the case record.

There is no time limit for an individual to submit medical expenses for a spenddown; however, the worker will follow the processing time frame when the first medical bill for a spenddown is received.

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C. Eligibility Worker Actions

When verification of incurred expenses is received, the worker must record the expenses in the record, determine how much of the spenddown liability - evaluation at the end of the 30-day processing time frame for spenddown re-evaluations. The 30-day processing time frame begins the date the first medical bill for that spenddown is received in the agency.

2. Send Notice of Action

After completing a re-evaluation of the individual's spenddown, A "Notice of Action on Medicaid..." (#032-03-008) is sent to the applicant. *Generate the notice from VaCMS, or* print the form with the appropriate block checked. In the section marked "Other", tell the individual that he must complete a review or reapply in order to be evaluated for Medicaid after the spenddown period ends.

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CHAPTER M13
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SUBCHAPTER 30

SPENDDOWN BUDGET PERIODS

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M1330.000 SPENDDOWN BUDGET PERIODS

M1330.100 SPENDDOWN BUDGET PERIODS

A. Introduction

An individual's medically needy (MN) spenddown eligibility is determined based on the income received within a specified spenddown budget period. The spenddown budget period is based on the application month.

The spenddown budget periods are the:

- the retroactive budget period,
- first prospective budget period, and
- consecutive budget period.

B. Spenddown Budget Period Rules

1. Every Medicaid application has a retroactive period.

2. Budget periods are based on application months. Applications for non-institutionalized individuals create a 6-month prospective budget period. If another Medicaid application is in the month immediately after the end of the first prosepective budget period in which spenddown eligibility was established, the new application has no retroactive period and the subsequent spenddown budget period is a consecutive 6 months.

   If another application is not filed in the month immediately after the end of a spenddown budget period in which spenddown eligibility was established, the application has a retroactive budget period and a first prospective budget period. If the retroactive spenddown budget period abuts a prior spenddown budget period in which eligibility was established, the retroactive spenddown budget period is also a consecutive budget period.

3. When there is a 6-month prospective budget period in which spenddown eligibility is not established, part of that spenddown budget period may become a retroactive spenddown budget period based on a subsequent application.

4. Spenddown budget periods do not run consecutively when there is a break in spenddown eligibility.

5. The current budget period is the budget period for which spenddown eligibility is being determined.

6. The retroactive spenddown budget period is prorated when one or two of the months in the retroactive period were included in a medically needy spenddown budget period in which spenddown eligibility was established or in the case of death of the individual in the retroactive period.

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7. A retroactive spenddown budget period is always followed by a first prospective budget period.

8. The prospective spenddown budget period is prorated (shortened) when the only MN individual in the assistance unit dies, becomes ineligible for a reason other than income, becomes institutionalized, or becomes eligible in another Medicaid classification.

9. Deduction of old bills in a spenddown budget period depends on whether the expense was fully deducted in a previous spenddown budget period during which spenddown eligibility was established. If the expense was fully deducted in a previous spenddown budget period during which spenddown eligibility was established, it CANNOT be deducted in another spenddown budget period. If the expense was not fully deducted, the remaining balance for which the individual is liable may be carried forward and used as a deduction in a following spenddown budget period(s) if there is no break in spenddown eligibility.

10. **Paid** and unpaid expenses incurred during the retroactive spenddown budget period are deducted in the first prospective budget period to the extent that they were not used to meet the retroactive spenddown and remain the liability of the individual.

11. A break in spenddown eligibility does not necessarily mean that there is a break between budget periods. A break between spenddown budget period always means that that there is a break in spenddown eligibility.

M1330.200 RETROACTIVE SPENDDOWN BUDGET PERIOD

A. Policy

The retroactive spenddown budget period is the 3 months immediately prior to the application month if none of the months were included in a previous spenddown budget period in which spenddown eligibility was established.

Eligibility for retroactive Medicaid coverage must be determined in all cases if an individual received a Medicaid covered service during the three-month period prior to the month of application. This includes those applying for Auxiliary Grants or Medicaid. Eligibility for retroactive coverage is determined at the same time ongoing eligibility is determined, using the same application.

If an applicant states that a Medicaid covered service was received in any one of the 3 retroactive months, determine eligibility for all months included in the retroactive spenddown budget period. If the applicant states that a Medicaid covered service was not received in the retroactive months, do not determine retroactive eligibility.

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B. Months Included In The Retroactive Budget Period

The retroactive spenddown budget period consists of all 3 months in the retroactive period when none of the months was included in a previous Medicaid medically needy spenddown budget period in which spenddown eligibility was established. The retroactive spenddown budget period is prorated when one or two of the months in the retroactive period was included in a previous Medicaid medically needy spenddown budget period in which spenddown eligibility was established, or in the case of death. If all 3 retroactive months were included in a medically needy spenddown budget period in which spenddown eligibility was established, there is no retroactive spenddown budget period. If a month in the retroactive period was included in a previous medically needy spenddown budget period in which spenddown eligibility was established, that month(s) CANNOT be included in the retroactive spenddown budget period.

C. Income Counted

Only the actual income, minus income exclusions, received in the retroactive spenddown budget period is counted in determining retroactive eligibility. The countable income is applied to the appropriate Medically Needy Income Limit (MNIL) for the number of months actually included in the retroactive spenddown budget period. When the individual's countable income in the retroactive spenddown budget period exceeds the MNIL for the period, he has a spenddown liability for the retroactive spenddown budget period.

EXAMPLE #1: An individual's spenddown budget period ended April 30. He files an application for Medicaid in July and has a Medicaid-covered service in May and June (the second and third months of the retroactive period). The retroactive spenddown budget period based on his July application is prorated and consists of May and June because April was in a prior spenddown budget period in which spenddown eligibility was established. His countable income received in May and June is compared to the monthly MNIL for one person in the locality, multiplied by 2 months in the retroactive spenddown budget period.

EXAMPLE #2: A legally emancipated child age 17, living alone, applies for Medicaid on June 15. He has never applied for Medicaid before this application. He has a Medicaid covered service expense in the first retroactive month, March. The retroactive period is March, April and May. He meets the MI covered group and income requirements in April only. His income exceed the MI limit in March and May. The retroactive spenddown budget period is 3 months – March, April and May. His countable income in the 3 months is determined and the MN income limit for 1 person for 3 months is subtracted. The remainder is the spenddown liability for the retroactive spenddown budget period.

M1330.300 FIRST PROSPECTIVE BUDGET PERIOD

A. Policy

A first prospective budget period is 6 months for non-institutionalized individuals; 1 month for institutionalized individuals.

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The first prospective budget period is the period that begins:

- the first day of the month the individual first applied for Medicaid and is placed on a spenddown, or
- the first day of the month after the date Medicaid was canceled because of excess income, or
- when a new application is filed after a break in spenddown eligibility.

B. Income Counted

The gross income, minus applicable income exclusions, anticipated to be received by the applicant's assistance unit in the first prospective budget period is counted and compared to the MNIL. Countable income anticipated to be received in the application month is projected over the entire 6-month period, unless the first prospective budget period must be prorated. When the first prospective budget period is prorated, count the income received in the month(s) included in the prorated first prospective budget period and compare it to the MNIL for the same number of months. The difference is the spenddown liability.

C. Example – Individual's First Application For Medicaid

EXAMPLE #3: An individual first applies for Medicaid in July 1999 and has a Medicaid covered service in the retroactive period. He has never applied for Medicaid before. The retroactive period consists of April, May and June 1999. His countable income received for April 1999 through June 1999 is compared to the 3-months MNIL in the locality for one person. The first prospective budget period consists of July 1999 through December 1999. His countable income for July is projected for 6 months and compared to the semi-annual MNIL in the locality for one person.

D. Example – Medicaid Canceled Due To Excess Income

EXAMPLE #4: A Medicaid recipient's coverage is canceled because of excess income effective July 31, 1999. He is placed on a spenddown for the first prospective budget period of August 1, 1999 through January 31, 2000. His countable income for July is projected for 6 months. The semi-annual MNIL in the locality for one person is subtracted from his total countable income.

E. Example – Break In Spenddown Eligibility

EXAMPLE #5: A recipient's Medicaid spenddown eligibility is canceled because of excess resources effective May 31, 1999. He reapplies for Medicaid on October 13, 1999. He had a Medicaid covered medical expense in the retroactive period.

He is placed on a spenddown for the retroactive period of July – September 1999. His countable income received in July – September 1999 is compared to the 3-months MNIL in the locality for one person. The first prospective budget period is October 1, 1999 through March 31, 2000. His countable income for October is projected for 6 months. The semi-annual MNIL in the locality for one person is subtracted from his total countable income. For the 6-month spenddown budget period.



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M1330.400 CONSECUTIVE BUDGET PERIODS

A. Policy

Consecutive budget periods are any spenddown budget periods that occur when there is no interruption in spenddown eligibility. Consecutive budget periods can occur after there has been a break in spenddown eligibility IF spenddown eligibility has been re-established. A retroactive or prospective spenddown budget period is a consecutive budget period when it follows a spenddown budget period in which eligibility was established.

B. Income Counted

The gross income, minus applicable income exclusions, anticipated to be received by the applicant's assistance unit in a consecutive budget period is counted and compared to the MNIL. Countable income anticipated to be received in the application month is projected over the entire 6-month period, unless the consecutive budget period is prorated.

EXAMPLE #6: A non-institutionalized individual applies for Medicaid in July 1999 and has a Medicaid covered service in the retroactive period. The retroactive period consists of April, May and June 1999. The first prospective budget period consists of July 1999 through December 1999. He meets both spenddowns. On January 20, 2000, he files an application for Medicaid and is placed on a spenddown for the period January 2000 through June 2000. Because spenddown eligibility was established in the prior spenddown budget period, the January 2000 through June 2000 prospective budget period is a consecutive budget period. His countable income for January is projected is projected and the total is compared to the semi-annual MNIL in the locality for one person. He meets the spenddown for the period January 2000 through June 2000.

He files an application in July 2000 and is placed on a spenddown for the period July 2000 through December 2000, which is considered a consecutive budget period. He does not meet the spenddown for this period. A break in spenddown eligibility has occurred.

He files an application in January 2001 and is placed on a spenddown for the period January 2001 through June 2001, which is not a consecutive budget period. He meets the spenddown on May 2, 2001. He files an application in June 2001 and is placed on a spenddown for the period July 2001 through December 2001, which is a consecutive budget period.

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CHAPTER M13
SPENDDOWN
SUBCHAPTER 40

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M1340 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-20	7/1/21	Paged 4, 5
TN #DMAS-15	1/1/20	Pages 16, 18 Page 17 is a runover page.
TN #DMAS-14	10/1/19	Page 2, 18
TN #DMAS-12	4/1/19	Page 2
TN #DMAS-9	7/1/18	Pages 6a
TN #DMAS-7	1/1/18	Pages 18, 20, 22
TN #100	5/1/15	Pages 4, 5
TN #95	3/1/11	Page 6
TN #94	9/1/10	Page 6
TN #93	1/1/10	Page 18

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M1340.000 SPENDDOWN DEDUCTIONS

M1340.100 SPENDDOWN DEDUCTIONS

A. Introduction

Medical expenses incurred by the individual, family or a financially responsible relative that are not subject to payment by a third party are deducted from the individual's spenddown liability. An expense is incurred on the date liability for the expense arises. The agency must determine which incurred expenses can be deducted and must deduct those expenses in accordance with section M1340.200 below.

The policy and procedures for deducting old bills and incurred expenses are based on federal regulations which were developed to remove the incentive for individuals to not pay their old bills.

B. Policy

Only those medical, dental, or remedial care expenses incurred by the applicant, budget unit member(s) and the applicant's spouse and/or child in the household who is not included in the applicant's assistance unit, are considered as potential deductions from spenddown.

1. Legal Liability For Expense

Medical expenses, or portions of medical expenses, that are covered by Medicare or other health insurance are not legal obligations of the individual and cannot be deducted from spenddown. If the expense was covered by a state or local public program as defined in section M1340.1100, see that section.

If a legally responsible relative's income is deemed to the assistance unit, the legally responsible relative's incurred expenses are deducted from the unit's spenddown. When the legally responsible relative also has a spenddown liability that has not been met, the legally responsible relative must choose the spenddown from which the incurred expense is deducted. An incurred expense can be deducted from only one spenddown. If not totally used to meet the spenddown, the balance can be applied to another spenddown.

2. Projected Expenses

"Projected" expenses are for services that have not yet been rendered. Projected expenses for medical services cannot be deducted, except for nursing facility care. Expenses included in a prepaid package of services cannot be deducted prior to the date the service(s) is actually rendered. See subchapter M1460 or M1480 for nursing facility patients.

3. Chronological Deduction

Expenses are deducted in chronological order based on the date they are incurred. The date incurred is the date the service was received or, in the case of health insurance premiums *that are withheld from monthly benefit payments, the first day of the month the premium payment is due.*

4. Multiple Spenddown Periods

When an individual has established more than one spenddown period, medical expenses are first deducted from the spenddown period during which they were incurred. If not used to achieve eligibility, the bill can be evaluated for use in succeeding budget periods. Specific instructions for treatment of prior

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incurred expenses can be found in sections M1340.600, M1340.700 and M1340.800.

M1340.200 KINDS OF ALLOWABLE DEDUCTIONS

A. Policy To determine the allowable incurred expenses that will be deducted from *the spenddown liability*, the agency must identify the kind of service.

B. Kinds of Service In determining allowable incurred expenses, the medical or remedial care expenses listed below may be deducted from the spenddown liability.

1. Health Insurance Expenses Medicare and other health insurance premiums are allowable health insurance expenses. *See M1340.300*

2. Noncovered Services Expenses Noncovered services expenses are expenses incurred by the individual or family or financially responsible relative for necessary medical or remedial care services which are not covered by the Virginia Medicaid State Plan. Noncovered services include expenses for Medicaid-covered services that exceed the State Plan limits on the amount, duration and scope of services. Medicaid co-payments and deductibles on covered services are "noncovered services." Section M1340.400 lists noncovered services.

3. Covered Services Expenses Covered services expenses are expenses incurred by the individual or family or financially responsible relative for necessary medical or remedial care services which are covered by the Virginia Medicaid State Plan.

M1340.300 HEALTH INSURANCE PREMIUMS, DEDUCTIBLES, COINSURANCE

A. Policy Incurred expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, including deductibles and copayments imposed by Medicaid, are deducted from the spenddown liability.

B. Health Insurance Premiums Health insurance premium payments include:

1. Private Health Insurance Payments made from the applicant's own income for private medical insurance are allowed deductions. Income protection insurance **(**indemnity) policy premiums are not medical expenses and are not deducted from the spenddown liability.

2. Medicare Premiums Medicare Part A, Part B and/or *Part D* premium payments are allowed deductions when the premiums are paid from the applicant's own income.

3. Amount Deducted The amount deducted is the amount of the premium paid.

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4. When Deducted

A health insurance premium is deducted from the spenddown liability when the monthly premium is due. The worker cannot deduct a pre-paid premium that is paid before the month the premium is due.

When a health insurance premium is withheld from the individual's monthly benefit check, the premium is deducted on the first day of the month. For example, the individual receives a Social Security benefit from which is deducted the Medicare Part B premium. The Social Security check is dated December 13. The Medicare Part B premium is deducted from the individual's spenddown liability on December 1.

C. Deductibles, Coinsurance, and Copayments

Deductibles, coinsurance and co-payment amounts are those portions of a medical services expense which the health insurance policy designates as the individual's responsibility to pay. The health insurance policy will not pay these amounts.

1. Amount Deducted

The amount deducted is the amount of the deductible, coinsurance or co-payment owed for the service.

2. When Deducted

A deductible, coinsurance or co-payment amount is deducted from the spenddown liability on the date the service was received.

D. Verification

Verification of health insurance premiums, deductibles, coinsurance and copayment amounts include:

- a copy of the insurance premium notice,
- the explanation of benefits paid by health insurance,
- *the statement, or a copy of the statement, from the Medicare Part D prescription drug plan (PDP),*
- Medicaid co-pays and deductibles as listed in chapter M18, or the Virginia Medicaid Handbook**.**

M1340.400 NONCOVERED SERVICES

A. Policy

Noncovered services expenses are incurred expenses for necessary medical or remedial care services which are not covered by the Virginia Medicaid State Plan, including the amounts for covered services that exceed the State Plan limits on amount, duration and scope of services. Noncovered services must be ordered by a physician or dentist in order to be deducted.

Noncovered services expenses are deducted on the date the service was rendered**.** For medical supplies and equipment that are ordered, the date of service is the date the supply or equipment was delivered to the individual. Expenses included in a prepaid package of services cannot be deducted prior to the date the service(s) is actually rendered.

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B. Noncovered Services

Noncovered services (not covered by Medicaid) include:

1. services of other licensed practitioners of the healing arts such as chiropractors, naturopaths or acupuncturists, unless the services are covered by Medicare and the individual has Medicare.

2. professional nursing services in an individual's home when prescribed by the individual's physician and the cost is not part of a home health program or a Medicaid CBC waiver.

3. medical services provided by non-participating providers (providers who do not participate in Virginia Medicaid) unless the services are covered by Medicare and the individual has Medicare.

4. over-the-counter medications and medical supplies when ordered by a physician and the cost is not covered by Medicaid or Medicare, if the individual has Medicare.

C. Not Medical/ Remedial Care Services

The following are examples of services that are NOT medical/remedial care services and CANNOT be deducted from a spenddown liability, even if ordered by a physician:

- air conditioners or humidifiers,
- refrigerators, whole house generators and other non-medical equipment,
- assisted living facility (ALF) room & board and services**,**
- personal comfort items, such as reclining chairs or special pillows,
- health club memberships and costs,
- animal expenses such as for seeing eye dogs,
- cosmetic procedures.

D. Verification

Verification of noncovered services expenses includes:

1. a copy of the provider's bill or the insurance company's explanation of benefits paid, that shows:
   - the amount still owed that is the patient's responsibility, and
   - the service provider's name, address, and profession.
2. a prescription, physician's referral, or statement from the patient's physician or dentist that the service was medically necessary.

M1340.500 COVERED SERVICES

A. Policy

Covered services expenses are incurred expenses for necessary medical or remedial care services which are covered by the Virginia Medicaid State Plan. Covered services expenses are deducted on the date the service was rendered. For medical supplies and equipment that are ordered, the date of service is the

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date the supply or equipment was delivered to the individual. Expenses included in a prepaid package of services cannot be deducted prior to the date the service(s) is actually rendered.

B. Covered Services

Some of the medical services covered by Medicaid, and the limits on these services, are described in chapter M18. Medicaid covered services include:

- inpatient and outpatient hospital care
- physicians' services
- *dental services*
- prescription drugs
- lab and x-ray services
- nursing facility care
- home health care
- rehabilitative services
- psychiatrists' and psychologists services
- licensed clinical social worker and licensed professional counselor services
- physical therapy services
- medical supplies and equipment
- transportation to secure medical care which is purchased, not provided in the individual's own vehicle.

C. Verification

Medical supplies and drugs must be prescribed or ordered by a physician or dentist.

Covered services expenses verification includes:

1. A copy of the provider's bill or the insurance company's explanation of benefits paid, that shows:
   - the amount still owed that is the patient's responsibility, and
   - the service provider's name, address, and profession.
2. Documentation that the service is or was medically necessary. Documentation can include a prescription, physician's referral, statement from the patient's physician or dentist, or authorization from a licensed mental health provider or other individual as specified by DMAS to authorize a Medicaid covered service.

D. Medicare Part D Prescription Drug Expenses

Because enrollment in Medicare Part D is voluntary, not all Medicare beneficiaries will be enrolled in a Medicare PDP. For those enrolled in a PDP, not all drugs will be covered. Each PDP may have a different combination of deductibles, co-pays and coverage gaps.

The PDP must issue a periodic (at least monthly) statement to the beneficiary explaining all benefits paid and denied, and any deductible and/or co-pays incurred by the beneficiary. Use the PDP statement to verify prescription drug costs that remain the beneficiary's responsibility.

To determine if drug costs incurred by Medicare beneficiaries are allowable under spenddown, apply the following rules:



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1. **Beneficiary NOT In Medicare PDP on Date of Service**

If the Medicare beneficiary was not enrolled in a Medicare PDP on the date of the prescription drug service, allow the prescription drug cost that is the responsibility of the beneficiary as a spenddown deduction.

2. **Beneficiary in Medicare PDP on Date of Service**

If the Medicare beneficiary was enrolled in a Medicare PDP on the date of service, allow the prescription drug cost (deductible, co-pays and/or coverage gap) that is the responsibility of the beneficiary as a spenddown deduction.

3. **PDP Denies Drug Coverage**

If a Medicare PDP denies coverage of a prescription drug, the beneficiary has the right to request an exception for coverage of the drug. The beneficiary is notified in writing of the decision on any exception requested.

- Do NOT allow the charge if the drug charge appears on the statement as a denial and no exception was requested.
- Allow the charge if the drug charge appears on the statement as a denial, and an exception was requested and denied.

Medicare beneficiaries who are enrolled in a Medicare PDP should be advised to keep their statements and other related documentation for consideration under spenddown.

M1340.600 OLD BILLS

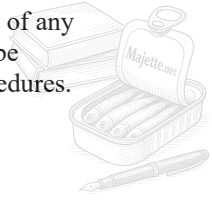
A. Policy

Old bills are any unpaid medical, dental and/or remedial care expenses incurred prior to the retroactive period based on an initial application. Unpaid medical, remedial, and dental care expenses incurred prior to a re-application and its retroactive period may also be deducted as old bills provided that:

- they were not incurred during a prior spenddown budget period, in which spenddown eligibility was established, *or*
- *they were incurred during the retroactive period if the individual either did not meet the retroactive spenddown or was not eligible for Medicaid in the retroactive period (for example, due to excess resources), and*
- they were not fully deducted from any previous spenddown that was met, and
- they remain the liability of the individual.

Old bills may include medical bills that were paid by a state or local program.

An unused portion of an old bill which is still the liability of the individual may be applied to a future consecutive spenddown budget period(s) only if there is no break in spenddown eligibility. If there is a break in spenddown eligibility, only current payments made on old bills based on a prior spenddown application can be deducted in the current budget period. The old bill from a prior application is no longer an "old bill" as defined in section M1310.300. Only the amount of any "current payment" made on that expense in the current budget period can be deducted. Go to section M1340.800 for current payments policy and procedures.



B. Procedures Decide whether an old bill is deducted using the following procedures:

1. Verification Request the following verification from the individual or his representative:

- proof that the bill is still owed *to the medical provider;*

  – *Use of a credit card: if the individual has used a credit card to pay an old bill and the provider is satisfied the bill as being paid, the individual has paid the provider. The amount is now owed to the credit card company and no longer considered an old bill.*

  – *Unpaid bill in collections: The worker will need to determine the status of the unpaid bill in collections. If the provider is using a third party entity to collect an old bill and the amount is still owed directly to the provider, it would be counted as an old bill. If the provider has "written" or "charged" off an old bill, it would no longer be recognized as being owed, thus would not be counted as an old bill. If a collection agency has 'purchased' a charged off debt from the provider and is attempting to collect, the individual owes the collection agency, and not the provider. Though still an owed amount, it is not recognized as an old bill.*

- if applicable, the amount owed that was not covered by the patient's insurance or liable third party,

- the service provider's name, address, and profession

- proof the service was medically necessary (prescription, physician's referral, statement from the patient's physician or dentist).

2. Determine Amount of Deduction Upon receipt of the requested documentation, determine the unpaid balance still owed on the old bill minus the amount used to meet a prior spenddown, if any.

3. Subtract The Old Bill Subtract the old bill amount from the spenddown liability on the first day of the spenddown budget period according to policy in subsection A above.

C. Example--Deduct Balance of Old Bill **EXAMPLE #1:** The application month is October 1999. The individual never applied for Medicaid before October 1999. He did not receive a Medicaid-covered service in the retroactive period. The spenddown liability for the first prospective budget period October 1999 through March 2000 is $560. The individual provides verification that he still owes $100 for a medically necessary service received in May 1999 (prior to the retroactive period). The $100 old bill is deducted from the first prospective budget period spenddown liability, leaving him a spenddown balance of $460 on October 1, 1999.

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M1340.700 CARRY-OVER EXPENSES

A. Policy

Carry-over expenses are unpaid medical or remedial care expenses that:

- were incurred within a retroactive or prospective budget period in which spenddown eligibility was established,
- remain the liability of the individual, and
- were not fully counted in any previous spenddown that was met.

Note: Old bills never become carry-over expenses because old bills, by definition, are incurred outside a spenddown budget period in which spenddown eligibility was established. Carry-over expenses are incurred during a spenddown budget period in which spenddown eligibility was established.

B. Procedures

Determine if the carry-over expenses are fully or partially deducted by using the following procedures:

1. Verification

Request the following verification from the individual or his representative:

- proof that the amount of the carry-over expense is still owed,
- if applicable, the amount owed that was not covered by the patient's insurance or liable third party;
- the service provider's name, address, and profession,
- proof that the service was medically necessary (prescription, physician's referral, or statement from the patient's physician or dentist).

2. Determine Amount of Deduction

Upon receipt of the requested documentation, determine the amount of the expense that can be deducted from the spenddown liability for the current spenddown budget period. Any amount of the expense that was deducted from a previous spenddown that was met CANNOT be deducted in the current spenddown budget period.

3. Subtract Carry-over Expense

Subtract the carry-over expense amount that was not used to meet a previous spenddown from the spenddown liability on the first day of the current spenddown budget period, after deducting old bills.

C. Remaining Balance

The remaining balance of carry-over expenses is applied to the spenddown liability of the next consecutive budget period. If that spenddown is met and there is still a balance remaining on the carry-over expenses, that remaining balance may be deducted in subsequent consecutive budget periods until there is a break in spenddown eligibility.

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When a break in spenddown eligibility occurs, only the amount of "current payments" made on that expense in the current spenddown budget period can be deducted from the spenddown liability. See Current Payments on Expenses in section M1340.800 below.

D. Example--Carry-over Expenses

EXAMPLE #2: An individual has been on spenddowns consecutively during the two previous 6-month periods (April through September and October through March). He met both spenddowns. He reapplies for Medicaid on April 1. The spenddown liability for April through September is $560. The individual provides verification that he still owes $100 for a medically necessary noncovered service he received the prior November. The $100 is a carry-over expense and is deducted from the current spenddown budget period's spenddown liability on the first day of the current spenddown budget period (April through September), leaving him a spenddown balance of $460 on April 1.

M1340.800 CURRENT PAYMENTS ON EXPENSES

A. Policy

Current payments are payments made in the current spenddown budget period on unpaid balances of old bills or carry-over expenses incurred before the current spenddown budget period:

- which were not fully used in establishing eligibility in a previous spenddown budget period, and
- when there has been a break in spenddown eligibility.

B. Procedures

Decide whether a current payment is deducted using the following procedures:

1. Verification

Request the following verification from the individual or his representative:

- proof that the expense is still owed,
- if applicable, the amount owed that was not covered by the patient's insurance or liable third party,
- the service provider's name, address, and profession,
- proof that the service was medically necessary (prescription, physician's referral, or statement from the patient's physician or dentist), and
- the amount, frequency and dates of the payments made.

2. Determine Amount of Current Payment

Upon receipt of the requested documentation, determine if there is any remaining amount of the expense that was not used to meet a previous spenddown. If an amount remains, the amount of the current payment can be deducted.



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3. Subtract Current Payment

Subtract the payment(s) made in the current spenddown budget period from the current spenddown liability, effective the date the payment is made to the provider.

C. Examples

1. Current Payment on Unpaid Balance of Old Bill

EXAMPLE #3: A request for Medicaid is filed on July 5, 1999. The individual had a prior spenddown application dated July 1996 for the period July 1996 through December 1996, which was met. She also had an application filed in January 1999, which was approved as CNNMP January 1, 1999 and closed March 31, 1999, due to excess countable resources. No medical, dental, or remedial services were received during the retroactive period based on the July 1999 application (April 1, 1999 through June 30, 1999).

The first prospective budget period based on her July 5, 1999 re-application is July 1, 1999 through December 31, 1999. The individual provides verification that she still owes $100 for a medically necessary dental service she received back in March 1996, which is an old bill based on her July 1996 application and which was not used to meet the July 1996 through December 1996 spenddown. She pays the dentist $10 per month on this old bill. Because there was a break in her spenddown eligibility, only the current payment she makes on the March 1996 dental bill can be deducted from her current spenddown. The $10 current payment is deducted on July 8, 1999, the date she makes the payment.

2. Current Payment on Carry-over Expense

EXAMPLE #4: The individual has been on spenddowns consecutively during the two previous 6-month periods which were July 1, 1998 through December 31, 1998 and January 1, 1999 through June 30, 1999. His spenddown liability for each spenddown budget period was $600. He provided verification of a $1,000 bill for a medically necessary noncovered service he received in February 1998. His first spenddown was met by deducting $600 of the $1,000 old bill from the spenddown liability. The remaining $400 balance of the old bill was deducted from his second spenddown liability but eligibility was not established.

He reapplies for Medicaid in July 1999. Because he did not establish eligibility by meeting a spenddown in the spenddown budget period preceding the current spenddown budget period (July through December) only the current payments made on the February 1998 noncovered service can be deducted from his current spenddown liability. These payments are deducted on the date(s) they are actually made. He makes payments of $10 per month on the expense. On July 5, 1999, he makes a $10 payment. This payment is a current payment and is deducted from the current spenddown budget period's spenddown liability. Subsequent payments made in the current spenddown budget period will be deducted on the date made.

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M1340.900 WHEN TO DEDUCT INCURRED EXPENSES

A. Incurred Expenses

When determining allowable incurred expenses, the agency must identify the following:

1. Retroactive Spenddown Budget Period

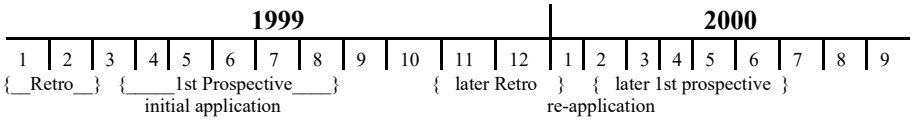
a. The First Retroactive Spenddown Budget Period

The first retroactive spenddown budget period is the retroactive spenddown budget period based on an individual's initial Virginia Medicaid medically needy spenddown application. In the first retroactive spenddown budget period, deduct:

- old bills, and
- paid or unpaid expenses incurred during the retroactive spenddown period.

b. A Later Retroactive Spenddown Budget Period

1) Break in Spenddown Eligibility



a) Policy

In a later retroactive spenddown budget period based on a Virginia Medicaid re-application filed when there is a break in spenddown eligibility, deduct:

- old bills based on the re-application month,
- current payments made on all expenses incurred prior to the first day of the most recent break in spenddown eligibility, and
- paid or unpaid expenses incurred during the retroactive period based on the re-application month,

to the extent that the expenses have not been deducted previously in establishing spenddown eligibility.

In a later retroactive budget period when there has been a break in spenddown eligibility, balances on "old bills" based on previous applications are only deducted as current payments.

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b) Procedures

Determine if the expense was incurred in a prior spenddown budget period. If the expense was incurred in a prior spenddown budget period that has already been met and the expense was incurred prior to the date the spenddown was met, recalculate the spenddown eligibility using this expense. If the spenddown is met on an earlier date, re-enroll the individual with an earlier eligibility begin date using “Type 4" eligibility.

If the expense was incurred in a prior spenddown budget period in which the spenddown was not met, determine if the expense meets the spenddown in that period. If the expense meets the spenddown, the individual establishes spenddown eligibility in that period, effective the date the spenddown is met. If the expense does not meet the spenddown, the expense may be an old bill based on a subsequent re-application.

A re-application’s retroactive period may include months that were included in a previous spenddown budget period that was not met. See section M1330.200 for policy regarding the retroactive spenddown budget period.

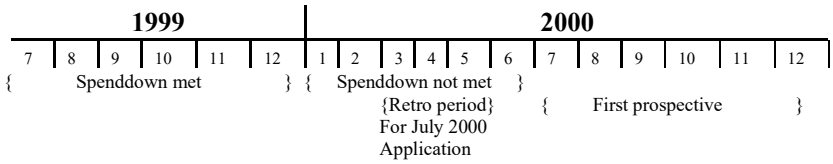
Re-evaluate whether a break in spenddown eligibility has occurred. If a break in spenddown eligibility has occurred, then all expenses incurred prior to the re-application’s retroactive period and subsequent to the last day of the last spenddown budget period that was met and which were not fully used to establish spenddown eligibility in any prior spenddown budget period that was met should be evaluated for deductions as old bills for the new application.

If a break in spenddown eligibility has not occurred, go to section 2. below for procedures to use when no break in spenddown eligibility has occurred.

EXAMPLE #5: Mr. Smith’s initial application was filed July 1999. He was placed on a spenddown for the period July 1999 through December 1999. He met the spenddown on August 15, 1999. He reapplied for Medicaid on January 8, 2000. He was placed on a spenddown for the period January 2000 through June 2000. He did not meet the spenddown for that period (January 2000 through June 2000). He reapplies for Medicaid July 19, 2000. The retroactive period for the July 2000 re-application is April 2000 through June 2000. Because he did not establish spenddown eligibility in the January 2000 through June 2000 spenddown budget period, his July 2000 application has a retroactive spenddown budget period consisting of April, May and June 2000.

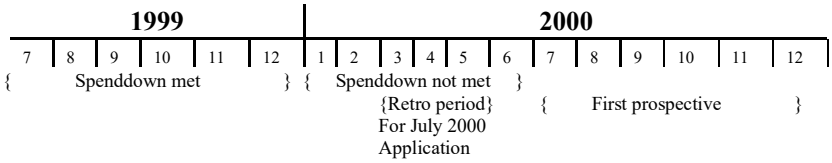
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He presents a bill for a medical expense he incurred on March 3, 2000. The worker determines that the expense was incurred in a previous spenddown budget period that was not met (January 2000 through June 2000). The worker recalculates Mr. Smith's spenddown eligibility for that period by deducting the expense from the January 2000 through June 2000 spenddown liability. He does not meet the spenddown for the period January 2000 through June 2000. The worker next evaluates his eligibility for the retroactive spenddown budget period, April 2000 through June 2000. The March 2000 expense is an old bill based on the July 2000 re-application and is deducted on the first day of the retroactive spenddown budget period, April 2000.

EXAMPLE #6: Ms. Jones' initial application was filed in July 1999. She was placed on a spenddown for the period of July 1999 through December 1999. She met the spenddown on September 2, 1999. She re-applied on January 10, 2000 and was placed on a spenddown for the period of January 2000 through June 2000. She did not meet the spenddown for that period (January 2000 through June 2000). She re-applies for Medicaid on July 5, 2000. The retroactive period for July 2000 re-application is April 2000 through June 2000. Because she did not establish spenddown eligibility in the January 2000 through June 2000 spenddown budget period, her July 2000 re-application has a retroactive spenddown budget period consisting of April, May and June.



The worker calculates the spenddown liability for the retroactive spenddown budget period. The worker re-evaluates the bills in the case record which were submitted during the previous spenddown budget period (January 2000 through June 2000). The expenses incurred January 2000 through March 2000 are old bills if they remain the liability of Ms. Jones. The old bills are deducted on the first day of the retroactive spenddown budget period and the paid and unpaid expenses incurred during the spenddown budget period are deducted chronologically.

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2) No Break in Spenddown Liability

A later retroactive spenddown budget period based on a Virginia Medicaid re-application filed when there is no break in spenddown eligibility is also a consecutive budget period. Go to section 3. below for "Consecutive Budget Period".

2. First Prospective Budget Period

a. The First Prospective Budget Period

When the first prospective budget period is the prospective budget period based on an individual's initial Virginia Medicaid medically needy spenddown application and there is a retroactive spenddown budget period, deduct:

1) unpaid balances on old bills carried forward from the retroactive spenddown budget period that were not used to meet the retroactive spenddown. The unpaid balance on an old bill is deducted from the first prospective budget period when:

   - there is no retroactive spenddown budget period, or
   - the individual was eligible without a spenddown in the retroactive period, or
   - the individual does not meet the retroactive spenddown, or
   - the individual meets the retroactive spenddown without using all of the balance of the old bill(s).

2) paid or unpaid expenses incurred during the retroactive spenddown budget period that were not used to meet the retroactive spenddown, including any co-pays, etc., incurred while the individual was eligible for Medicaid in the retroactive period.

3) paid or unpaid expenses incurred during the first prospective budget period.

b. A Later First Prospective Budget Period

A later first prospective budget period is a budget period based on a Virginia Medicaid re-application filed when there **has been** a break in spenddown eligibility. In this budget period, deduct:

- unpaid balances on old bills based on the re-application month **(balances on old bills based on previous applications cannot be deducted as old bills; they may be deducted as current payments),** which are carried forward from the re-application's spenddown retroactive budget period and were not used to meet the re-application's retroactive spenddown.

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- current payments made on all expenses (not used previously) incurred prior to the first day of the most recent break in spenddown eligibility;

- paid or unpaid expenses incurred during the retroactive spenddown budget period based on the re-application month, that were not used to meet the retroactive spenddown, including any co-pays, etc., incurred while the individual was eligible for Medicaid; and

- paid or unpaid expenses incurred during the first prospective budget period based on the re-application month,

to the extent that the expenses have not been deducted previously in establishing spenddown eligibility.

EXAMPLE #7: In Example #6 above, Ms. Jones established spenddown eligibility in the retroactive budget period on April 1 by deducting a portion of the old bills incurred in January, February and March 2000. The remaining balance of the old bills from January, February and March 2000 is deducted from her spenddown liability in the first prospective budget period that begins July 1, 2000 and ends December 31, 2000.

She verifies that she started making payments on July 1, 2000, on a noncovered medical expense she incurred in December 1999 which was prior to January 1, 2000, the first day of the most recent break in spenddown eligibility. The payment she made on July 1 is deducted on July 1 as a current payment. She submits a receipt for payment of a dental service she received on May 2, 2000. This expense is deducted from the spenddown liability on the first day of the later first prospective budget period (July 1, 2000). Any medical expenses she incurs during the later first prospective budget period are deducted on the date incurred.

3. Consecutive Budget Period

In a consecutive budget period, deduct:

a. unpaid balances on old bills carried forward that were not used to meet a previous spenddown,

b. carry-over expenses incurred during the retroactive spenddown budget period, the first prospective spenddown budget period, and/or a subsequent spenddown prospective budget period which were not deducted previously in establishing spenddown eligibility, IF:

- the individual established eligibility in each spenddown budget period preceding the current spenddown budget period, AND

- the expenses are unpaid and remain the individual's liability, are allowable by kind of service and are carried over from the preceding spenddown budget period(s) because the individual met each preceding spenddown without deducting all such incurred unpaid expenses,

c. paid or unpaid expenses incurred during the current spenddown budget period, and.

d. current payments made on all expenses (not used previously) incurred prior to the first day of the most recent break in spenddown eligibility.

B. Order of Deduction

The agency must deduct allowable incurred expenses that are the liability of the individual (see section M1340.1100 for expenses paid by a state or local program). Expenses are deducted in chronological order (date of service) first, and then by kind of service if multiple kinds are received on the same date.

Expenses, including expenses in a prepaid package of services, cannot be deducted prior to the date the service(s) is actually rendered.

1. Chronological Order

a. Unpaid balances on old bills and/or carry-over expenses are deducted first, on the first day of the spenddown budget period.

b. Paid or unpaid expenses incurred within the current spenddown budget period are deducted in chronological order by date of service.

c. Current payments are deducted in chronological order by the date of payment.

2. Kind of Service

If multiple service expenses are incurred on the same day, the expenses are deducted on that date in the following order:

a. expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, including enrollment fees, deductibles and copayments imposed by Medicaid.

b. noncovered services - expenses for necessary medical or remedial care services which are not covered by the Virginia Medicaid State Plan, including those that exceed the plan's limits on amount, duration and scope of services.

c. covered services - expenses for necessary medical or remedial care services which are covered by the Virginia Medicaid State Plan.

M1340.1000 THIRD PARTY PAYMENTS

A. Policy

A third party is any individual, entity, or program that is or may be liable to pay all or part of the individual's expenses for medical or remedial care

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services recognized under state law.

An incurred medical expense cannot be deducted from the spenddown liability until the third party has made a decision to either deny or make some payment on the expense. Only that portion of the expense which is the applicant's legal responsibility shall be deducted from excess income in determining spenddown eligibility, unless the expense was covered by a state or local public program. If the expense was covered by a state or local public program, see section M1340.1100 below.

The application processing time standards apply to the receipt of third party payment or verification of third party intent to pay. Efforts to determine the liability of a third party shall continue through the last day of the application processing time standard (90 days for disability determinations; 45 days for all other applicants). If information regarding third party liability is not received by this date, eligibility must be determined based on the information available, if any, about the actual amount of the third party's payment.

If the amount subject to payment by a third party cannot be determined based on information available, the bill in question to which the third party liability applies cannot be used in determining spenddown eligibility. However, if information becomes available at a later date, the spenddown eligibility shall be redetermined and the effective date of spenddown eligibility revised.

Exception: In the case of an individual covered by Medicare who receives a service from a Community Services Board (CSB), the service may be used as a spenddown deduction per M1340.1100 without requiring that Medicare first be billed for the service as long as the CSB provides a statement that the service is not covered by Medicare.

B. Determining The Amount of The Third Party Payment

Determine the balance of the expense for which the individual is legally liable to pay. Use the third party's explanation of benefits paid (EOB) or similar statement received by the individual which shows the date of service, type of service, service provider, amount charged, amount approved, and amount paid by the liable third party.

Use the EOB's statement of the individual's responsibility as the amount to deduct from the spenddown liability. If the EOB does not show this amount, calculate the individual's responsibility.

1. Service Provider Accepts Approved Charges

When the service provider accepts the third party's approved charges, subtract the amount of the third party's payment from the approved charges. The remainder is the individual's responsibility and is the amount deducted from the spenddown liability.

2. Service Provider Does Not Accept Charges

When the service provider does NOT accept the third party's approved charges, subtract the amount of the third party's payment from the provider's charges. The remainder is the individual's responsibility and is the amount deducted from the spenddown liability.



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C. Procedures

1. Worker

a. Inform the applicant that:

1) an expense cannot be deducted until his/her insurance or other third party, if applicable, has taken action on the claim

2) the applicant must provide evidence documenting:

- the claim was denied, or
- the amount paid by the third party on the claim.

3) only the amount not covered by the third party(ies) and which remains the liability of the individual may be deducted from the spenddown (unless the expense was covered by a state or local public program as described in section M1340.1100 below).

b. The EW must take reasonable measures to determine the liability of a third party to pay for the incurred expense. However, because of the application processing time standards, do not delay a spenddown determination simply because the third party has not yet made payment or has not yet denied the expense. Complete the determination without deducting the expense. Note the medical expenses submitted but not deducted due to pending TPL on the Medical Expense Record. Notify the applicant of the decision and of which bills (expenses) were not used in the determination because documentation of the third party's action was not received.

2. Applicant

The applicant is responsible to submit:

- verification that a claim for the incurred expense was submitted, and
- evidence of the third party's denial or amount of payment.

M1340.1100 STATE OR LOCAL PUBLIC PROGRAMS

A. Policy

Expenses for incurred medical services received

- for which the applicant is or was legally liable, and
- which were or will be provided, covered, or paid for by a state or local (or territorial) public program

can be deducted from the spenddown even though the applicant does not owe anything for the service.

Expenses covered by federally-funded and/or administered programs such as Medicare and Medicaid cannot be deducted from spenddown. Local health department programs, although administered by the Virginia Department of Health, are not state or local public programs because the health departments receive some federal funds.

B. State or Local Public Programs

State or local public programs are state or local public health care programs which are wholly or partially funded and administered by local government,

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and which do not have any federal funding or administration. State or local public programs include, but are not limited to:

1. General Relief (GR)
2. Community Service Boards (CSB) services.
3. Department of Behavioral Health and Developmental Services (DBHDS) institutional services.
4. Virginia Commonwealth University (VCU) Health System and University of Virginia (UVA) Health System clinics, care centers, and hospitals
5. Crime victims compensation (Virginia Workers Compensation Commission)
6. Local "free" clinics funded and administered by local governments that do not charge any fee to any patient for any service.
7. Community Services or Neighborhood Assistance programs.

C. Procedures

1. Worker

a. Inform the applicant that expenses for medical services for which the applicant was legally liable and which were provided, covered, or paid for by a state or local public program will be deducted from the spenddown even though the applicant does not owe anything for the service.

b. The EW must take reasonable measures to determine the public program's payment or coverage of the medical or remedial care service. However, because of application processing time standards, do not delay a spenddown determination because the public program's payment is not verified. Complete the determination without deducting the expense, notify the applicant of the decision and that the public program expense(s) was not used in the determination because verification was not received

Exception: In the case of an individual covered by Medicare who receives a service from a CSB, the service may be used as a spenddown deduction without requiring that Medicare first be billed for the service as long as the CSB provides a statement that the service is not covered by Medicare.

2. Applicant

The applicant is responsible to submit:

- verification that the medical/remedial service was received and that a claim for the incurred expense was submitted, and
- evidence of the public program's amount of payment for the service.

M1340.1200 SPENDDOWN LIABILITY CALCULATION

A. Retroactive Spenddown Budget Period

The procedures for calculating a retroactive spenddown liability for a spenddown budget period follow:

1. Determine the total income for the assistance unit in each of the 3 retroactive months.

2. Subtract the appropriate ABD or F&C medically needy income exclusions from each month's total income. The remainder is the monthly countable income for each month.

3. Add each month's countable income together; the result is the countable income for the retroactive spenddown budget period.

4. Subtract the 3-months MNIL for the number of persons in the assistance unit in the locality group from the countable income for the retroactive spenddown budget period.

5. The remainder is the retroactive spenddown liability.

B. Prospective Budget Period

The procedures for calculating liability in a prospective budget period follow:

1. Determine total income anticipated to be received by the assistance unit in the application month.

2. Subtract the appropriate ABD or F&C medically needy income exclusions from the monthly income. The remainder is the monthly countable income.

3. Multiply the monthly countable income by 6 (6 months in the spenddown budget period). The result is the countable income for the spenddown budget period.

   NOTE: This procedure is not applicable to long-term care.

4. Subtract the semi-annual (6 months) MNIL for the number of persons in the assistance unit in the locality group from the countable income.

5. The remainder is the spenddown liability.

M1340.1300 SPENDDOWN ENROLLMENT

A. Retroactive Spenddown Budget Period

Enrollment in Medicaid begins the date the retroactive spenddown was met - the date within the retroactive period that the spenddown liability amount, after deducting incurred expenses, reached zero. When the spenddown is not met, retroactive spenddown eligibility does not exist.

- When the retroactive spenddown is met entirely by old bills or carry-over expenses, eligibility begins the first day of the retroactive spenddown budget period.

- When the retroactive spenddown is met by current payments or expenses incurred during the retroactive spenddown budget period,



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eligibility begins the date the retroactive spenddown was met.

If the individual continues to meet the MN requirements, eligibility continues for the remainder of the retroactive spenddown budget period.

1. Begin Date The coverage begin date is the date the spenddown was met.

2. End Date The end date of Medicaid eligibility is the end date of the retroactive spenddown budget period, if the individual continued to meet the MN requirements throughout the period.

3. Coverage Type Enroll the individual in "Type 2" retroactive coverage. Coverage will automatically end after the coverage period end date.

4. *Aid Category* The *aid category* for the individual is the medically needy (MN) *aid category (AC*) of the individual's MN covered group.

5. Reference See Appendix 1 of this subchapter for further examples of retroactive spenddown budget periods.

B. Prospective Budget Period Enrollment in Medicaid begins the date the spenddown was met - the date within the prospective budget period that the spenddown liability amount, after deducting incurred expenses, reached zero. When the spenddown is not met, eligibility does not exist.

* When the spenddown is met entirely by old bills or carry-over expenses, eligibility begins the first day of the prospective budget period.

* When the spenddown is met by current payments or by expenses incurred during the prospective budget period, eligibility begins the date the spenddown was met.

If the individual continues to meet the MN requirements, eligibility continues for the remainder of the prospective budget period.

1. Begin Date The coverage begin date is the date the spenddown was met.

2. End Date The end date of coverage is the end date of the prospective budget period, if the individual continues to meet the MN requirements throughout the prospective budget period.

3. Coverage Type Enroll the individual in the appropriate coverage type.

4. *Aid Category* The *aid category* for the individual is the medically needy (MN) *aid category (AC)* of the individual's MN covered group.

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C. Example--First Prospective Budget Period

EXAMPLE #8: Mr. Not lives in Group III and applied for Medicaid on November 21, 1999, as disabled. The MDU determined that he is disabled. He had been on Medicaid once before after meeting a spenddown; his Medicaid was canceled at the end of the spenddown period on May 31, 1999.

He has an $8,400 hospital bill and a $1,500 physician's bill for July 10 to July 20, 1999 (total $9,900) on which he still owes a total of $9,000. He incurred a $578 outpatient hospital bill on October 3, 1999, which he paid. He has no health insurance. His income is $800 per month disability benefit from a private company. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His resources are within the Medicaid limit in November 1999 (application month).

The first prospective budget period is November 1, 1999 through April 30, 2000. The income limit is $1,950. His spenddown liability is $2,730:

$ 800	disability benefit
- 20	general income exclusion
780	countable income
x 6	months
4,680	countable income for first prospective budget period
-1,950	MNIL for first prospective budget period Group III
$2,730	first prospective spenddown liability

His verified balances on the July 1999 services (incurred during the break in spenddown budget periods) are old bills. His eligibility is calculated:

$ 2,730	spenddown liability
- 2,730	July hospital bill (old bill for November 21 application)
$ 0	spenddown balance on November 1, 1999

Because the spenddown was met on November 1, 1999, Mr. Not is entitled to Medicaid for the period November 1, 1999 - April 30, 2000. The unpaid balance of old bills not used to meet the spenddown can be applied to the budget period beginning May 1, 2000, if another application is filed and he is placed on a spenddown.

D. Example--Consecutive Budget Period

EXAMPLE #9 ***(Using June 2000 figures)*****:** Ms. Sub lives in Group I and applied for Medicaid on June 6, as disabled. She had applied the previous December and was on a retroactive spenddown for the period September 1 through November 30, which she met on September 12. She met her December 1 through May 31 spenddown on January 2. She verifies that she has a $1,300 noncovered dental bill for August 15 (an old bill based on the December initial application) and a $1,500 balance on a nonparticipating physician's bill for September 10 to September 12 which was not used to meet a prior spenddown. She pays $50 a month on each bill to each provider. She has no health insurance and is not eligible for Medicare.

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Her income is projected from her $550 per month June SSA disability check. The budget period is June 1 through November 30; the income limit is $1,300. Her spenddown liability is $1,880.

$ 550	SSA disability
- 20	general income exclusion
530	countable income
x 6	months
3,180	countable income for subsequent budget period
- 1,300	MNIL for subsequent budget period Group I *(using June 2000 figures)*
$ 1,880	spenddown liability June 1 - November 30

The current budget period based on her re-application abuts her previous spenddown budget period. It is a consecutive budget period because she established eligibility in the preceding budget period and, therefore, the $1,300 balance owed on the old bill and the carry-over September expenses are deducted from her current spenddown liability. She owes a total of $2,800 on these expenses as of June 1. Her eligibility is calculated:

$ 1,880	spenddown liability June 1 - November 30
- 1,300	old bill balance from August dental bill
580	spenddown liability after deducting dental bill
- 580	September carry-over expense; balance of $920 remains
$ 0	spenddown balance on June 1

NOTE: The non-covered dental expense and the physician's bill meet the definition of an old bill. The remaining balance of the carry-over expense can be used in a consecutive budget period if still owed.

Because the spenddown was met on June 1, Ms. Sub is enrolled in Medicaid for the period June 1 through November 30, eligibility *Aid Category 058.*

E. Reference

See Appendix 1 to this subchapter for further examples of spenddown budget periods.

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MEDICAL EXPENSE RECORD – MEDICAID

FORM NUMBER - 032-03-023

PURPOSE OF FORM -
1. To inform the individual or family who is ineligible for Medicaid, due to excess income, of the amount which must be spent or incurred for medical services before eligibility can be established;
2. To provide space to keep a running record of medical expenses;
3. To enable the client to estimate with some degree of accuracy the appropriate time to submit expenses to the agency and request a re-evaluation of his spenddown; and
4. To provide the agency with a method of determining the specific date the spenddown was met.

USE OF FORM - Used by the individual or family with excess income to record all medical expenses for himself and/or others for whom he has requested Medicaid. At such time as he believes he has incurred expenses equal to his spenddown liability, the client should submit the form with his bills to the local agency where his spenddown will be re-evaluated. The "Agency Use Only" section will be completed by the agency when:

1. a client submits bills for medial expenses that have been paid or incurred or
2. the agency has knowledge that current medical expenses, such as hospitalization may result in a negative spenddown balance.

When an individual or family returns with the form and has medical bills, the worker must apply the bills to the spenddown liability in accordance with the procedures specified in chapter M13 in the Medicaid manual. In some instances the individual or family will not be able to keep a running record of medical expenses and the bills alone will provide sufficient information.

NUMBER OF COPIES - Original and one copy.

DISTRIBUTION OF COPIES - Original must be prepared for the client. A copy must be filed in the eligibility case file.

INSTRUCTION FOR PREPARATION OF FORM - Enter in the appropriate spaces:
1. the name of the county or city Department of Social Services.
2. the full name of the individual.
3. the Medicaid case number.
4. the dates identifying the spenddown budget period.
5. the amount of the spenddown liability.

Give the form to the client and place a copy in the eligibility case file.

When the form 032-03-023 showing medical expenses or medical bills paid or incurred in the spenddown period is returned by the client, the agency will determine if the spenddown has been met. In listing medical obligations, expenses for a period can be consolidated into a lump sum as long as there is a positive balance. As the balance approaches zero, the dates services were rendered must be listed chronologically (with amounts) in order to determine the specific date on which the spenddown was met. This evaluation can be done on either the client or the agency copy of Form 032-03-023. If the client's form is used, a copy of that evaluation must be placed in the agency record. Regardless of which form is used by the agency to evaluate the effect of the client's medical expenses on the spenddown, the client's copy of the Form 032-03-023 must be returned to him, showing the balance of the spenddown liability amount, or stating that the spenddown has been met.



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COMMONWEALTH OF VIRGINIA DEPARTMENT OF SOCIAL SERVICES **MEDICAL EXPENSE RECORD - MEDICAID**	COUNTY/CITY
CASE NAME(S)	CASE NUMBER
BUDGET PERIOD (DATES)	SPENDDOWN LIABILITY FOR THE BUDGET PERIOD $

You are not eligible for full Virginia Medicaid coverage at this time because your countable income exceeds the Medicaid income limit. If your medical and dental expenses equal your spenddown liability (the amount by which your income exceeds the income limit) at any time during the period shown above, you may be eligible for Medicaid at that time for the remainder of the period, provided all other eligibility requirements continue to be met. Also, your medical bills you still owe may be used to reduce the spenddown liability balance. Once those bills are used to reduce a spenddown and you become eligible, they cannot be used against any future spenddown liability.

You should keep a daily record of all medical expenses for yourself and/or others for whom you have requested Medicaid. This will help you to know when you have medical expenses totaling the spenddown liability amount shown above. The space below is for your guidance and use. Include medical costs paid by other state and local programs such as General Relief or State-Local Hospitalization. When you believe you have met the spenddown, contact your worker at the Social Services Department.

AGENCY USE ONLY

DATE OF SERVICE MONTH/DAY/YEAR	WHO GAVE MEDICAL CARE	WHO RECEIVED THE SERVICE	AMT. PAID OR BILL AMOUNT	AMOUNT USED TO ACHIEVE ELIGIBILITY	BALANCE

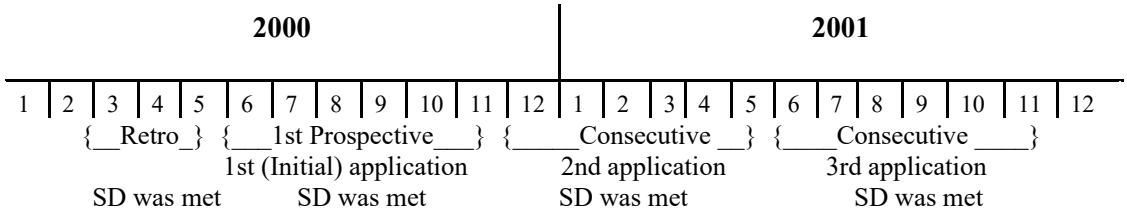
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DETERMINING SPENDDOWN ELIGIBILITY CHARTS

EXAMPLE #1:



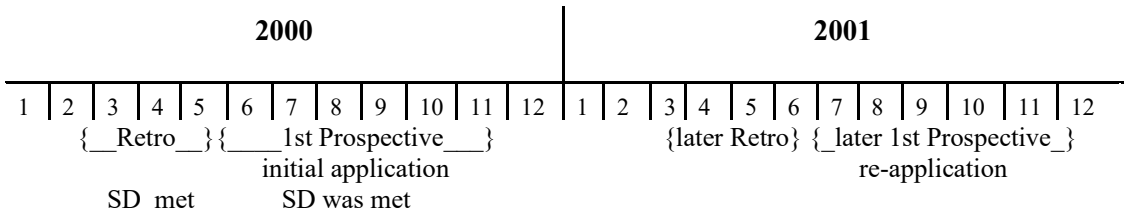
First application (initial application) date: June 2000. A retroactive budget period of March 1, 2000 - May 31, 2000 and a first prospective budget period of June 1, 2000 - November 30, 2000 were established.

Second application date December 2000. Spenddown budget period is December 1, 2000 - May 31, 2001.

Third application date June 2001. Spenddown budget period is June 1, 2001 - November 30, 2001.

Old bills are any bills incurred before March 2000. They are used to meet the retroactive spenddown. The unused balance is used to meet the 1st prospective spenddown and the consecutive spenddowns (until no old bill balance remains) because there is no break in spenddown eligibility (each spenddown was met).

EXAMPLE #2:



The initial application was filed in June 2000. Retroactive budget period is March 1, 2000 - May 31, 2000 and first prospective budget period is June 1, 2000 - November 30, 2000. Old bills based on the initial application are any bills incurred prior to March 2000. Any bills incurred in March through May (the retroactive budget period), whether paid or unpaid, are carry-over expenses in the 1st prospective budget period.

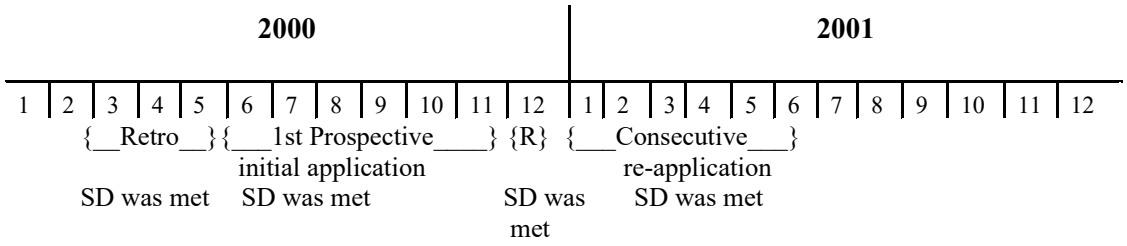
There is a break between spenddown budget periods. The new Medicaid application was filed July 2001. This is a re-application with a later retroactive budget period and a later 1st prospective budget period. For the July 2001 application, old bills are those incurred after November 30, 2000 and on or before March 31, 2001. The balance of any old bills incurred before December 1, 2000 cannot be applied to a later retroactive or prospective budget period. Only the current payments made on those prior expenses can be deducted.



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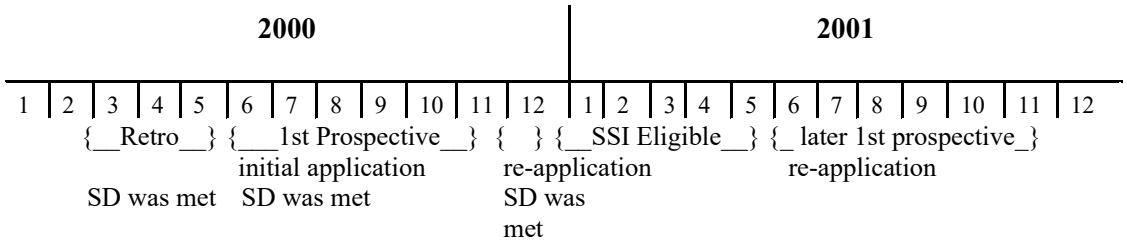
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EXAMPLE #3:



First application date is June 2000. The re-application date is January 2001. Old bills are those that were incurred before March 1, 2000, the initial application's retroactive budget period. Re-application is filed in January 2001, so the retroactive period based on the re-application is prorated to one month - December 1999. There is no break between spenddown budget periods and no break in spenddown eligibility; all these periods are consecutive.

EXAMPLE #4:



Initial application dated June 2000: a retroactive (March 1, 2000 - May 31, 2000) and a 1st prospective (June 1, 2000 - November 30, 2000) spenddown budget periods are established.

Re-application dated December 2000. Prorated consecutive budget period established for December 2000 only, because SSI was approved effective January 1, 2001. Individual is eligible without spenddown effective January 1, 2001.

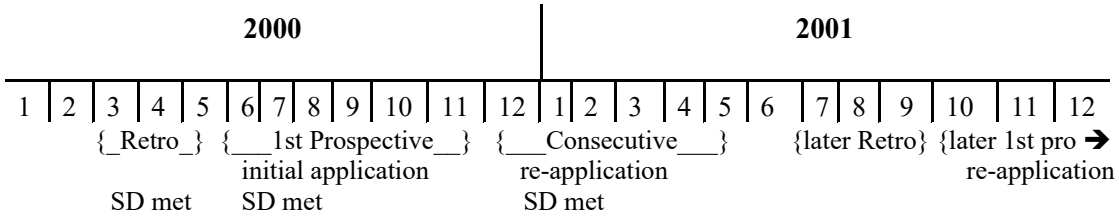
SSI ends May 2001 and creates a first prospective spenddown budget period for June 1, 2001 - November 30, 2001.

All expenses incurred prior to January 1, 2001 are deducted as current payments because there has been a break in spenddown eligibility (January - May 2001 is CN budget period). Expenses incurred January 1, 2001, through May 31, 2001, are deducted as old bills for the June 2001 re-application.

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EXAMPLE #5:



Initial application date June 2000.

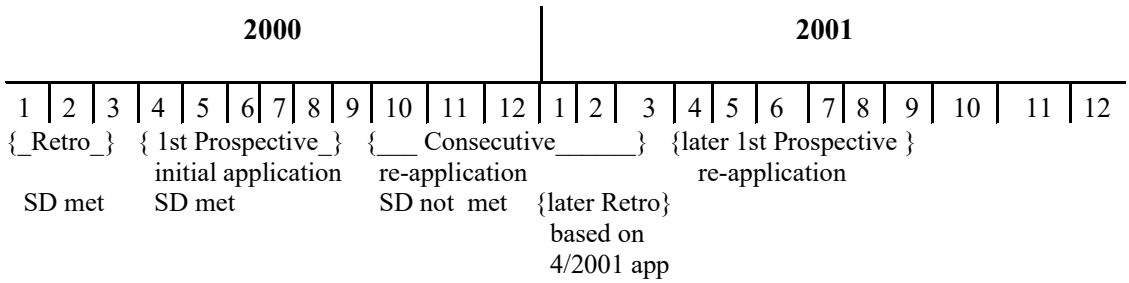
Old bills are any medical expenses incurred before March 2000 (the retroactive period based on the initial application). The retroactive budget period is March 2000 through May 2000. The first prospective budget period is June 2000 through November 2000. The retroactive and first prospective spenddowns were met.

A second application dated December 2000 is filed. The spenddown budget period is December 1, 2000, through May 31, 2001. Unpaid old bill balance, and unpaid balances of carry-over expenses incurred in retroactive & first prospective periods, are deducted on 1st day of consecutive budget period or December 1, 2000, because there was no break in spenddown eligibility.

Third application dated October 2001 is a re-application.

Old bills are only those incurred in June 2001 because there is a break in spenddown eligibility. Any unpaid balance on the old bills from the initial application is no longer deducted as an "old bill". Only current payments made on the old bill balance(s) can be deducted. Current payments are deducted the date paid in the October 2001 re-application's retroactive and/or first prospective budget periods.

EXAMPLE #6:



Initial application filed April 2000.

Old bills are any medical expenses incurred before January 2000 (the retroactive period based on the initial application). The retroactive budget period is January 2000 - March 2000. The first prospective budget period is April 2000 through September 2000. The retroactive and first prospective spenddowns were met.

Second application dated October 2000 is filed. The consecutive spenddown budget period is October 2000 - March 2001. Unpaid old bill balance, and unpaid balances of carry-over expenses incurred in retroactive & first prospective periods, are deducted on 1st day of consecutive budget period or October 1, 2000, because there was no break in spenddown eligibility. Expenses incurred during the consecutive

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budget period are deducted on the date incurred. The October 2000 - March 2001 spenddown was not met.

Third application dated April 2001 is filed. The retroactive budget period is January 2001 - March 2001. Old bills are those incurred after September 30, 2000, and prior to January 1, 2001, and are deducted on January 1, 2001. Paid and unpaid expenses incurred during the retroactive period (January 2001 through March 2001) are deducted on the date incurred. All expenses incurred prior to October 1, 2000, are deducted as current payments because there has been a break in spenddown eligibility. The later first prospective budget period is April 2001 - September 2001. Unpaid balances on old bills (incurred after September 30, 2000, and prior to January 1, 2001) not used to meet the retroactive spenddown are deducted on April 1, 2001. Paid and unpaid expenses incurred during the retroactive spenddown budget period that were not used to meet the spenddown are deducted on April 1, 2001. Paid or unpaid expenses incurred during the later first prospective period (April 2001 through September 2001) are deducted on the date incurred. All expenses incurred prior to the break in spenddown eligibility (October 1, 2000) are deducted as current payments.

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CHAPTER M13
SPENDDOWN
SUBCHAPTER 50

CHANGES PRIOR TO MEETING SPENDDOWN

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M1350 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-13	7/1/19	Table of Contents Page 2, 4,14 Pages 14a and 14b were added.
TN #DMAS-9	7/1/18	Page 4
TN #DMAS-7	1/1/18	Pages 11,12
TN #96	10/1/11	pages 7, 8

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M1350.000 CHANGES PRIOR TO MEETING SPENDDOWN

M1350.100 CHANGES PRIOR TO MEETING SPENDDOWN

A. Policy

When changes occur in the individual's or family's situation after applying for Medicaid, but before meeting the spenddown liability, the amount of countable income, the spenddown liability and the spenddown budget period may change.

1. Retroactive Spenddown Budget Period

The retroactive spenddown budget period is prorated (shortened) when:

- one or two of the months in the retroactive period were included in a prior Medicaid medically needy spenddown budget period in which eligibility was established, or
- the only medically needy individual in the assistance unit dies in the first or second month of the retroactive period.

2. Prospective Budget Period

The prospective spenddown budget period is prorated when:

- the only medically needy individual in the assistance unit dies,
- the only medically needy individual in the assistance unit becomes ineligible before the end of the spenddown budget period because of excess resources or nonfinancial reasons, or
- the individual's or assistance unit's covered group classification changes from medically needy to categorically needy or categorically needy non-money payment.

B. Case Transfer

When the MN assistance unit moves to a new locality, transfer the case according to procedures in section M1520.600.

It is the responsibility of the sending agency to:

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

It is the responsibility of the receiving agency to review the spenddown to determine if a recalculation based on a different income limit is required.

C. References

Procedures for handling changes that occur during the spenddown budget period are in the following sections:

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- M1350.200 Increase in Assistance Unit Size
- M1350.210 Decrease in Assistance Unit Size Not Due To Institutionalization
- M1350.220 Decrease in Assistance Unit Size Due To Institutionalization
- M1350.300 Income Changes
- M1350.400 Income Limit Changes
- M1350.500 Resource Changes
- M1350.600 Nonfinancial Eligibility Requirement Not Met
- M1350.700 Change of Covered Group Classification
- M1350.800 Individual Becomes Institutionalized
- *M1350.850 Individual Becomes Incarcerated*
- M1350.900 Changes Due To Death

M1350.200 INCREASE IN ASSISTANCE UNIT SIZE

A. Policy

When the assistance unit size increases and Medicaid is requested for an additional family member(s) not already on a spenddown, the spenddown budget period remains the same but the spenddown liability amount must be recalculated.

There can be only one spenddown budget period per assistance unit. If the additional family member was already on his own spenddown when he joined the assistance unit, wait until after one of the spenddown budget periods has expired to recalculate the spenddown liability amount for the remaining budget period.

1. Step 1

For the months prior to the month in which the change occurred, calculate the family's income based on the number of members in the assistance unit at the time of application.

For the months during which the additional member was added to the assistance unit, calculate the family's income based on the increased number in the assistance unit.

2. Step 2

Total the family's income for the entire 6-month spenddown budget period. The result is the family's recalculated income for the spenddown budget period.

3. Step 3

Determine the income limit for the assistance unit size for the number of months before the change occurred. Determine the income limit for the assistance unit size for the number of months in which the additional member was included. Add together the income limits. The result is the recalculated income limit for the spenddown budget period.

4. Step 4

Subtract the recalculated income limit from the family's recalculated income. The result is the recalculated spenddown liability for the spenddown budget period.

If the recalculated income is within the recalculated income limit for the spenddown budget period, the assistance unit is eligible for the entire spenddown budget period. However, the additional assistance unit member(s) (who was not included during the entire period) is only eligible for the month(s) when he was included in the unit.



B. Example--Increase In Assistance Unit Size

EXAMPLE #1 (Using June 2000 figures): Mr. D lives in Group II and applies for Medicaid on June 6 for himself and his family. He is temporarily disabled. He lives with his wife and 13 year old child. The assistance unit size is 3 persons when determining eligibility. The family's income totals $3,000 per month worker's compensation- $2,000 for Mr. D and $1,000 for Mrs. D; the child has no income. Since the F&C countable income exceeds the MI limit and they are within the resource limit for a family of 3, a MN determination is done. The first prospective budget period is June 1 through November 30. The MN income limit for a family of 3 living in a Group II locality, is $2,150. The spenddown liability is $15,850.

$ 3,000	total worker's compensation
x 6	months
18,000	countable income for the spenddown budget period
- 2,150	MNIL for 3 persons Group II for budget period
$15,850	spenddown liability for spenddown budget period June - November

The family has not met the spenddown. On September 5, they report that their eldest son, age 16, returned to the home to live with them on September 2 and they want to apply for Medicaid for him, as well. He has no income. The assistance unit size for September through November (3 months) is 4 persons; the income limit is $1,200. The family's income, income limit and spenddown liability are recalculated:

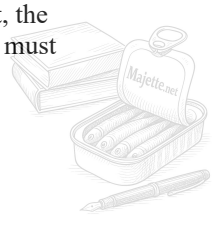
$ 3,000	total worker's compensation
x 6	months June - November
$18,000	countable income for spenddown budget period June - November
1,075	MNIL for 3 persons Group II June - August
+ 1,200	MNIL for 4 persons Group II September - November
2,275	MNIL for spenddown budget period June - November
$18,000	countable income for spenddown budget period June - November
- 2,275	MNIL for spenddown budget period
$15,725	spenddown liability for spenddown budget period June - November

The family's spenddown liability for the June 1 through November 30 spenddown budget period is $15,725.

M1350.210 DECREASE IN UNIT SIZE NOT DUE TO INSTITUTIONALIZATION

A. Policy

When the assistance unit size decreases (NOT due to institutionalization of an assistance unit member) and the decrease is reported by the applicant, the spenddown budget period remains the same but the spenddown liability must



be recalculated. *Decrease in assistance unit size may include a change if an assistance unit member becomes incarcerated during a spenddown budget period.*
See section M1350.220 for procedures to follow when an assistance unit member is institutionalized.

1. **Step 1** For the months prior to the month in which the change occurred, calculate the family's income based on the number in the assistance unit at the time of application.

   For the months during which the assistance unit decreased, calculate the family's income based on the decreased number in the assistance unit.

2. **Step 2** Total the family's income for the entire 6-month spenddown budget period. The result is the family's recalculated income for the spenddown budget period.

3. **Step 3** Determine the income limit for the assistance unit size for the months prior to the change and for the month the change occurred. Determine the income limit for the assistance unit size for the number of months after the change occurred. Add together the income limits. The result is the recalculated income limit for the spenddown budget period.

4. **Step 4** Subtract the recalculated income limit from the family's recalculated income. The result is the recalculated spenddown liability for the spenddown budget period.

   If the recalculated spenddown liability is within the recalculated income limit for the six-month spenddown budget period, the assistance unit is eligible for the entire spenddown budget period. However, the assistance unit member(s) who left the unit is only eligible for the month(s) when he was included in the unit.

   $11,100 countable income for June through August
   + 9,000 countable income for September through November
   20,100 countable income for spenddown budget period of June through September
   - 3,150 MNIL for 5 persons Group III
   $16,950 spenddown liability for spenddown budget period June through November

   The family's recalculated spenddown liability for the June 1 - November 30 spenddown budget period is $16,950.

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assistance unit size for September through November (3 months) is 4 persons; the income limit is $1,450. The family's income, income limit and spenddown liability are recalculated:

$ 3,500	total income per month
x 6	months June - November
$21,000	countable for spenddown budget period June through November
1,575	5 persons MNIL Group III for June-August
+1,450	4 persons MNIL Group III for September-November
3,025	MNIL for budget period
$21,000	income for spenddown budget period June through November
- 3,025	MNIL for spenddown budget period June through November
$17,975	spenddown liability for spenddown budget period June through November

The family's spenddown liability for the June 1 through November 30 spenddown budget period is $17,975

M1350.220 DECREASE IN UNIT SIZE DUE TO INSTITUTIONALIZATION

A. Policy

An institutionalized individual becomes a separate assistance unit for the income eligibility determination purposes as of the first day of the month of institutionalization.

B. Recalculate Family's Spenddown

When the individual was included in the assistance unit with a spouse and/or children, the spouse's and/or children's spenddown liability is recalculated to reflect a decrease in assistance unit size. The decreased assistance unit size begins the first day of the month in which the individual is institutionalized.

Only those medical bills incurred by the institutionalized individual during the months in the spenddown budget period when he was in the assistance unit are deducted from the family's spenddown.

C. Institutionalized Individual

Determine the institutionalized individual's eligibility separately beginning the first day of the month during which he becomes institutionalized. See subchapter M1460 for instructions on determining eligibility for institutionalized individuals.

M1350.300 INCOME CHANGES

A. Policy

When an income change is reported, the spenddown liability must be recalculated based on the income actually received in the spenddown budget period. The spenddown budget period does not change. When the applicant reports an income change, request verification, take appropriate action and document the case record.



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1. **Reported Before Spenddown Budget Period Ends** — If the change is reported before the end of the spenddown budget period, project the changed income for the remaining months in the spenddown budget period. Average any irregular income received and project the average for the remaining months in the spenddown budget period.

2. **Reported After Spenddown Budget Period Ends** — If the change is reported after the spenddown budget period ends, recalculate the spenddown liability using the actual income received during the spenddown budget period.

B. Example--Income Changes

EXAMPLE #3 (*Using June 2000 figures)*: Mr. Green lives in Group III and applies for Medicaid on June 8 for himself and his family. He lives with his wife and their 3 children ages 6, 8, and 11. Neither Mr. nor Mrs. Green meet a Medicaid covered group. The assistance unit size is 5 persons when determining the children's eligibility (F&C). The family's income totals $3,700 per month private company pension - $3,000 for Mr. Green and $700 for Mrs. Green; the children have no income. The first prospective budget period is June 1 through November 30, 1999; the income limit for 5 persons in Group III is $3,150. The spenddown liability is calculated:

$ 3,700	total family income per month
x 6	months
$22,200	countable income for the spenddown budget period June – November
- 3,150	MNIL for 5 persons Group III
$19,050	spenddown liability for spenddown budget period June through November

The family has not met the spenddown. On September 5, they report that their income changed on September 1; Mrs. Green no longer receives a pension benefit and she has no other income. The assistance unit's monthly income for September through November (3 months) is $3,000; their monthly income for June through - August (3 months) is $3,700. The family's spenddown liability is recalculated:

$ 3,700	income per month
x 3	months (June, July, and August)
$11,100	countable income for first 3 months

$ 3,000	total income per month
x 3	months (September, October, and November)
$ 9,000	countable income for second 3 months

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$11,100 countable income for June through August
+ 9,000 countable income for September through November
20,100 countable income for spenddown budget period of June through September
- 3,150 MNIL for 5 persons Group III
$16,950 spenddown liability for spenddown budget period June through November

The family's recalculated spenddown liability for the June 1 - November 30 spenddown budget period is $16,950.

M1350.400 INCOME LIMIT CHANGES

A. Policy

Recalculate the spenddown liability for the spenddown budget period when:

- the applicant moves to a different locality group at some point within the spenddown budget period; or
- the Medicaid income limit(s) changes at some point within the spenddown budget period. ***Note that the effective date for changes in MN income limits is July 1.***

B. Procedure

1. Use the "old" income limit for the month in which the applicant moved. Multiply the "old" monthly income limit by the number of months in the spenddown budget period during which it was effective.
2. Multiply the "new" monthly income limit by the number of months in the spenddown budget period during which it was effective. Add both results together. The total is the recalculated income limit.
3. Subtract the applicant's countable income for the spenddown budget period from the recalculated income limit. The result is the recalculated spenddown liability for the spenddown budget period.

C. Example--Income Limit Changes When Individual Moves

EXAMPLE #4 (Using *July 2011* figures): Mr. E lives in Group III and applies for Medicaid on *July* 6 for himself. He is aged and lives alone. His income totals $1,575 per month SSA benefit. The first prospective budget period is *July* 1 through *December* 31. The income limit for 1 person in Group III is *$2,567.56*. His spenddown liability is *$6,762.44*.

$ 1,575.00 SSA per month
- 20.00 general income exclusion
1,555 countable monthly income
x 6 months
$9,330.00 countable income for the spenddown budget period
- 2,567.56 1 person *semi-annual* MNIL Group III for spenddown budget period
$6,762.44 spenddown liability for spenddown budget period *July* through *December*



On *September* 23 he moves to a Group II locality and requests re-evaluation of his spenddown.

His spenddown liability is recalculated for the *July -December* spenddown budget period:

$1,283.76	1 person MNIL Group III for 3 months *July - September*
+ 987.51	1 person MNIL Group II for 3 months *October - December*
2,271.27	MNIL for spenddown budget period
$ 9,330.00	countable income for the spenddown budget period
- 2,271.27	MNIL for spenddown budget period
$7,058.73	spenddown liability for the spenddown budget period *July 1 – December 31, 2011*

M1350.500 RESOURCE CHANGES

A. Policy

When determining if the spenddown is met, evaluate any change in resources owned or in the value of resources owned to determine if the assistance unit's resources are still within the Medicaid limit. When resources exceed the Medicaid limit in some months, the spenddown budget period and the spenddown liability must be recalculated. Prorate the spenddown budget period to include the month(s) before the first full month in which the excess resources create ineligibility.

If resources exceed the limit, send a written notice to the applicant informing him of his ineligibility for Medicaid spenddown for the month(s) in which the resources exceeded the limit during the entire month.

B. Notice Requirements

Send a written notice to the applicant that states:

- the reason for ineligibility for Medicaid (excess resources) for the months in which excess resources exist (specify the months), and
- the spenddown liability amount for the months during which resources were within the limit (specify the months). Include the explanation that if medical or dental bills equal or exceed the spenddown liability, he may be eligible for limited Medicaid eligibility for the month(s) during which his resources were within the Medicaid limit (specify the dates).

C. Example-- Resource Changes

EXAMPLE #5 (Using June 2000 figures): Mr. G lives in Group I and applies for Medicaid on June 6 for himself. He is disabled and lives alone. His income totals $1,475 per month SSA benefit. The first prospective budget period is June 1 through November 30; the income limit for 1 person in Group I is $1,300. His spenddown liability is $7,430.

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$1,475	SSA per month
- 20	general income exclusion
1,455	monthly countable income
x 6	months
8,730	countable income for the spenddown budget period
- 1,300	1 person MNIL Group I for spenddown budget period
$7,430	spenddown liability for spenddown budget period June 1-November 30

His application is denied and he is placed on spenddown. When he requests re-evaluation of his spenddown on October 26, the worker finds that his resources exceed the Medicaid limit for the entire month of October, but were within the limit in June - September. The worker prorates the spenddown budget period to 4 months - June 1 through September 30. The worker recalculates the spenddown liability:

$1,455.00	monthly countable income
x 4	months (June- September)
5,820.00	countable income for the spenddown budget period
- 866.68	1 person MNIL Group I for 4 months spenddown budget period
$4,953.32	spenddown liability for spenddown budget period June 1 - September 30

The worker determines that verified incurred expenses totaling $800 on August 18 and $45 on September 4 do not meet the spenddown liability. A liability balance of *$4,108.32* remains for the prorated spenddown budget period.

The worker sends Mr. E a notice which states:

- You are not eligible for Medicaid for the months of June through September 30 because of excess income. Your spenddown liability is *$4,953.32*. You have incurred $845 in expenses, leaving a balance of *$4,108.32*. You have not met the spenddown.

- You are not eligible for Medicaid for the month of October because of excess resources. If you want your Medicaid eligibility determined again, you must reapply for Medicaid.

M1350.600 NONFINANCIAL ELIGIBILITY REQUIREMENT NOT MET

A. Policy

When an individual fails to meet a nonfinancial Medicaid eligibility requirement (such as MN covered group not met), he cannot become eligible by meeting a spenddown. At the time a change is reported in the individual's or family's nonfinancial Medicaid eligibility, evaluate the change to determine if the individual or family continues to meet the nonfinancial Medicaid eligibility requirements.

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If a nonfinancial eligibility requirement(s) is not met in any month in the spenddown budget period, send a written notice to the individual specifying the new denial reason (specify the nonfinancial requirement(s) that is not met).

If all nonfinancial requirements are not met in any of the months of the spenddown budget period, the spenddown liability and spenddown budget period will change. Prorate the spenddown budget period to include the month(s) before the first full month in which the nonfinancial requirement was not met.

B. Notice Requirements

Send a written notice to the applicant that states the new reason for denial:

- specify the nonfinancial requirement that is not met, and for which months the requirement is not met (specify the months), and
- the spenddown liability amount for the months during which the requirements were met (specify the months). Include the explanation that if medical or dental bills equal or exceed the spenddown liability by the end of the month for the new prorated spenddown budget period, the individual may be eligible for Medicaid coverage for the month(s) during which the Medicaid nonfinancial eligibility requirements were met.

C. Example--Nonfinancial Eligibility Requirement Not Met

EXAMPLE #6 (*Using June 2000 figures)*: Mr. H lives in Group I and applies for Medicaid on June 8 for himself. He is disabled (MDU determined) and lives alone. His income totals $*1,475* per month private disability benefit. The first prospective budget period is June 1 through November 30. The income limit for 1 person in Group I is $1,300. His spenddown liability is *$7,430.*

$ 1,475	income per month
- 20	general income exclusion
1,455	monthly countable income
x 6	months
$ 8,730	countable income for the spenddown budget period

$ 8,730	countable income for spenddown budget period
- 1,300	1 person MNIL Group I for spenddown budget period
$ 7,430	spenddown liability for spenddown budget period June 1 - November 30

His application is denied and he is placed on spenddown. He requests re-evaluation of his spenddown on October 26. The worker finds he is no longer disabled as of September 30, per an MDU review. The worker prorates the spenddown budget period to 4 months - June 1 through September 30.

The worker recalculates the spenddown liability:

$1,455.00	monthly countable income
x 4	months
5,820.00	countable income for the spenddown budget period
- 866.68	1 person MNIL Group I for 4 months spenddown budget period
$4953.32	spenddown liability for spenddown budget period June 1 - September 30

The worker verified $500 incurred expenses on July 8 and $245 on August 4. The spenddown liability was not met. A liability balance of $4,208.32 remains for the prorated spenddown budget period.

The worker notifies Mr. H that he did not meet his spenddown for the spenddown budget period June 1 through September 30, of the MDU determination that he is no longer disabled and that he does not meet another Medicaid covered group. The notice states:

- You are not eligible for Medicaid for the months of June through September 30 because of excess income. Your spenddown liability is $4,953.32. You have incurred $745 in expenses, leaving a balance of $4,208.32. You have not met the spenddown.

- You are not eligible for Medicaid for the month of October 1999 because the MDU determined that you are no longer disabled. You do not meet another Medicaid covered group as of October 1. Should your condition worsen, it is necessary for you to reapply if you want your Medicaid eligibility determined again.

M1350.700 CHANGE OF COVERED GROUP

A. Policy

An individual is entitled to Medicaid in a new classification effective the first day of the month in which he meets that new classification.

1. Assistance Unit of One

The spenddown budget period changes and the spenddown is recalculated when an individual who is an assistance unit of one person becomes eligible for Medicaid in a non-medically needy covered group.

The individual remains on a spenddown for the month(s) before the change in classification.

When an individual is institutionalized, his covered group classification changes to CN *(Categorically Needy)* if his gross income is within the 300% SSI income limit. If his gross income exceeds the 300% SSI limit, he remains medically needy and his classification does not change. However, his spenddown budget period and spenddown liability must be changed. See section M1350.800 below.

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EXAMPLE #7 (Using June 2000 figures): A disabled, single man living in Group I receives worker's compensation of $600 per month. He applies for Medicaid on June 10. The Medicaid Disability Unit determines him disabled. Disability onset was prior to March 1 of that year. His total monthly countable income was and is $600. The MNIL is $1,300. He did not incur any medical bills during the retroactive period. He does not have any old bills. The first prospective budget period is June through November. His spenddown liability is $2,180.

$ 600	income per month
- 20	general income exclusion
580	monthly countable income
x 6	months
3,480	countable income for the spenddown budget period
-1,300	1person MNIL Group I for spenddown budget period
$2,180	spenddown liability for spenddown budget period June 1 - November 30

His application is denied. He is placed on a spenddown for the first prospective budget period. On September 20, he requests re-evaluation of his spenddown due to his receipt of $512 per month SSI effective September. His worker's compensation income ended August 31. He incurred $1,000 in medical bills during July. He is eligible for Medicaid as categorically needy beginning September 1.

His spenddown budget period is prorated to June - August (3 months). His spenddown liability for the prorated spenddown budget period is recalculated:

$ 580	countable income for June - August
x 3	months
1,740	countable income for prorated spenddown budget period June - August
- 650	1 person MNIL Group I for 3 months
$1,090	spenddown liability for spenddown budget period June 1 - August 31

He incurred $1,100 worth of medical bills on July 15. He met his spenddown on that date. He is eligible effective July 15 - August 31 as medically needy, *Aid Category 0*58. Effective September 1, he is eligible as categorically needy, *Aid Category 0*51.

2. Assistance Unit of Two or More

When the entire assistance unit's classification changes, the spenddown budget period changes and the spenddown liability is recalculated. Eligible family members are entitled to Medicaid in the new classification effective the first day of the month in which they meet that new classification. They

remain on spenddown for the month(s) before the change in classification. When all children in the assistance unit become eligible as *MI*, the spenddown budget period changes and the spenddown liability is recalculated. The children are eligible as *MI* effective the first day of the month in which they meet the *MI* requirements. They remain on a spenddown for the months prior to *establishing MI* eligibility.

The assistance unit size decreases when an individual member of an assistance unit of two or more becomes eligible in another classification. The individual is no longer included in the original assistance unit. The spenddown liability is recalculated using the procedures in section M1350.210 above.

M1350.800 INDIVIDUAL BECOMES INSTITUTIONALIZED

A. Policy

When an individual becomes institutionalized and his gross income exceeds the 300% SSI limit, he remains medically needy. His classification does not change. However, his spenddown budget period must be changed. His spenddown liability is recalculated.

1. Prorate Spenddown Budget Period & Recalculate Spenddown Liability

Prorate the individual's spenddown budget period for the month(s) in which he was not institutionalized. Do not include the month in which he became institutionalized.

Total the monthly countable income he received in the prorated spenddown budget period. Subtract the MN income limit for the number of months in the prorated spenddown budget period. The remainder is the recalculated spenddown liability for the months during which he was not institutionalized.

2. Determine Institutional-ized Spenddown

The MN budget period for an institutionalized individual is one month. Go to subchapter M1460 to determine the individual's spenddown as an institutionalized individual.

B. Example--Individual Becomes Institutionalized

EXAMPLE #8 (Using June 2000 figures): A disabled, single man living in Group I receives worker's compensation of $1,550 per month. He applies for Medicaid on June 6. This is his initial application. The Medicaid Disability Unit determines him disabled. Disability onset is February. His monthly countable income was and is $1,550. The MNIL is $1,300. He did not incur any medical bills during the retroactive period. He does not have any old bills. The first prospective budget period is June through November. His spenddown liability is calculated:

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$1,550	income per month
- 20	general income exclusion
1,530	countable monthly income
x 6	months
9,180	countable income for the spenddown budget period June 1 – November 30
- 1,300	1 person MNIL Group I for spenddown budget period
$7,880	spenddown liability for spenddown budget period June 1 - November 30

His application is denied. He is placed on spenddown for the first prospective budget period. On October 20, he becomes institutionalized when he is admitted to a nursing facility for permanent care. His worker's compensation income has not changed. He incurred $5,000 in medical bills during September. His spenddown budget period is prorated to June - September (4 months). His spenddown liability for the prorated spenddown budget period is recalculated:

$1,530.00	monthly countable income for June - September
x 4	months (June-September)
6,120.00	countable income prorated for spenddown budget period June - September
- 866.68	1 person MNIL Group I for 4 months
$5,253.32	spenddown liability for spenddown budget period June 1 – September 30

He incurred $5,000 in medical bills in September. He did not meet the prorated spenddown. The worker sends Mr. T a notice informing him that he did not meet his spenddown for the prorated spenddown budget period of June 1 through September 30. The $5,000 in medical bills did not meet the prorated spenddown of $5,253.32. He has a balance left of $253.32. His spenddown eligibility as an institutionalized individual is determined according to policy in subchapter M1460.

M1350.850 INDIVIDUAL BECOMES INCARCERATED

A. Policy

If an individual becomes incarcerated during his spenddown budget period, the spenddown liability must be recalculated.

For other individuals in the offender's (pre-incarceration) assistance unit who may be on a spenddown, follow the appropriate policy. For assistance unit change - M1350.210; income change – M1350.300; and resource change – M1350.500.

1. Recalculate the Spenddown Liability

Recalculate the offender's spenddown liability and follow policies for income (see M1350.210) and resources (see M1350.500). The offender will be an assistance unit of one and would use the same pre-incarceration group and MNIL.

2. ***Conduct a Partial Review***

Determine if the offender is eligible in a CN covered group based upon the first day he became incarcerated. See (M0140.300.A.1).

If the offender is determined eligible for coverage, enroll as of the day the individual entered the correctional facility.

If offender does not meet a covered group, his spenddown budget period will remains in effect until it ends. The worker will not send the offender an application at the end of the spenddown period. The offender may reapply for coverage (see M0140.200)

B. *Example (ABD)—Single Individual Becomes Incarcerated*

EXAMPLE #9 (Using July 2018 figures): *A disabled single man living in Group I receives SSA payment of $1,020 per month and also receiving Medicare. He applies for Medicaid in June and the MNIL is $1904.55. He has not incurred any medical bills and has no old bills. The spenddown budget period is June through November. His spenddown liability is calculated:*

$1,020	income per month
- 20	general income exclusion
1,000	countable monthly income
x 6	months
6,000	countable income for the SD budget period 6/1 – 11/30
-1,904.55	1 person MNIL Group I SD budget period liability semi-annual
$4,095.45	SD liability for the budget period 6/1 – 11/30

On September 10 he is incarcerated, and SD amount is recalculated. SSA payments will suspend at the end of September, and he will have no income in October or November.

$1,020	income per month
- 20	general income exclusion
1,000	countable monthly income
x 4	months (months of June, July, August, and September)
4,000	income for the period 6/1 – 9/30
+ -0-	No income for remaining two months 10/1 – 11/30
$4,000	countable income for the SD budget period 6/1 – 11/30
- 1,904.55	1 person MNIL Group I SD budget period liability semi-annual
$2,095.45	Recalculated SD liability for the budget period 6/1 – 11/30

Worker conducts a partial review. The offender is not eligible for QMB (due to incarceration), not eligible for MAGI (he receives Medicare), and over income for ABD 80% (income limit $810). However, with zero income for October and ongoing, he qualifies for ABD coverage beginning 10/1.

C. *Example (MAGI)-Single Individual Becomes Incarcerated*

EXAMPLE #10 (Using July 2018 figures): *A 40 year old single man on Medicare, lives in Group II and has income from a trust fund in the amount of $1,500 per month. He applied for Medicaid in February but was over the ABD (MSP) income limits. His MNIL is $2,154.48. He has no medical bills or old bills. The spenddown budget period is February through July. His spenddown liability is calculated:*



$1,500 income per month
- 20 general income exclusion
1,480 countable monthly income
x 6 months
8,880 countable income for the SD budget period 2/1 – 7/30
-2,154.48 1 person MNIL Group I SD budget period liability semi-annual
$6,725.52 SD liability for the budget period 2/1 – 7/30

On March 1 he is incarcerated. His SD liability would be recalculated. However, his trust income payments continue even though he is incarcerated, so the spenddown liability will not change and remains at $6,752.52.

The worker conducts a partial review. The offender is not eligible for QMB (due to incarceration), not eligible for MAGI (he receives Medicare), and is still over the income limit for ABD 80% (income limit $810). His spenddown liability continues for the remainder of the budget period.

M1350.900 CHANGES DUE TO DEATH

A. Policy

1. Individual Applicant When an individual who meets an MN covered group, dies within the spenddown budget period, the spenddown budget period and the spenddown liability change. The spenddown liability and spenddown budget period are recalculated using actual income received.

2. Death of a Assistance Unit Member When an individual member of an assistance unit dies, and at least one other assistance unit member meets a MN covered group, the family's assistance unit size decreases. The policy and procedures in section M1350.210 above apply.

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B. Example--Individual Applicant Dies

EXAMPLE #9 (*Using June 2000 figures)*: Mr. T is an aged widower living in Group I. He receives an SSA benefit of *$620* per month. He applies for Medicaid on June 6. His monthly countable income was and is *$620*. The MNIL is $1,300. The spenddown budget period is June through November. His spenddown liability is *$2,300*. He has Medicare Parts A & B. He did not incur any medical bills during the retroactive period. He does not have any old bills.

$ *620* SSA income per month
- 20 general income exclusion
600 countable monthly income
x 6 months (June - November)
$3,600 countable income for the spenddown budget period June - November

$3*,600* countable income for the spenddown budget period
-1,300 1 person MNIL Group I for spenddown budget period
$2,300 spenddown liability for spenddown budget period June through November

His application is denied. He is placed on a spenddown for the first prospective budget period. On September 20, his daughter reports that Mr. T died on September 10. He incurred medical expenses in August and September. She requests re-evaluation of his spenddown. He incurred $*1,400* in Medicare hospital deductible and coinsurance charges on August 21. He incurred a $25 per day Medicare coinsurance charge for physician's services for 10 days - August 30 through September 8. His spenddown budget period is prorated to June - September. His spenddown liability is recalculated:

$ *600.00* monthly countable income
x 4 months
2,400.00 total countable income for June - September
- 866.68 MNIL for 1 person Group I for 4 months
1*,533.32* spenddown liability for spenddown budget period June - September
- 45.50 Medicare premium June 3
1*,487.82* spenddown liability balance June 3
- 45.50 Medicare premium July 3
1,442.32 spenddown liability balance on July 3
- 45.50 Medicare premium August 3
1*,396.82* spenddown liability balance August 3
-1400.00 hospital deductible and coinsurance charges August 21
$ 0 spenddown balance on August 21

The *$1,400.00* in medical expenses incurred on August 21, met his spenddown liability on that date. He is eligible for Medicaid effective August 21 through September 10 (date of death).

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M1360 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-30	1/1/24	Page 4
TN #DMAS-13	7/1/19	Page 4 Page 4a was deleted
TN #DMAS-12	4/1/19	Page 4, 4a
TN #DMAS-9	7/1/18	Page 4 Page 4a was added.

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M1360.000 CHANGES AFTER SPENDDOWN IS MET

M1360.100 CHANGES AFTER SPENDDOWN IS MET

A. Policy

Spenddown budget periods do not change when changes occur in an individual's or family's situation after meeting a spenddown liability within a spenddown budget period. The amount of countable income and the spenddown liability may change, but the spenddown budget period never changes.

B. Decrease in Assistance Unit

Do not recalculate the spenddown liability when the assistance unit decreases. Cancel the Medicaid coverage of the deleted assistance unit member(s). The remaining unit members are eligible until the end of the spenddown budget period.

C. Increase in Assistance Unit

When the assistance unit size increases, Medicaid may be requested for the additional member(s). Recalculate the spenddown liability based on the changes in the income limit and the family's income (if any) for the month(s) that the individual(s) is added to the unit and for subsequent month(s).

The additional family member's(s') medical bills (including old bills) can be deducted only for the months during which he is included in the assistance unit.

1. Spenddown Liability Decreases

Re-enroll the family with an earlier coverage begin date if the spenddown liability decreases and is met earlier because of the decrease. Enroll the additional unit member(s) no earlier than the date he became a part of the unit.

EXAMPLE #1 ***(Using April 2000 figures)*****:** Mr. D lives in Group II and applies for Medicaid on April 6 for himself and his family. He is disabled and lives with his wife and 13 year old child. They have no health insurance. The assistance unit size is 3 persons when determining Mrs. D's and the child's eligibility (F&C); Mr. D's unit size is 1 person (ABD). The family's income totals $2,800 per month. Mr. D receives a $1,000 SSA and a $1,000 private pension. Mrs. D receives $800 worker's compensation. The first prospective budget period is April 1 through September 30. The income limit for the F &C MN determination is $2,150. The spenddown liability is $14,650.

$ 2,800	total countable income per month
x 6	months
16,800	countable income for the spenddown budget period
- 2,150	MNIL for 3 persons Group II
$14,650	spenddown liability for spenddown budget period April 1 - September 30

The family incurs $14,650 in hospital and physicians' expenses as of May 28. The child is enrolled in Medicaid effective May 28, Type 3 eligibility



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(which will be canceled effective September 30). On July 15, the family reports their eldest son, age 16, returned to the home to live with them on July 12. They want to apply for Medicaid for him, as well. He has no income. The assistance unit size for July through September (3 months) is 4 persons; the income limit is $2,400.

The family's income limit and spenddown liability is recalculated:

1,075	MNIL for 3 persons Group II April - June
+ 1,200	MNIL for 4 persons Group II July - September
2,275	MNIL for spenddown budget period

$16,800	countable income for the spenddown budget period
- 2,275	MNIL for spenddown budget period
$14,525	spenddown liability for budget period

The family's recalculated spenddown liability for the April 1 through September 30 budget period is $14,525. The worker redetermines the spenddown and determines that the family incurred $14,525 in medical expenses on May 25. Because this date is earlier than the May 28 coverage begin date originally determined, the 13 year old child (but not the 16-year-old son) is re-enrolled in Medicaid beginning May 25 (ending September 30). The 16 year-old is enrolled in Type 3 eligibility beginning July 1, the first day of the month he came to live with the family, and ending September 30.

2. Liability Increases

When the spenddown liability increases, the spenddown budget period does not change. Cancel the family's coverage if the recalculated spenddown liability has not been met.

If the recalculated spenddown liability has been or is met, enroll the additional assistance unit member(s) no earlier than the date he became part of the unit.

EXAMPLE #2 ***(Using April 2000 figures)*****:** Ms. S lives in group III and applies for Medicaid on April 6 for herself and her family. She lives with her husband and 13 year old child. They have no health insurance. The assistance unit size is 3 persons when determining the child's eligibility (F&C MN child < 18). Their income exceeds the CNNMP limit. Mr. and Mrs. S do not meet an MN covered group.

The family's income totals $2,400 per month SSA retirement - $1,200 for Mr. S and $1200 for Mrs. S; the child has no income. The first prospective budget period is April 1 through September 30. The income limit is $2,650. The spenddown liability is calculated:

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$ 2,400	total SSA retirement per month
x 6	months
14,400	countable income for the spenddown budget period
- 2,650	MNIL for 3 persons Group III
$ 11,750	spenddown liability for spenddown budget period April 1 - September 30

The family incurs $11,750 in hospital and physicians' expenses as of June 12. The child is enrolled in Medicaid beginning June 12 (ending September 30). On August 1, they report that their eldest son, age 16, returned to the home to live with them on July 1. They want to apply for Medicaid for him, as well. He has no income. However, Mr. S's income increased in July to $1,400 per month. The assistance unit size for July through September (3 months) is 4 persons; the income limit is $2,900. The family's income, income limit and spenddown liability are recalculated:

$ 2,400	total family income per month
x 3	months April - June
$ 7,200	total family income for April - June
$ 2,600	total family income per month
x 3	months July - September
$ 7,800	total family income for July - September
+ 7,200	total family income for April - June
$15,000	total income for spenddown budget period April - September
1,325	MNIL for 3 persons Group III April - June
+ 1,450	MNIL for 4 persons Group III July - September
2,775	MNIL for spenddown budget period April - September
$15,000	countable income for the spenddown budget period
- 2,775	MNIL for spenddown budget period
$12,225	spenddown liability for spenddown budget period

The family's recalculated spenddown liability for the April 1 through September 30 budget period is $12,225. The worker determines that the family has a spenddown liability balance of $475 left on June 12. Because the spenddown liability has not been met, the family members' Medicaid coverage is canceled effective July 31 because of excess income; spenddown liability balance of $475. The 16-year-old son is not eligible for Medicaid and is not enrolled.

D. Income Decreases

Recalculate the spenddown liability for the spenddown budget period based on the actual income received. If the recalculated spenddown liability is met earlier in the spenddown budget period, re-enroll the eligible members of the unit with the earlier eligibility begin date.

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E. Income Increases

Recalculate the spenddown liability for the spenddown budget period based on the actual income received. If the new spenddown liability has not been met, cancel eligibility. Notify the recipient of the new spenddown liability and the balance of the spenddown liability which must be met by the last day of the spenddown budget period.

NOTE: **This subsection does not apply to medically needy *children or* pregnant women who apply for and are enrolled in Medicaid on or before the date the pregnancy terminates. Income increases are excluded for these MN *children and* pregnant women.**

F. Resource Changes

Redetermine the assistance unit's eligibility based on a change in resources.

1. Resources Within Limit

When resources are within the Medicaid limit, the unit remains eligible as medically needy for the remainder of the spenddown budget period.

2. Resources Exceed Limit

When the resources exceed the limit, cancel the unit's Medicaid eligibility after the advance notice is sent if the effective date of cancellation is prior to the end of the spenddown budget period. Do not change the spenddown liability or the spenddown budget period.

3. Example-- Resource Change

EXAMPLE #3: Mr. and Mrs. Jones applied for Medicaid on July 10. They were put on a spenddown for the spenddown budget period July - December, which they met on August 3. They were enrolled effective August 3 through December 31. On September 2, they reported that they inherited some real property worth $20,000. It is not excluded since it is saleable. They are sent an advance notice on September 4 stating their Medicaid eligibility is canceled effective September 30 because of excess resources.

G. Change Due to Incarceration

A review must be conducted for all individuals in the assistance unit when a member of the assistance unit becomes incarcerated. See M1350.850 for changes due to incarceration prior to meeting a spenddown.

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M1370 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-33	10/1/24	Pages 1 and 3
TN #DMAS-5	7/1/17	Table of Contents, page i. Pages 1-3 Pages 4, 5 and 6 were removed.
TN #DMAS-3	1/1/17	Pages 3-5
TN #100	5/1/15	Title page
TN #99	1/1/14	Page 2
UP #9	4/1/13	Table of Contents Pages 1-5 Page 6 was added.
TN #94	9/1/10	Table of Contents Pages 1-5

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M1370.100 SPENDDOWN – LIMITED BENEFIT ENROLLEES

A. Introduction

This policy applies to individuals enrolled in one of the following limited benefit Medicaid covered groups:

- Qualified Medicare Beneficiaries (QMBs),
- Special Low-income Medicare Beneficiaries (SLMBs),
- Qualified Individuals (QIs),
- Qualified Disabled Working Individuals (QDWIs), and
- Plan First individuals who meet a medically needy (MN) covered group.

These enrollees are eligible for only a limited package of Medicaid services. They do not receive full Medicaid coverage, therefore they must be evaluated to determine if they could become eligible for full Medicaid coverage as medically needy (MN) by meeting a spenddown.

QMB, SLMB, QI, and QDWI individuals meet the ABD MN covered group. Individuals *who have opted to be* enrolled in the Plan First covered group do not necessarily meet an MN covered group. If a Plan First enrollee also meets a MN covered group listed in M0320 or M0330, he must be evaluated to determine if he could become eligible for full Medicaid coverage MN by meeting a spenddown.

This policy does not apply to individuals in full-benefit covered groups.

1. Placement on Spenddown

At application and redetermination, limited benefit enrollees who meet the MN covered group and resource requirements are placed on two six-month spenddown budget periods within the 12 month renewal certification period. They may also be eligible for retroactive MN spenddown eligibility.

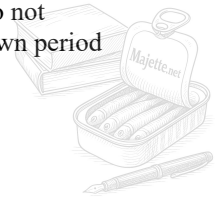
When only one spouse of an aged, blind or disabled (ABD) couple is eligible for limited benefit Medicaid (i.e., one spouse has Medicare and the other does not), the couple is an assistance unit of two for spenddown purposes and placed on two six-month spenddowns.

2. Spenddown Not Met

If an individual who is enrolled in limited-benefit Medicaid coverage does not meet the spenddown, he continues to be eligible for limited benefits. He is subject to the eligibility review policies in M1520.

The spenddown budget period is based on the application date. At renewal, the new spenddown budget period begins the month following the end of the previous spenddown budget period if the renewal is filed in the last month of the spenddown budget period or the following month.

If the renewal is filed two or more months after the end of the last spenddown budget period, the new spenddown budget periods (retroactive or prospective) are based on the date the renewal form was received in the LDSS. Do not complete an early renewal on a spenddown case because the spenddown period must not be shortened by the completion of an early renewal.



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M1370.200 ENROLLMENT PROCEDURES FOR LIMITED-BENEFIT ENROLLEES WHO MEET A SPENDDOWN

A. Policy

QMBs are eligible only for Medicaid coverage of their Medicare premiums, the Medicare deductible and coinsurance charges for Medicare covered services. Medicare does not cover all of the services that Medicaid covers. For example, Medicare does not cover non-emergency transportation.

SLMBs and QDWIs are eligible only for Medicaid coverage of certain Medicare premiums.

Plan First enrollees are eligible only for limited Medicaid coverage related to family planning services and transportation to access those services.

B. Entitlement After Meeting Spenddown

When an enrolled QMB, SLMB, QDWI or Plan First enrollee meets a medically needy spenddown, he is eligible for Medicaid as medically needy beginning the date the spenddown was met and ending the last day of the spenddown budget period.

C. Enrollment Procedures

The *enrollee's limited coverage* must be canceled and *full coverage* reinstated *in VaCMS* in order for the individual to receive the full scope of Medicaid services for the portion of the spenddown budget period in which he is eligible as medically needy. Take the following actions:

1. Cancel Limited Benefit Coverage

Cancel the enrollee's current coverage line that has the limited-benefit aid category (AC).

a. Cancel date is the date **before** the date the spenddown was met.

b. Cancel reason is "024".

2. Reinstate MN Coverage

Reinstate the enrollee in the appropriate medically needy aid category (AC).

- enter the eligibility begin date as the date the spenddown was met.
- enter the eligibility end date - the date the spenddown budget period ends.

Be sure that the application date is the first month in the spenddown budget period. Eligibility will be cancelled effective the end date entered.

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D. Continuing Eligibility and Enrollment After Spenddown Ends

When the spenddown budget period ends, reinstate the enrollee's Medicaid eligibility *in their previous covered group* beginning the day after the MN spenddown budget period eligibility cancel date. Use the original Medicaid application date. Limited-benefit Medicaid eligibility resumes the first day of the month following the end of the spenddown budget period. The month in which the spenddown budget period ends is considered the month in which the agency determines the enrollee's limited benefit eligibility.

Use the procedures in section M1520.200 for completing the annual *renewal* and establishing new spenddown budget periods. Eligibility for each spenddown budget period is evaluated.

Note *for* Plan First: Enrollees do not have a resource test, *so* it is necessary to obtain resource information for Plan First enrollees who meet an MN covered group at the time of renewal. *Prior to reopening Plan First after the spenddown period of eligibility is over, make sure the individual has opted in for Plan First coverage.*

E. Example--QMB Meets Spenddown

EXAMPLE #1: Mr. B is 69 years old. He has Medicare Parts A & B. He applied for Medicaid on July 14, 2005. Resources are within the medically needy limit. His income exceeds the medically needy limit, but is less than the QMB limit. His eligibility is determined on August 1, 2005. He is enrolled in Medicaid QMB coverage effective September 1, 2005, the month following the month the agency determined his QMB eligibility. He is placed on two consecutive 6-month spenddown budget periods, July 1, 2005 through December 31, 2005 and January 1 through June 30, 2006. The agency enrolls him with an eligibility begin date of September 1, 2005, AC 023.

On September 15, 2005, he brings in prescription drug bills. He meets the spenddown on September 13, 2005. On September 25, 2005, the agency cancels his QMB coverage (AC.023) effective September 12, 2005. He is reinstated with MN Medicaid eligibility as AC 028 (dual-eligible medically needy aged) with a begin date of September 13, 2005, an application date of July 14, 2005, and an end date of December 31, 2005.

His spenddown eligibility ends December 31, 2005. On January 1, 2006, the agency worker reinstates his QMB-only Medicaid coverage with a begin date of January 1, 2006, AC 023, application date July 14, 2005. He remains on a spenddown for the spenddown budget period January 1, 2006 through June 30, 2006.

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CHAPTER M14

LONG-TERM CARE

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M1410.010 GENERAL--LONG-TERM CARE

A. Introduction

Chapter M1410 contains the rules that apply to individuals needing long-term services and support (LTSS). The rules are contained in the following subchapters:

- M1410 General Rules
- M1420 Pre-admission Screening
- M1430 Facility Care
- M1440 Community-based Care Waiver Services
- M1450 Transfer of Assets
- M1460 Financial Eligibility
- M1470 Patient Pay - Post-eligibility Treatment of Income
- M1480 Married Institutionalized Individuals' Financial Eligibility

The rules found within this Chapter apply to those individuals applying for or receiving Medicaid who meet the definition of institutionalization.

B. Definitions

The definitions found in this section are for terms used when policy is addressing types of long-term services and support (LTSS), institutionalization, and individuals who are receiving that care.

1. Authorized Representative

An **authorized representative** is a person who is authorized to conduct business for an individual. A competent individual must designate the authorized representative in a written statement, which is signed by the individual applicant. The authorized representative of an incompetent or incapacitated individual is the individual's

- spouse
- parent
- attorney-in fact (person who has the individual's power-of-attorney)
- legally appointed guardian
- legally appointed conservator (formerly known as the committee)
- trustee.

2. Institutionalization

Institutionalization means receipt of 30 consecutive days of

- care in a medical institution (such as a nursing facility), or
- Medicaid Home and Community-Based Services (HCBS), or
- a combination of the two.

The definition of institutionalization is also met when an individual has a signed hospice election that has been in effect for 30 consecutive days.

The 30 days begins with the day of admission to the medical institution or receipt of Medicaid HCBS. The date of discharge into the community (not in LTSS) or death is **NOT** included in the 30 days.

The institutionalization provisions may be applied when the individual is already in a medical facility at the time of the application, or the

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individual has been authorized to receive LTC or Long-term Services and Supports (LTSS) and it is anticipated that he is likely to receive the services for 30 or more consecutive days. If it is known at the time the application is processed that the individual did not or will not meet the 30 consecutive day requirement, the individual is not to be treated as an institutionalized individual *unless community LTSS has been authorized*.

The 30-consecutive-days requirement is expected to be met if the authorization for LTSS is provided verbally or in writing. This allows the agency to begin the evaluation of the applicant in the 300% SSI covered group for institutionalized individuals and to use the special rules for married institutionalized individuals who have a community spouse, if appropriate. However, prior to approval of the individual for Medicaid payment of LTSS, the worker must have received the DMAS-96 that was signed by the supervising physician (or an electronic equivalent) or the signed Waiver Level of Care form (or an electronic equivalent). Applicants must be evaluated as non-institutionalized individuals for the months prior to the month in which the completed form is dated.

The worker must verify that LTSS started within *180* days of the date on the Notice of Action on Medicaid. If services do not start within *180* days of the Notice of Action on Medicaid, the individual can no longer be considered an institutionalized individual and continued eligibility must be re-evaluated as a non-institutionalized individual.

CBC Waiver applicants cannot receive Medicaid payment of CBC services prior to the date the DMAS-96 was signed by the supervising physician. For applicants for whom a Waiver Level of Care form is the appropriate authorization document, Medicaid payment of CBC services cannot begin prior to the date the form has been signed.

For purposes of this definition, continuity is broken by *180* or more consecutive day's absence from a medical institution or by non-receipt of waiver services. For applicants in a nursing facility, if it is known at the time of application processing that the individual left the nursing facility and did not stay for 30 consecutive days *or begin receiving another type of LTSS*, the individual is evaluated as a non-institutionalized individual. Medicaid recipients without a community spouse who request Medicaid payment of LTSS, except MN individuals, and are in the nursing facility for less than 30 consecutive days will have a patient pay determination (see M1470.320).

3. Institution An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor is an **institution**.

4. In An Institution **"In an institution"** refers to an individual who is admitted to live in an institution and receives treatment or services provided there that are appropriate to his requirements.

5. **Long-term Care** **Long-term care** is medical treatment and services directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or lessening of illness, disability or pain which have been received, or are expected to be received, for longer than 30 consecutive days.

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6. Medical Institution (Facility)

A **medical institution** is an institution (facility) that:

- is organized to provide medical care, including nursing and convalescent care,
- has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,
- is authorized under state law to provide medical care, and
- is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

An acute care hospital is a medical institution.

7. Patient

An individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or lessening of illness, disability, or pain, is a **patient.**

8. Inpatient

An **inpatient** is a patient who has been admitted to a medical institution on the recommendation of a physician or dentist **and** who:

- receives room, board, and professional services in the institution for a 24-hour period or longer, **or**
- is expected by the institution to receive room, board, and professional services in the institution for a 24-hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility, and does not actually stay in the institution for 24 hours.

9. Assisted Living Facility (ALF) / Memory Care Unit

An assisted living facility (ALF) or memory care unit are not long-term care facilities or a Medicaid medical institution. An ALF or memory care unit may be located within the same setting or campus such as a continuing care or a long-term care facility, however the level of care differs from that of a Medicaid medical institution.

10. Independent living facility

A senior living center/senior apartment/retirement community are independent living arrangements or residences and are not medical institutions.

11. Group Homes

Group homes providing services through the Community Living Waiver are not medical institutions.

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M1410.020 NON-FINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

To be eligible for Medicaid payment of long-term care, an individual must be eligible for Medicaid. The Medicaid non-financial eligibility requirements in chapter M02 apply to all Medicaid applicants and recipients, including those individuals in long-term care. The non-financial requirements and the location of the manual policy for each requirement are:

B. Citizenship/ Alienage

The citizenship and alien status policy is found in M0220.

C. Virginia Residency

The Virginia state resident policy for patients in medical institutions is found in subchapter M1430.101; the state resident policy for CBC patients is found in M0230.

D. Social Security Number

The social security number policy is found in M0240.

E. Assignment of Rights

The assignment of rights and support cooperation policy is found in M0250.

F. Application for Other Benefits

The application for other benefits policy is found in M0270.

G. Institutional Status

The institutional status policy for facility patients is in subchapter M1430.100. The institutional status policy for CBC waiver services patients is found in subchapter M1440.010.

H. Covered Group (Category)

The Medicaid covered groups eligible for long-term care services are listed in subchapter M1460. The category requirements for the covered groups are found in chapter M03.

M1410.030 FACILITY CARE

A. Introduction

Medicaid covers care provided in a medical institution to persons whose physical or mental condition requires nursing supervision and assistance with activities of daily living. Some institutions have both medical and residential sections. An individual in the medical section of the institution is a patient in a medical facility; however, an individual in the residential portion of the institution is a resident of a residential facility NOT a patient in a medical facility.

This section contains descriptions of the types of **facilities** (medical institutions) in which Medicaid provides payment for services received by eligible patients. See subchapter M1430 for specific policy and procedures which apply to patients in facilities.

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B. Ineligible Individuals

Individuals under age 65 who are patients in an institution for mental diseases (IMD) *are not eligible for Medicaid* unless they are under age 22 and receiving inpatient psychiatric services.

C. Types of Medical Institutions

The following are types of medical institutions in which Medicaid will cover part of the cost of care for eligible individuals:

1. Chronic Disease Hospitals

Specially certified hospitals, also called **"long-stay hospitals"**. There are two of these hospitals enrolled as Virginia Medicaid providers:

- Hospital for Sick Children in Washington, D.C., and
- Lake Taylor Hospital in Norfolk, Virginia.

2. Hospitals and/or Training Centers for the Intellectually Disabled

Facilities (medical institutions) that specialize in the care of intellectually disabled individuals. Intermediate Care Facilities for the Intellectually Disabled (ICF/IDs) are certified by the Department of Health to provide care in a group home setting. Patients in these facilities may have income from participating in work programs.

NOTE: Medically needy (MN) individuals are not eligible for Medicaid payment of LTC services in an ICF/ID because ICF/ID services are not covered for the medically needy.

3. Institutions for Mental Diseases (IMDs)

A hospital, nursing facility or other medical institution that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, of persons with mental diseases. An institution for the mentally retarded is not an IMD.

NOTE: Medically needy (MN) patients age 65 or older are not eligible for Medicaid payment of LTC in an IMD because these services are not covered for medically needy individuals age 65 or over.

4. Intermediate Care Facility (ICF)

A medical institution licensed by the state to provide, on a regular basis, health-related services to patients who do not require hospital or skilled nursing facility care, but whose mental or physical condition requires services in addition to room and board which can be made available only in an institutional setting.

5. Nursing Facility

A medical institution licensed by the state to provide, on a regular basis, health-related services to patients who do not require hospital care, but whose mental or physical condition requires services, such as nursing supervision and assistance with activities of daily living, in addition to room and board and such services can be made available only in an institutional setting. Nursing facilities provide either skilled nursing care services or intermediate care services, or both.

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6. Rehabilitation Hospitals A hospital certified as a rehabilitation hospital, or a unit of a hospital certified by the Department of Health as excluded from the Medicare prospective payment system, which provides inpatient rehabilitation services.

M1410.040 COMMUNITY-BASED CARE WAIVER SERVICES

A. Introduction Medicaid covers long-term care in a community-based setting to individuals whose mental or physical condition requires nursing supervision and assistance with activities of daily living.

This section provides general information about the Community-based Care (CBC) Waiver Services covered by Medicaid. The detailed descriptions of the waivers and the policy and procedures specific to patients in CBC are contained in subchapter M1440.

B. Community-Based Care Waivered Services (CBC) Community-Based Care Waiver Services or Home and Community-based Care or CBC are titles that are used interchangeably. These terms are used to mean a variety of in-home and community-based services reimbursed by the Department of Medical Assistance Services (DMAS) that are authorized under a Section 1915(c) waiver designed to offer individuals an alternative to institutionalization. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid nursing facility placement.

C. Virginia's Waivers Virginia has approved Section 1915(c) home and community-based *care* waivers. These waivers contain services that are otherwise not available to the general Medicaid population. The target population and service configuration for each waiver is outlined in subchapter M1440. An individual cannot receive services under two or more waivers simultaneously; the individual can receive services under only one waiver at a time.

1. *Commonwealth Coordinated Care Plus Waiver* *Effective July 1, 2017, the Elderly or Disabled with Consumer-Direction (EDCD) Waiver and the Technology Assisted (Tech) Waiver were combined and are known as the Commonwealth Coordinated Care Plus (CCC Plus) Waiver. The CCC Plus Waiver serves aged individuals and disabled individuals who would otherwise require institutionalization in a nursing facility. The waiver also serves "technology-assisted" individuals who are chronically ill or severely impaired and who need both a medical device to compensate for the loss of a vital body function, as well as substantial and ongoing skilled nursing care to avert death or further disability.*

The individual may choose to receive agency-directed services, consumer-directed services or a combination of the two. Under consumer-directed services, supervision of the personal care aide is provided directly by the recipient and/or the person directing the care for the recipient. If an individual is incapable of directing his own care, a spouse, parent, adult child, or guardian may direct the care on behalf of the recipient. Services available through this waiver include:



- agency-directed and consumer-directed personal care
- adult day health care
- agency-directed respite care (including skilled respite) and consumer-directed respite care
- Personal Emergency Response System (PERS).

Services provided through CCC Plus Waiver for technology-assisted individuals are expected to prevent placement, or to shorten the length of stay, in a hospital or nursing facility and include:

- private duty nursing
- nutritional supplements
- medical supplies and equipment not otherwise available under the Medicaid State Plan.

2. Community Living Waiver (Formerly the Intellectual Disabilities Waiver)

As part of the My Life, My Community Developmental Disabilities Waiver Redesign, the Intellectual Disabilities (ID) Waiver was renamed the Community Living Waiver in 2016. The waiver is targeted to provide home and community-based services to individuals with developmental disabilities and individuals under the age of six years at developmental risk who have been determined to require the level of care provided in an ICF/ID, and to individuals with related conditions currently residing in nursing facilities who require specialized services. See M1440, Appendix 1 for a list of services available through this waiver.

5. Family and Individual Supports Waiver (Formerly the Individual and Family Developmental Disabilities Support Waiver)

As part of the My Life, My Community Waiver Developmental Disabilities Redesign, the Individual and Family Developmental Disabilities Support (DD) Waiver was renamed the Family and Individual Supports Waiver in 2016. The waiver provides home and community-based services to individuals with developmental disabilities. See M1440, Appendix 1 for a list of services available through this waiver.

6. Building Independence Waiver (Formerly the Day Support Waiver for Individuals with Intellectual Disabilities)

As part of the My Life, My Community Waiver Developmental Disabilities Redesign, the Day Support Waiver for Individuals with Intellectual Disabilities (DS Waiver) was renamed the Building Independence Waiver in 2016. The waiver is targeted to provide home and community-based services to individuals with intellectual disabilities who have been determined to require the level of care provided in an ICF/ID. See M1440, Appendix 1 for a list of services available through this waiver.

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- nursing services for assessments and evaluations
- therapeutic social and recreational programming which provides daily activities for individuals with dementia.

D. Children's Mental Health Program—Not Medicaid CBC

Children's Mental Health Program services are home and community-based services to children who have been discharged from psychiatric residential treatment facilities. **Children's Mental Health Program services are NOT Medicaid CBC services.** See M1520.100 E. for additional information.

E. Program for All-Inclusive Care for the Elderly (PACE)

PACE is the State's community model for the integration of acute and long-term care. Under the PACE model, Medicaid and Medicare coverage/funding are combined to pay for the individual's care. PACE is centered around the adult day health care model and provides the entire spectrum of acute and long-term care services to enrollees without limitations on the duration of services or the dollars spent. Participation in PACE is in lieu of the EDCD Waiver and is voluntary. PACE serves individuals aged 55 and older who (1) meet the nursing facility level of care criteria and (2) reside in their own communities. PACE provides all of an individual's health care and medical long-term care needs.

PACE is NOT a HCBS Waiver; however, the preadmission screening, financial eligibility and post eligibility requirements for individuals enrolled in PACE are the same as those for individuals enrolled in the CCC Plus (formerly EDCD) Waiver.

M1410.050 FINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

An individual in LTSS must meet the financial eligibility requirements that are specific to institutionalized individuals; these requirements are contained in this chapter:

B. Asset Transfer

The asset transfer policy is found in subchapter M1450.

C. Resources

The resource eligibility policy for individuals in LTSS who do not have a community spouse and for MAGI Adults regardless of their marital status is found in subchapter M1460 of this chapter.

Only certain resource eligibility requirements are applicable to individuals in the Modified Adjusted Gross Income (MAGI) Adults covered group who are institutionalized.

The resource eligibility requirements for married individuals in LTSS who have a community spouse, other than MAGI Adults, are found in subchapter M1480 of this chapter. The policy in subchapter M1480 for married institutionalized individuals is NOT used to determine eligibility for MAGI Adults, regardless of their marital status

D. Income

The income eligibility policy for individuals in LTSS who do not have a community spouse is found in subchapter M1460 of this chapter. MAGI Adults in LTSS are evaluated using the MAGI income policy in Chapter M04.

The income eligibility policy for individuals in LTSS who have a community spouse is found in subchapter M1480.

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M1410.060 POST-ELIGIBILITY TREATMENT OF INCOME (PATIENT PAY)

A. Introduction

Most Medicaid-eligible individuals must pay a portion of their income to the LTSS provider; Medicaid pays the remainder of the cost of care. The portion of their income that must be paid to the provider is called "patient pay." Patient pay policy does NOT apply to MAGI Adults.

B. Patient Pay

The policies and procedures for patient pay determination are found in subchapter M1470 of this chapter for individuals who do not have community spouses and in subchapter M1480 for individuals who have community spouses.

M1410.100 LONG-TERM CARE APPLICATIONS

A. Introduction

The general application requirements applicable to all Medicaid applicants/ recipients found in chapter M01 also apply to applicants/recipients who need LTSS services. This section provides those additional or special application rules that apply only to persons who meet the institutionalization definition.

B. Responsible Local Agency

The local social services department in the Virginia locality where the institutionalized individual (patient) last resided outside an institution retains responsibility for receiving and processing the application.

If the patient did not reside in Virginia prior to admission to the institution, the local social services department in the county/city where the institution is located has responsibility for receiving and processing the application.

Home and Community-Based Services (HCBS) applicants apply in their locality of residence.

C. Procedures

1. Application Completion

A signed application is received. A face-to-face interview with the applicant or the person authorized to conduct his business is not required, but is strongly recommended, in order to correctly determine eligibility.

2. Pre-admission Screening

Notice from pre-admission screener is received by the local Department of Social Services (DSS).

NOTE: Verbal communications by both the screener and the local DSS Eligibility Worker (EW) may occur prior to the completion of screening. Also, not all LTC cases require pre-admission screening; see M1420.

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3. Processing

EW completes the application processing. Processing includes receipt of required verifications, completion of the non-financial and financial eligibility determinations, and necessary case record documentation. See chapter M15 for the processing procedures.

An individual's eligibility is determined as an institutionalized individual if he is in a medical facility or has been authorized for Medicaid LTSS. For any month in the retroactive period, an individual's eligibility can only be determined as an institutionalized individual if he met the definition of institutionalization in that month (i.e. he had been a patient in a medical institution—including nursing facility or an ICF-ID-- for at least 30 consecutive days).

If it is known at the time the application is processed that the individual did not or will not receive LTSS (i.e. the applicant has died since making the application) do not determine eligibility as an institutionalized individual.

If the individual's eligibility was determined as an institutionalized individual prior to the receipt of waiver services, the EW must verify that LTSS started within *180* days of the date of the Notice of Action on Medicaid. If LTSS did not start within *180* days of the date of the Notice of Action on Medicaid, the individual's continued eligibility must be re-evaluated as a non-institutionalized individual.

4. Notices

See section M1410.300 for the required notices.

M1410.200 INITIATING LONG-TERM CARE FOR CURRENT RECIPIENTS

A. Introduction

Individuals who currently receive Medicaid and enter LTSS must have their eligibility redetermined using the special rules that apply to LTSS.

For example, an enrollee may be ineligible for Medicaid payment of LTSS because he/she transferred assets without receiving adequate compensation. The asset transfer policy found in M1450 applies to individuals who receive any type of LTSS. Individuals who are ineligible for Medicaid payment of LTSS may remain eligible for other Medicaid-covered services.

B. Authorization for LTSS

An individual must have an assessment to determine that LTSS are appropriate, and LTSS must be authorized for Medicaid payment for LTSS. Subchapter M1420 contains the policies and procedures regarding LTSS authorization.

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C. Recipient Enters LTC

A re-evaluation of eligibility must be done when the EW learns that a Medicaid recipient has started receiving LTSS services. An LTSS screening **is required.**

If an annual renewal **has been** done within the past six months, a partial review to address factors pertinent to receipt of LTC, such as asset transfer, spousal resource assessment, etc., must be done. If an annual renewal **has not** been done within the past six months, a complete renewal must be done. A new application is not required. See subchapter M1520 for renewal procedures.

- For an SSI recipient who has no community spouse and owns no countable real property, verify continued receipt of SSI through SOLQ-I or SVES, obtain information regarding asset transfer from the enrollee or authorized representative, and document the case record. See section M1430.103 for additional information regarding an SSI recipient who enters a nursing facility.

- Rules for married institutionalized recipients, with the exception of MAGI Adults, who have a community spouse are found in subchapter M1480.

D. Notification

When the re-evaluation is done, the EW must complete and send all required notices. See section 1410.300 below. If it is known at the time of application processing that the individual did not or will not receive LTSS services, do not determine eligibility as an institutionalized individual.

M1410.300 NOTICE REQUIREMENTS

A. Introduction

A notice to an applicant or recipient provides formal notification of the intended action or action taken on his/her case, the reason for this action and the authority for proposing or taking the action. The individual needs to clearly understand when the action will take place, the action that will be taken, the rules which require the action, and his right for redress.

Proper notice provides protection of the client's appeal rights as required in 1902(a)(3) of the Social Security Act.

The Notice of Action on Medicaid provides an opportunity for a fair hearing if action is taken to deny, suspend, terminate, or reduce services.

The Medicaid Long-term Care Communication Form (DMAS-225) notifies the LTSS provider of changes to an enrollee's eligibility for Medicaid and for Medicaid payment of LTSS services.

The notice requirements found in this section are used for all LTSS cases.

Individuals in the AAL Waiver have Medicaid eligibility determined in the AG covered group (see M0320.202) and do not have Medicaid eligibility determined as institutionalized individuals. There are no post-eligibility requirements. The enrollment and notification procedures used with non-institutionalized Medicaid recipients are followed (see M0130.300).

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B. Forms to Use

1. Notice of Action on Medicaid & FAMIS (#032-03-0008)

The EW must send the Notice of Action on Medicaid generated by VaCMS or the equivalent hard form, available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms to the applicant/ recipient or his authorized representative to notify him of the agency's decision on the initial Medicaid application, and on a redetermination of eligibility when a recipient starts LTC services.

2. Notice of Patient Pay Responsibility (#032-03-0062)

The Notice of Patient Pay Responsibility is sent to the applicant/enrollee or the authorized representative to notify them of the amount of patient pay responsibility. The form is generated and sent by the Virginia Case Management System (VaCMS) on the day the case is authorized, or by the Medicaid enrollment system if a change is input directly into that system.

3. Medicaid LTC Communication Form (DMAS-225)

The Medicaid Long-term Care (LTC) Communication Form is available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms. The form is used by LTC providers and local departments of social services (LDSS) to exchange information, other than patient pay information, such as:

- a change in the LTC provider, including when an individual moves from CBC to a nursing facility or the reverse;
- the enrollee's physical residence, if different than the LDSS locality;
- changes in the patient's deductions (e.g. a medical expense allowance);
- admission, death or discharge to an institution or community-based care service;
- *when a person is enrolled in a full coverage AC that provides LTSS but they are not eligible, for example, a MAGI Adult passed a screening for CBC but failed to return information to determine asset transfer;*
- changes in eligibility status; and
- changes in third-party liability.

Do not use the DMAS-225 to relay the patient pay amount. Providers are able to access patient pay information through the Department of Medical Assistance Services (DMAS) provider verification systems.

a. When to Complete the DMAS-225

The EW completes the DMAS-225 at the time initial patient pay information is added to VaCMS, when there is a change in the enrollee's situation, including a change in the enrollee's LTC provider, or when a change affects an enrollee's Medicaid eligibility.

b. Where to Send the DMAS-225.

If the individual is enrolled in a *Cardinal Care managed care organization* (MCO), send the DMAS-225 to the individual's MCO. If known, send it to the individual's care coordinator. Contact information for the *Cardinal Care* MCOs is available at *MCO Member Contact Information - Updated August 1, 2023 (virginia.gov)*.

If the individual is not in managed care, send the DMAS-225 as indicated below:

1) For hospice services patients, including hospice patients in a nursing facility or those who are also receiving CBC services, send the original form to the hospice provider.
2) For facility patients, send the original form to the nursing facility.
3) For PACE or adult day health care recipients, send the original form to the PACE or adult day health care provider.
4) For Medicaid CBC, send the original form to the following individuals
   - the case manager at the Community Services Board, for the Family and Individual Supports (formerly Developmental Disabilities) Waivers;
   - the case manager (support coordinator), for the FIS (DD) Waiver,
   - the personal care provider, for agency-directed *CCC Plus Waiver* personal care services and other services. If the patient receives both personal care and adult day health care, send the DMAS-225 to the personal care provider.
   - the service facilitator, for consumer-directed *CCC Plus Waiver* services,
   - the case manager, for any enrollee with case management services, and
   - the case manager at DMAS, for CCC Plus Waiver *Private Duty Nursing (PDN)* services), at the following address:

     Office for Community Living
     600 E. Broad St,
     Richmond, VA 23219

Retain a copy of the completed DMAS-225 in the case record.

4. Advance Notices of Proposed Action

The recipient must be notified in advance of any adverse action that will be taken on his/her Medicaid eligibility or patient pay.

a. Advance Notice of Proposed Action

The system-generated Advance Notice of Proposed Action or hard equivalent **(#032-03-0018)**, available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, must be used when:

- eligibility for Medicaid will be canceled,
- eligibility for full-benefit coverage Medicaid changes to QMB, SLMB, or QWDI limited coverage, or
- Medicaid payment for *LTSS* services will not be allowed for a period of time because of an asset transfer.

b. Notice of Patient Pay Responsibility

When a change in the patient pay amount is entered in VaCMS, a "Notice of Patient Pay Responsibility" will be generated and sent as the advanced notice to the recipient or the authorized representative.

Patient pay must be entered into VaCMS no later than close-of-business on the system cut-off date, to meet the advance notice requirement.

Do not send the "Advance Notice of Proposed Action" when patient pay increases.

5. Administrative Renewal Form

A system-generated paper Administrative Renewal Form is used to redetermine Medicaid eligibility of an individual who is in long-term care. The individual or his authorized representative completes and signs the form where indicated. The EW completes and signs the eligibility evaluation sections on the form.

A renewal can also be completed online using CommonHelp or by telephone by calling the Cover Virginia Call Center. See M1520.200 for information regarding Medicaid renewals.

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CHAPTER M14
LONG-TERM *SERVICES AND SUPPORTS (LTSS)*
SUBCHAPTER 20

SCREENING *FOR MEDICAID LTSS*

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M1420 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-35	7/1/25	Page 5
TN #DMAS-33	10/1/24	Pages 2-5
TN #DMAS-30	1/1/24	Page 1
TN #DMAS-26	1/1/23	Pages 1 and 2
TN #DMAS-25	10/1/22	Table of Contents Pages 1-5
TN #DMAS-24	7/1/22	Table of Contents Pages 1-5 Appendix 1 Page 6 was removed. Appendix 1 was removed and Appendix 2 was renumbered to Appendix 1.
TN #DMAS-19	4/1/21	Page 2
TN #DMAS-17	7/1/20	Pages 1-6
TN #DMAS-12	4/1/19	Page 2
TN #DMAS-11	1/1/19	Entire subchapter
TN #DMAS-7	1/1/18	Table of Contents Pages 2, 5. Appendix 2.
TN #DMAS-5	7/1/17	Pages 2-6
TN #DMAS-1	1/1/17	Table of Contents Pages 3-6 Appendix 3 Appendices 4 and 5 were removed.
TN #DMAS-1	6/1/16	Pages 3-5 Page 6 is a runover page. Appendix 3, page 1
TN #99	1/1/14	Page 4
UP#7	7/1/12	Pages 3, 4
TN #94	09/01/10	Table of Contents Pages 3-5 Appendix 3
TN #93	01/01/10	Pages 2, 3, 5 Appendix 3, page 1 Appendix 4, page 1

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M1420.000 AUTHORIZATION FOR MEDICAID LTSS

M1420.100 MEDICAID LTSS AUTHORIZATION REQUIREMENTS

A. Introduction

Medicaid covers long-term services and supports (LTSS) in a medical facility or community-based setting for individuals whose mental or physical condition requires assistance with activities of daily living. For Medicaid to cover LTSS, the individual must:

- meet the definition of an institutionalized individual in subchapter M1410. The individual's eligibility as an institutionalized individual may be determined when the individual is already in a medical facility at the time of the application, or the individual has been authorized to receive LTSS and it is anticipated that they are likely to receive the services for 30 or more consecutive days. If it is known at the time the application is processed that the individual did not or will not meet the 30 consecutive day requirement, the individual is not to be treated as an institutionalized individual *unless community LTSS has been authorized*;
- meet all Medicaid non-financial eligibility requirements in Chapter M02;
- be financially eligible based on the policy and procedures in subchapter M1460 for unmarried individuals and married institutionalized individuals without a community spouse or subchapter M1480 for institutionalized individuals with a community spouse; and
- Meet the asset transfer policies in subchapter M1450.

This subchapter describes the LTSS authorization required for the types of LTSS, which are facility-based care, home-and-community-based (HCBS) services covered under a Section 1915(c) waiver, and the Program for All Inclusive Care for the Elderly (PACE).

B. Operating Policies

1. Payment Authorization

An LTSS authorization is needed for Medicaid payment of nursing facility (medical institution), HCBS waiver, and PACE services for Medicaid recipients. The authorization is not required for the local DSS to determine financial eligibility using the more liberal rules for institutionalized individuals, including the 300% SSI covered group and the special rules for married institutionalized individuals with a community spouse. If the individual meets the definition of institutionalization they are evaluated using these rules. The appropriate authorization document (form or screen print) or documentation of institutionalization must be maintained in the individual's case record.

2. Required Authorization Documents

a. Nursing facility-based care, the Commonwealth Coordinated Care Plus Waiver, and PACE

The Medicaid LTSS Authorization Form, DMAS 96 or the equivalent information printed from the electronic Medicaid LTSS Screening system (eMLS) or the Minimum Data Survey (MDS) is used to authorize nursing facility-based care, the Commonwealth Coordinated Care (CCC) Plus Waiver, and PACE. The Authorization form certifies the type of LTSS service.

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If documentation is not available when placement needs to be made, verbal assurance from a screener that the form approving LTSS will be mailed or electronically available is sufficient to determine Medicaid eligibility as an institutionalized individual. This information must be received prior to approval and enrollment in Medicaid as an institutionalized individual.

a. The Community Living Waiver, Building Independence Waiver, and Family and Individual Supports Waiver.

The Waiver Authorization System (WaMS) (see M1420, Appendix 3) or Intellectual Disability On-line System (IDOLS) are used to authorize services received under the Community Living (CL) Waiver, Building Independence (BI) Waiver, and Family and Individual Supports Waiver. Copies of the authorization screens or a *LTSS Communication form (DMAS*-225) stating services have started are acceptable.

3. Authorization Not Received

If the appropriate documentation authorizing LTSS is not received, Medicaid eligibility for an individual who is living in the community must be determined as a non-institutionalized individual.

4. *Continuing* Authorization

Providers re-evaluate the individual's level of care periodically. The authorization for Medicaid payment of LTSS may be rescinded by the physician or by DMAS at any point that the individual is determined to no longer meet the required Medicaid level of care criteria via level of care review process.

When an individual is no longer eligible for a HCBS Waiver service, the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

When an individual leaves the PACE program and no longer receives LTSS services, the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

Facilities document the level of care using the Minimum Data Survey (MDS). For an individual in a nursing facility who no longer meets the level of care but continues to reside in the facility, **continue to use the eligibility rules for institutional individuals** even though the individual no longer meets the level of care criteria. Medicaid will not make a payment to the facility for LTSS.

M1420.200 RESPONSIBILITY FOR THE LTSS AUTHORIZATION

A. Introduction

The process for completing the required assessment and authorizing services depends on the type of LTSS.

B. Nursing Facility

In order to qualify for nursing facility care, an individual must be determined to meet functional criteria, have a medical or nursing need and be at risk of nursing facility or hospital placement within 30 days without services. An assessment known as the LTSS Screening is completed by a designated screener. For individuals who apply for Medicaid after entering a nursing facility, medical staff at facilities document the level of care needed using the Minimum Data Survey (MDS). The Eligibility Worker does not need to see any screening authorization if the individual applying is already a resident of a nursing *(or PACE)* facility when the Medicaid application is filed.

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The screener's approval for Medicaid LTSS for new admissions must be substantiated in the case record by a DMAS-96 or the equivalent information from the eMLS system, WaMS printout or the Minimum Data Survey (MDS). Medicaid payment for LTSS cannot begin prior to the date the DMAS-96 is signed by the physician and prior authorization of services for the individual has been given to the provider by DMAS or the managed care plan.

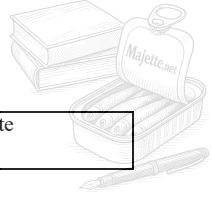
An overview of the screening requirements when an individual needs nursing home care is listed below:

- For hospital patients who are currently enrolled in Medicaid and will be admitted to a nursing facility with Medicaid as the payment source, the screening is completed by hospital staff.
- Nursing *(and PACE)* facilities are permitted to admit individuals who are discharged directly from a hospital to a nursing facility for skilled services without an LTSS screening if the skilled services are not covered in whole or partially by Virginia Medicaid. Once the individual is admitted to the nursing facility, if the individual requests an LTSS screening or applies for Medicaid coverage for LTSS, nursing facility staff will conduct a LTSS screening. The Eligibility Worker does not need to see the screening authorization if the individual applying is already a resident of a nursing facility *(or receiving PACE services)* when the Medicaid application is filed. DMAS will not pay for LTSS services unless the facility has documented that the applicant meets the nursing facility level of care.
- For individuals who are not inpatients in a hospital or are incarcerated prior to nursing facility admission, the screening is completed by local community-based teams (CBT) composed of agencies contracting with the Department of Medical Assistance Services (DMAS). The community-based teams usually consist of the local health department physician, a local health department nurse, and a local social services department service worker. Incarcerated individuals will be screened by the community-based team in the locality in which the facility is located.

C. CCC Plus Waiver

Effective July 1, 2017, the Elderly or Disabled with Consumer-Direction (EDCD) Waiver and the Technology Assisted (Tech) Waiver were combined and are known as the Commonwealth Coordinated Care Plus (CCC Plus) Waiver. Community-based teams, hospital screening teams and nursing facility *or PACE* screening teams are authorized to screen individuals for the CCC Plus Waiver. See M1420.400 C for more information.

An individual screened and approved for the CCC Plus Waiver will have a DMAS-96 signed and dated by the screener and the physician (or the nurse practitioner or the physician's assistant working with the physician) or the equivalent information printed from the eMLS system.



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If the individual elects consumer-directed services, DMAS or its contractor must give final authorization. If services are not authorized, the service facilitator will notify the LDSS, and the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

For individuals who qualify for Private Duty Nursing (PDN) under the CCC Plus Waiver, a Medicaid LTSS Communication form (DMAS-225) and a Commonwealth Coordinated Care Plus Waiver PDN Level of Care Eligibility form (DMAS-108 for Adults or DMAS-109 for children) will be completed and sent to the LDSS.

D. Program for All Inclusive Care for the Elderly (PACE)

Community-based screening teams, hospital screening teams and nursing *or PACE* facility screening teams are authorized to screen individuals for PACE. If the individual is screened and approved for LTSS, the team will inform the individual about any PACE program that serves the individual's locality. Individuals approved for PACE will have a DMAS-96 signed and dated by the screener and the supervising physician (or the nurse practitioner or the physician's assistant working with the physician) or the equivalent information printed from the eMLS system.

E. Community Living Waiver

Local Community Services Boards (CSBs) are authorized to screen individuals for the Community Living Waiver. Final authorizations for waiver services are made by Department of Behavioral Health and Developmental Services (DBHDS) staff.

Individuals screened and approved for the Community Living Waiver will have a printout of the WaMS or Intellectual Disability On-line System (IDOLS) authorization screen completed by the DBHDS representative. The screen print will be accompanied by a completed DMAS-225 form identifying the client, the Community Services Board providing the service, and begin date of service.

F. Family and Individual Supports Waiver

CSBs are authorized to screen individuals for the Family and Individual Supports Waiver. Final authorizations for waiver services are made by DBHDS staff.

Individuals screened and approved for the Family and Individual Supports Waiver will have a printout of the WaMS or IDOLS authorization screen completed by the DBHDS representative. The screen print will be accompanied by a completed DMAS-225 form identifying the client, the Community Services Board providing the service, and begin date of service.

G. Building Independence Waiver

Local CSB and DBHDS case managers are authorized to screen individuals for the Building Independence Waiver. Final authorizations for waiver services are made by DBHDS staff.

Individuals screened and approved for the Building Independence Waiver will have a printout of the WaMS or IDOLS authorization screen completed by the DBHDS representative. The screen print will be accompanied by a completed DMAS-225 form identifying the client, the Community Services Board providing the service, and begin date of service.

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M1420.300 COMMUNICATION PROCEDURES

A. Introduction

To ensure that nursing facility, PACE placement or receipt of Medicaid HCBS services are arranged as quickly as possible, there must be prompt communication between screeners and eligibility staff.

B. Procedures

1. LDSS Contact

The LDSS should designate an appropriate staff member for screeners to contact. Local social services, hospital staff, CBTs, Managed Care Organizations (MCOs) and nursing facilities should be given the name and contact information for that person to facilitate timely communication between screeners and eligibility staff.

2. Screeners

Screeners must inform the individual's eligibility worker when the screening process has been completed.

3. Eligibility Worker (EW) Action

The EW must inform the individual, the provider and the MCO once eligibility for Medicaid payment of LTSS has been determined. If the individual is found eligible for Medicaid and written assurance of approval by the screening team, DMAS, or the managed care plan has been received (DMAS-96, WaMS printout or the Minimum Data Survey [MDS]), the eligibility worker must give the LTSS provider the enrollee's Medicaid identification number.

M1420.400 LTSS SCREENING EXCLUSIONS (Special Circumstances)

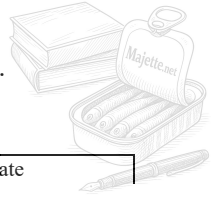
A. Purpose

The screening certification authorizes the local DSS to determine financial eligibility using the more liberal rules for institutionalized individuals, including the 300% SSI covered group and the special rules for married institutionalized individuals with a community spouse. The Eligibility Worker does not need to see any screening authorization if the individual applying is already a resident of a nursing (or PACE) facility when the Medicaid application is filed.

B. Screening Special Circumstances

Screening for LTSS is NOT required when:

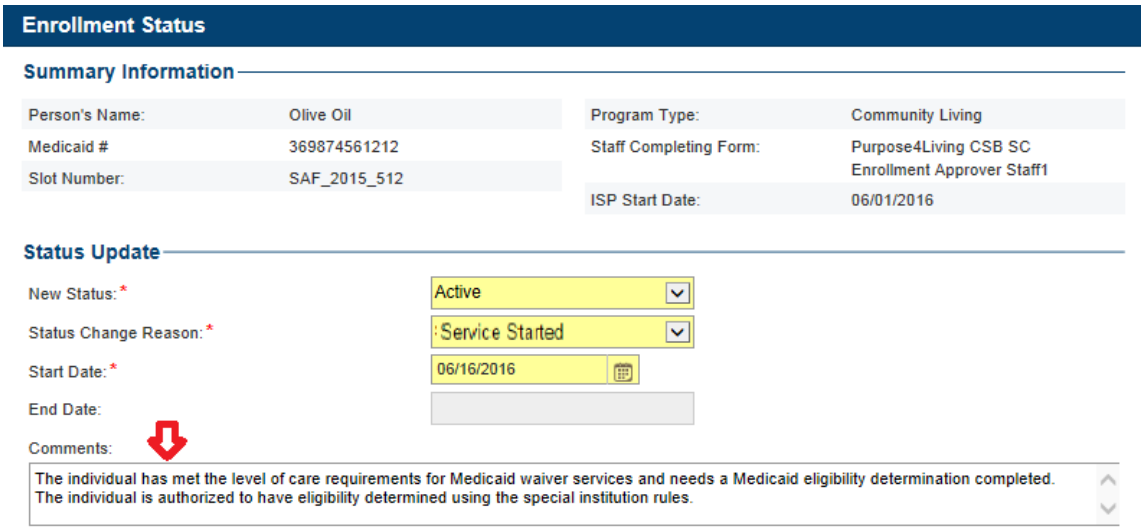
- the individual is a resident in a nursing facility, receiving CCC Plus Waiver services or in PACE at the time of application;
- the individual resides out of state (either in a community, hospital or nursing facility setting) and seeks direct admission to a nursing facility;
- the individual is an inpatient at an in-state owned/operated facility licensed by DBHDS, in-state or out of state Veterans hospital, military hospital or VA Medical Center, and seeks direct admission to a nursing facility;
- the individual enters a nursing facility directly from the CCC Plus Waiver or PACE services;
- *the individual is being enrolled in Medicaid Works;*
- the individual is being enrolled in Medicaid hospice.



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Waiver Management System (WaMS) Screen Print for Community Living Waiver, Building Independence Waiver, and Family and Individual Supports Waiver Authorizations



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M1430 Changes

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TN #DMAS-30	1/1/24	Page 3
TN #DMAS-26	10/1/22	Page 1
TN #DMAS-24	7/1/22	Page 3
TN #DMAS-20	7/1/21	Table of Contents Page 2 Appendix 1 was removed.
TN #DMAS-19	4/1/21	Pages 1, 2
TN #DMAS-10	10/1/18	Pages 3-5 Appendix 1
TN #DMAS-7	1/1/18	Pages 1, 2, 4 Appendix 1
TN #93	1/1/10	Appendix 1, page 1
Update (UP) #1	7/1/09	Appendix 1, page 1

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M1430.000 FACILITY CARE

A. Introduction

Medicaid covers care provided in a facility to persons whose physical or mental condition requires nursing supervision and assistance with activities of daily living.

This subchapter (M1430) contains the specific policy and rules that apply to individuals needing or receiving long-term supports and services (LTSS), also referred to as long-term care (LTC) services in medical institutions (facilities).

B. Definitions

Definitions for terms used when policy is addressing types of *LTSS*, institutionalization, and individuals who are receiving that care are found in Subchapter M1410.

M1430.010 TYPES OF FACILITIES & CARE

A. Introduction

This section contains descriptions of the types of medical facilities in which Medicaid provides payment for services received by eligible patients. *Also refer to M1410.010.B for additional guidance.*

B. Medical Facility Defined

A **medical facility** is an institution that:

- is organized to provide medical care, including nursing and convalescent care,
- has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,
- is authorized under state law to provide medical care, and
- is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

C. Types of Medical Facilities

The following are types of medical facilities in which Medicaid will cover part of the cost of care:

1. Chronic Disease Hospitals

Chronic disease hospitals are specially certified hospitals, also called "long-stay hospitals". There are two of these hospitals enrolled as Virginia Medicaid providers:

- Hospital for Sick Children in Washington, D.C.;
- Lake Taylor Hospital in Norfolk, Virginia.

2. Intermediate Care Facilities for the Intellectually Disabled (ICF-ID)

An **ICF-ID** is an institution for the intellectually disabled or persons with related conditions is an institution or a distinct part of an institution that

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- is primarily for the diagnosis, treatment or rehabilitation of individuals with intellectual disabilities or related conditions, and
- provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or rehabilitative services to help each individual function at his greatest ability.

Some community group homes are certified as Intermediate Care Facilities for the Intellectually Disabled (ICF-IDs) by the Department of Health. Patients in these facilities may have income from participating in work programs.

NOTE: Medically needy (MN) individuals are not eligible for Medicaid payment of LTC services in an ICF-ID because ICF-ID services are not covered for the medically needy.

3. Institutions for Treatment of Mental Diseases (IMDs)

An **IMD** is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, of persons with mental diseases. An institution for those intellectually disabled is NOT an IMD. For a list of state-operated IMDs in Virginia, see *M0280, Appendix 2*.

Federal regulations in 42 CFR 435.1008 prohibit federal financial participation (FFP) in most Medicaid services provided to individuals under age 65 years who are patients in an institution for the treatment of mental diseases (IMD), unless they are under age 22 and are receiving inpatient psychiatric services. However, an individual who is age 22 or over, but under age 65 and who is enrolled in Medicaid at the time of admission to an IMD may remain enrolled in Medicaid. The Department of Medical Assistance Services (DMAS) will coordinate with the Centers for Medicare and Medicaid Services (CMS) to ensure that no unauthorized FFP occurs.

Medically needy (MN) patients over 65 years of age are not eligible for Medicaid payment of LTSS services in an IMD because these services are not covered for medically needy individuals age 65 or over.

4. Nursing Facility

A **nursing facility** is a medical institution licensed by the state to provide, on a regular basis, health-related services to patients who do not require hospital care, but whose mental or physical condition requires services, such as nursing supervision and assistance with activities of daily living, in addition to room and board and such services can be made available only in an institutional setting. Nursing facilities provide either skilled nursing care services or intermediate care services, or both.

5. Rehabilitation Hospitals

A **rehabilitation hospital** is a hospital certified as a rehabilitation hospital, or a rehabilitation unit of a hospital certified by the Department of Health as excluded from the Medicare prospective payment system, which provides inpatient rehabilitation services.

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M1430.100 BASIC ELIGIBILITY REQUIREMENTS

A. Overview

To be eligible for Medicaid payment of long-term care, an individual must be eligible for Medicaid. The Medicaid non-financial eligibility requirements in Chapter M02 apply to all individuals in long-term care. The eligibility requirements and the location of the manual policy are listed below in this section.

B. Citizenship/ Alienage

The citizenship and alien status policy is found in subchapter M220.

C. Virginia Residency

The Virginia state resident policy specific to facility patient is found in subchapter M0230 and section M1430.101 below.

D. Social Security Number

The social security number policy is found in subchapter M0240.

E. Assignment of Rights

The assignment of rights is found in subchapter M0250.

F. Application for Other Benefits

The application for other benefits policy is found in subchapter M0270.

G. Institutional Status

The institutional status requirements specific to long-term care in a facility are in subchapter M0280.

H. Covered Group (Category)

The Medicaid covered groups eligible for LTC services, also called long-term services and supports (LTSS), are listed in M1460. The requirements for the covered groups are found in chapter M03.

I. Financial Eligibility

An individual who has been a patient in a medical institution (such as a nursing facility) for at least 30 consecutive days of care or who has been authorized for LTSS is treated as an institutionalized individual for the Medicaid eligibility determination. Financial eligibility for institutionalized individuals is determined as a one-person assistance unit separated from his/her legally responsible relative(s).

The 30-consecutive-days requirement is expected to be met if authorization for LTSS is provided verbally or in writing. If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has *180* days from the date on the Notice of Action to begin services.

For unmarried individuals, and for married individuals without community spouses other than MAGI Adults, the resource and income eligibility criteria in subchapter M1460 is applicable.

MAGI Adults in LTC are evaluated using the resource policy in M1460 and the MAGI income policy in M04. Only certain resource eligibility requirements are applicable to individuals in the Modified Adjusted Gross Income (MAGI) Adult covered group who are institutionalized.

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For married individuals with community spouses, *other than MAGI Adults*, the resource and income eligibility criteria in subchapter M1480 is applicable.

The asset transfer policy in M1450 applies to all facility patients, *including MAGI Adults.*

M1430.101 VIRGINIA RESIDENCE

A. Policy

An individual must be a resident of Virginia to be eligible for Virginia Medicaid while he/she is a patient in a medical facility. There is no durational requirement for residency. Additional Virginia residency requirements are in subchapter M0230.

B. Individual Age 21 or Older

An institutionalized individual age 21 years or older is a resident of Virginia if:

- the individual is in an institution in Virginia with the intent to remain permanently or for an indefinite period; or
- the individual became incapable of declaring his intention to reside in Virginia at or after becoming age 21 years, he/she is residing in Virginia and was not placed here by another state government agency.

1. Determining Incapacity to Declare Intent

An individual is incapable of declaring his/her intent to reside in Virginia if:

- he has an I.Q. of 49 or less or has a mental age of less than 7 years;
- he has been judged legally incompetent; or
- medical documentation by a physician, psychologist, or other medical professional licensed by Virginia in the field of *intellectual disabilities* supports a finding that the individual is incapable of declaring intent to reside in a specific state.

2. Became Incapable Before Age 21

An institutionalized individual age 21 years or older who became incapable of stating intent before age 21 is a resident of Virginia if:

- the individual's legal guardian or parent, if the parents reside in separate states, who applies for Medicaid for the individual resides in Virginia;
- the individual's legal guardian or parent was a Virginia resident at the time of the individual's institutional placement;
- the individual's legal guardian or parent who applies for Medicaid for the individual resides in Virginia and the individual is institutionalized in Virginia; or
- the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, the individual is institutionalized in Virginia, and the person who files the individual's Medicaid application resides in Virginia.
- if a legal guardian has been appointed for the individual and parental rights have been terminated, the guardian's state of residence is used to determine residency instead of the parent's.



C. Individual Under Age 21

An institutionalized individual under age 21 years who is not emancipated is a resident of Virginia if:

- the individual's legal guardian or parent was a Virginia resident at the time of the individual's institutional placement;
- the individual's legal guardian or parent who applies for Medicaid for the individual resides in Virginia and the individual is institutionalized in Virginia; or
- the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, the individual is institutionalized in Virginia, and the person who files the individual's Medicaid application resides in Virginia.
- if a legal guardian has been appointed for the individual and parental rights have been terminated, the guardian's state of residence is used to determine residency instead of the parent's.

D. Placed by Another State's Government

When an individual is placed in a facility by another (not Virginia) state or local government agency, the placing state retains responsibility for the individual's Medicaid. Placement by a government agency is any action taken by the agency beyond providing general information to the individual and the individual's family to arrange the individual's admission to an institution. A government agency includes any entity recognized by State law as being under contract with the state government.

E. Individual Placed Out-of-state by Virginia

An individual retains Virginia residency for Medicaid if he/she is placed by a Virginia government agency in an institution outside Virginia. Placement into an out-of-state LTC medical facility must be pre-authorized by DMAS.

When a competent individual voluntarily leaves the facility in which Virginia placed him/her, he/she becomes a resident of the state where he/she is physically located.

F. Disputed or Unclear Residency

If the individual's state residency is unclear or is disputed, contact your Regional *Consultant* for help. When two states cannot resolve the residency dispute, the state where the individual is physically located becomes his/her state of residency for Medicaid purposes.

M1430.10*2* ADVANCE PAYMENTS

A. Introduction

There are instances when a family member, or other individual, makes an advance payment to the facility for a prospective Medicaid patient prior to or during the Medicaid application process. This assures the patient's admission to, and continued care in, the facility. The individual may have been promised by the facility that the advance payment will be refunded if the patient is found eligible for Medicaid.



Advance payments which are expected to be reimbursed to an individual other than the Medicaid applicant once Medicaid is approved, and payments made to the facility to hold the bed while the patient is hospitalized, are not counted as income for either eligibility or patient pay determinations.

B. Reimbursement Any monies contributed toward the cost of the patient's care pending Medicaid eligibility determination must be reimbursed to the contributing party by the facility when Medicaid eligibility is established. The only exception is when the payment is made from the patient's own funds which exceeded the resource limit.

M1430.*103* SSI RECIPIENTS

A. Introduction This section provides information about SSI recipients who are admitted to medical facilities.

B. Unmarried SSI Recipient When an unmarried Medicaid-eligible SSI recipient enters a facility for LTC, review his/her Medicaid eligibility, especially institutional status, asset transfer and home property ownership.

1. Temporary Period An SSI recipient who is admitted to a medical facility temporarily, for 3 months or less, retains his/her usual monthly SSI payment and remains eligible for Medicaid if resources are within Medicaid limits. This "temporary" SSI payment is not counted available for patient pay. See M1470.

2. Indefinite Period If not admitted temporarily, or when the 3-month temporary period ends, the SSI income limit is reduced to $30 per month. If the individual has no other countable income, his SSI payment will usually be $30 per month. If he has countable income of $30 or more, his SSI payment will terminate.

Review his income eligibility when the SSI payment terminates. See M1460.

C. Married SSI Recipient When a married Medicaid-eligible SSI recipient enters a facility for LTC, review his/her Medicaid eligibility, especially institutional status, asset transfer and resources. Use the married institutionalized individuals' policy in M1480 to determine resource eligibility and patient pay.

1. Temporary Period An SSI recipient who is admitted to a medical facility temporarily, for 3 months or less, usually retains his/her usual monthly SSI payment and remains eligible for Medicaid if resources are within Medicaid limits. This "temporary" SSI payment is not counted available for patient pay. See M1470.

2. Indefinite Period If not admitted temporarily, or when the 3-month temporary period ends, the SSI income limit is reduced to $30 per month. If the individual has no other countable income, his SSI payment will usually be $30 per month. If he has countable income of $30 or more, his SSI payment will terminate. Review his income eligibility when the SSI payment terminates. See M1460.

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CHAPTER M14
LONG-TERM CARE
SUBCHAPTER 40

COMMUNITY-BASED CARE WAIVER SERVICES

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M1440 Changes

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TN #DMAS-7	1/1/18	Page 1. Appendix 1, Page 4.
TN #DMAS-5	7/1/17	Table of Contents Pages 3-9, 11, 12
TN #DMAS-3	1/1/17	Table of Contents Pages 3-12 Appendix 1 was added. Page 2 is a runover page. Pages 13-23 were deleted.
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M1440.000 COMMUNITY-BASED CARE WAIVER SERVICES

M1440.001 GOVERNING LAWS

A. Introduction

This subchapter provides information about the Medicaid Community-Based Care (CBC) waivers, the individuals eligible for waiver services, and information about the services provided in the waivers.

B. Community-Based Care Waiver Services (CBC)

Community-Based Care Waiver Services or Home and Community-Based Care or CBC are titles that are used interchangeably. These terms are used to mean a variety of in-home and community-based services reimbursed by DMAS that are authorized under a Section 1915(c) waiver designed to offer individuals an alternative to institutionalization in a medical facility. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid nursing facility placement.

C. Federal Law

Section 1915 of the Social Security Act has provisions which allow states to waive certain requirements of Title XIX as a cost saving measure. Virginia uses 1915(c) which allows the state to provide services not otherwise available under the State Plan to specifically targeted individuals. Individuals who may be targeted are those which it (the state) can show would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the *intellectually disabled,* the cost of which would be reimbursed under the State plan.

Under a 1915(c) waiver, the state may waive the requirements of Section 1902 of Title XIX, related to state wideness and comparability of services, and may apply the institutional deeming income and resource rules for home and community-based recipients. This allows individuals with catastrophic medical needs to retain income for their maintenance in the home.

Any waiver granted under Section 1915(c) must satisfy requirements established by the Secretary regarding cost-effectiveness (the cost to Medicaid of home and community-based services for recipients must not exceed 100% of the cost to Medicaid for their institutional care), the necessary safeguards taken to protect the health and welfare of individuals, financial accountability, evaluations and periodic re-evaluations of the need for an institutional level of care, the impact of the waiver and recipient choice informing procedure.

D. Virginia's Waivers

Virginia has approved Section 1915(c) home and community-based waivers. These waivers contain services that are otherwise not available to the general Medicaid population. The target population and service configuration for each waiver is outlined in this subchapter.

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M1440.010 BASIC ELIGIBILITY REQUIREMENTS

A. Introduction

Services provided through the Waivers can be covered by Medicaid when the applicant or recipient meets the Medicaid eligibility requirements in this section.

B. Waiver Requirements

The individual must meet the pre-admission screening criteria for CBC waiver services and the targeted population group requirement. Some of the targeted population groups are:

- individuals age 65 or older, blind or disabled
- individuals with mental retardation
- individuals who need a medical device to compensate for loss of a vital bodily function
- individuals with developmental disabilities who do not have a diagnosis of mental retardation

The eligibility worker does NOT make the determination of whether the individual meets the waiver requirements; this is determined by the pre-admission screener or by DMAS.

NOTE: The individual cannot be authorized to receive services under more than one waiver at a time.

C. Non-financial Eligibility

The individual must meet the Medicaid non-financial and financial eligibility requirements listed below:

1. Citizenship/ Alienage

The citizenship and alien status policy is found in subchapter M0220.

2. Virginia Residency

The Virginia state resident policy specific to CBC waiver services patients is found in subchapter M0230.

3. Social Security Number

The social security number policy is found in subchapter M0240.

4. Assignment of Rights/ Cooperation

The assignment of rights and support cooperation policy is found in subchapters M0250 and M0260.

5. Application for Other Benefits

The application for other benefits policy is found in subchapter M0270.

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6. Institutional Status

To be eligible for Medicaid, an individual approved for CBC waiver services must meet the institutional status requirement. A CBC waiver services recipient usually is not in a medical institution; most CBC recipients live in a private residence in the community. However, an individual who resides in a residential facility such as an assisted living facility (ALF) may be eligible for some CBC waiver services. The institutional status requirements applicable to CBC waiver services recipients are in subchapter M0280.

7. Covered Group

The requirements for the covered groups are found in subchapters M0320 and M0330.

D. Financial Eligibility

An individual who has been screened and approved for CBC services is treated as an institutionalized individual for the Medicaid eligibility determination. Financial eligibility is determined as a one-person assistance unit separated from his legally responsible relative(s) with whom he lives.

If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has *180* days from the date on the Notice of Action to begin receiving CBC services.

For unmarried individuals, and for married individuals without community spouses other than MAGI Adults, the resource and income eligibility criteria in subchapter M1460 is applicable.

MAGI Adults in LTC are evaluated using the resource policy in M1460 the MAGI income policy in M04. Only certain resource eligibility requirements are applicable to individuals in the Modified Adjusted Gross Income (MAGI) Adult covered group who are institutionalized.

For married individuals with community spouses, other than MAGI Adults, the resource and income eligibility criteria in subchapter M1480 is applicable.

The asset transfer policy in M1450 applies to all CBC waiver services recipients.

M1440.100 CBC WAIVER DESCRIPTIONS

A. Introduction

This section provides a brief overview of the Medicaid CBC waivers. The overview is a synopsis of the target populations, basic eligibility rules, available services, and the assessment and service authorization procedure for each waiver.

The eligibility worker does not make the determination of whether the individual is eligible for the waiver services; this is determined by the pre- admission screener or by DMAS. The policy in the following sections is only for the eligibility worker's information to better understand the CBC waiver services.

B. Definitions

Term definitions used in this section are:

1. Developmental Disability

"Developmental disability," as defined in Virginia Code § 37.2-100, means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated; and (vi) an individual from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v), if the individual, without services and supports, has a high probability of meeting those criteria later in life.

2. Financial Eligibility Criteria

means the rules regarding asset transfers; what is a resource; when and how that resource counts; what is income; when and how that income is considered.

3. Non-financial Eligibility Criteria

means the Medicaid rules for non-financial eligibility. These are the rules for citizenship and alienage; state residence; social security number; assignment of rights and cooperation; application for other benefits; institutional status; cooperation DCSE; and covered group and category requirements.

4. Patient

an individual who has been approved by a pre-admission screener to receive Medicaid waiver services.

C. Developmental Disabilities Waivers

In 2016, as part of the My Life, My Community Waiver Redesign, the Intellectual Disabilities Waiver, Day Support Waiver and Individual and Family Developmental Disabilities Support Waiver (DD waiver) were renamed. They were renamed to the Community Living Waiver, Building Independence Waiver, and Family and Individual Supports Waivers, respectively. These waivers are referred to collectively as the Developmental Disabilities Waivers. The services offered under these waivers are contained in M1440, Appendix 1.

M1440.101 *COMMONWEALTH COORDINATED CARE PLUS WAIVER (FORMERLY THE EDCD AND TECHNOLOGY ASSISTED WAIVERS)*

A. General Description

Effective July 1, 2017, the Elderly or Disabled with Consumer-Direction (EDCD) Waiver and the Technology Assisted (Tech) Waiver were combined and are known as the Commonwealth Coordinated Care Plus (CCC Plus) Waiver. The CCC Plus Waiver is targeted to provide home and community-based services to individuals age 65 or older, or who are disabled, who have been determined to require the level of care provided in a medical institution and are at risk of facility placement. The waiver also serves "technology-assisted"



individuals who are chronically ill or severely impaired and who need both a medical device to compensate for the loss of a vital body function, as well as substantial and ongoing skilled nursing care to avert death or further disability.

Recipients may select agency-directed services, consumer-directed services, or a combination of the two. Under consumer-directed services, supervision of the personal care aide is provided directly by the recipient. Individuals who are incapable of directing their own care may have a spouse, parent, adult child, or guardian direct the care on behalf of the recipient. Consumer-directed services are monitored by a Service Facilitator.

B. Targeted Population

This waiver serves persons who are:

a. age 65 and over, or

b. disabled; disability may be established either by SSA, DDS, or a pre-admission screener (provided the individual meets a Medicaid covered group and another category).

Waiver services are provided to any individual who meets a Medicaid covered group and is determined to need an institutional level of care by a pre-admission screening. The individual does not have to meet the Medicaid disability definition.

Technology assisted services are provided to individuals who need both
1) a medical device to compensate for the loss of a vital body function and
2) substantial and ongoing skilled nursing care.

C. Eligibility Rules

All individuals receiving waiver services must meet the Medicaid non-financial and financial eligibility requirements for an eligible patient in a medical institution. The income limit used for this waiver is 300% of the current SSI payment standard for one person, or the medically needy income limit (spenddown).

The resource and income rules are applied to waiver-eligible patients as if the patients were in a medical institution.

NOTE: CCC Plus Waiver services shall not be offered to any patient who resides in a nursing facility, an intermediate care facility for the intellectually disabled (ICF/ID), a hospital, board and care facility, or an adult care residence licensed by DSS.

Individuals needing technology-assisted services must have a live-in primary care giver who accepts responsibility for the individual's health and welfare.

D. Services Available

LTC services available through this waiver include:

- adult day health care
- agency-directed and consumer-directed personal care
- agency-directed respite care (including skilled respite) and consumer-directed respite care
- Personal Emergency Response System (PERS).

Services provided through CCC Plus Waiver for technology-assisted individuals include:

- *private duty nursing*
- *nutritional supplements*
- *medical supplies and equipment not otherwise available under the Medicaid State Plan.*

E. ***Assessment and Service Authorization*** *The nursing home pre-admission screeners assess and authorize CCC Plus Waiver services based on a determination that the individual is at risk of nursing facility placement.*

M1440.102 COMMUNITY LIVING WAIVER

A. General Description The Community Living Waiver program, formerly the Intellectual Disabilities (ID) Waiver, is targeted to provide home and community-based services to individuals with developmental disabilities and individuals under the age of six years at developmental risk who have been determined to require the level of care provided in an ICF/ID.

B. Eligibility Rules All patients receiving waiver services must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid-eligible in a medical institution. The resource and income rules are applied to waiver eligible individuals as if the individual were residing in a medical institution.

The income limit used for this waiver is 300% of the current SSI payment standard for one person**. Medically Needy individuals are not eligible for this waiver.** If the individual's income exceeds 300% SSI, the individual is not eligible for services under this waiver.

C. Services Available The services available under the Community Living Waiver are included in M1440, Appendix 1.

D. Assessment and Service Authorization The individual's need for CBC is determined by the Community Services Board (CSB), Behavioral Health Authority (BHA) or Department for Aging and Rehabilitative Services (DARS) case manager after completion of a comprehensive assessment.

All recommendations are submitted to Department of Behavioral Health and Developmental Services (DBHDS) or DMAS staff for final authorization.

1. CSB The CSB/BHA support coordinator/case manager may only recommend waiver services if:

- the individual is found Medicaid eligible; and
- the individual is intellectually disabled, or is under age 6 and at developmental risk; and
- the individual is not an inpatient of a nursing facility or hospital.

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2. DARS The DARS case manager may only recommend waiver services if:

- the individual is found Medicaid eligible, and
  - the individual is in a nursing facility and has a related condition such as defined in the federal Medicaid regulations.

M1440.103 BUILDING INDEPENDENCE WAIVER

A. General Description The Building Independence Waiver, formerly the Day Support (DS) Waiver, is targeted to provide home and community-based services to individuals with developmental disabilities who have been determined to require the level of care provided in an ICF/ID. These individuals may reside in an ICF/ID or may be in the community at the time of the assessment for Building Independence Waiver services.

B. Eligibility Rules All patients receiving waiver services must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid-eligible in a medical institution. The resource and income rules are applied to waiver eligible individuals as if the individual were residing in a medical institution.

The income limit used for this waiver is 300% of the current SSI payment standard for one person. **Medically needy individuals are not eligible for this waiver**. If the individual's income exceeds 300% SSI, the individual is not eligible for services under this waiver.

C. Services Available The services available under the Building Independence Waiver are included in M1440, Appendix 1.

D. Assessment and Service Authorization The individual's need for CBC is determined by the CSB, BHA or DBHDS support coordinator/case manager after completion of a comprehensive assessment. All recommendations are submitted to DBHDS staff for final authorization.

M1440.104 ALZHEIMER'S ASSISTED LIVING WAIVER

A. General Description The Alzheimer's Assisted Living (AAL) Waiver is available only to individuals who are Auxiliary Grants (AG) recipients. The AAL Waiver allows for the provision of services to individuals in approved assisted living facilities who, without the waiver, might require nursing home placement. **Individuals on this waiver do not have Medicaid eligibility determined as institutionalized individuals, and there are no post-eligibility requirements**.

The AAL waiver serves persons who are:

- Auxiliary Grants (AG) recipients,
- have a diagnosis of Alzheimer's or a related dementia and no diagnosis of mental illness or intellectual disability, and
- age 55 or older.

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B. Eligibility Rules

Individuals in the AAL Waiver have Medicaid eligibility determined in the AG covered group (see M0320.202) and do not have Medicaid eligibility determined as institutionalized individuals. There are no post-eligibility requirements.

The enrollment and notification procedures used with non-institutionalized Medicaid recipients are followed (see M0130.300).

C. Services Available

Services available under the AAL waiver are**:**

- assistance with activities of daily living
- medication administration by licensed professionals
- nursing services for assessments and evaluations
- therapeutic social and recreational programming which provides daily activities for individuals with dementia.

D. Assessment and Service Authorization

Local and hospital screening committees or teams are authorized to screen individuals for the AAL waiver; however, a copy of the pre-admission screening is not required for the Medicaid eligibility record.

M1440.105 FAMILY AND INDIVIDUAL SUPPORTS WAIVER

A. General Description

The Family and Individual Supports Waiver, formerly the Individual and Family Developmental Disabilities Support Waiver (DD waiver), provides home and community-based services to individuals with developmental disabilities, who do not have a diagnosis of developmental disability. The objective of the waiver is to provide medically appropriate and cost-effective coverage of services necessary to maintain these individuals in the community and prevent placement in a medical institution.

B. Eligibility Rules

All patients receiving waiver services must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid eligible in a medical institution. The resource and income rules are applied to waiver eligible individuals as if the individuals were residing in a medical institution.

The income limit used for this waiver is 300% of the SSI limit (see M0810.002 A. 3.). **Medically Needy individuals are not eligible for this waiver**. If the individual's income exceeds 300% SSI, the individual is not eligible for services under this waiver.

C. Services Available

The services available under the Family and Individual Supports Waiver are included in M1440, Appendix 1.

D. Assessment and Service Authorization

The individual's need for CBC is determined by the CSB, BHA or DBHDS support coordinator/case manager after completion of a comprehensive assessment. All recommendations are submitted to DBHDS staff for final authorization.

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M1440.106 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

A. General Description

PACE is NOT a CBC Waiver, but rather is the State's community model for the integration of acute and long-term care. PACE combines Medicaid and Medicare funding. PACE provides the entire spectrum of acute and long-term care services to enrollees without limitations on the duration of services or the dollars spent and is centered on an adult day health care model.

B. Targeted Population

PACE serves individuals aged 55 and older who (1) meet the nursing facility level of care criteria and (2) reside in their own communities. PACE provides all of their health care and long-term care medical needs. Individuals who meet the criteria for the *CCC Plus* Waiver may be enrolled in PACE in lieu of the *CCC Plus* Waiver.

C. Eligibility Rules

For Medicaid to cover PACE services, the individual must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid eligible in a medical institution. The resource and income rules are applied to PACE-eligible individuals as if the individuals were residing in a medical institution.

The income limit used for PACE is 300% of the SSI limit (see M0810.002 A. 3.) or the MN income limit and spenddown.

PACE is not available to individuals who reside in an assisted living facility (ALF) and receive Auxiliary Grant (AG) payments. Individuals who reside in an ALF may be enrolled in PACE if they meet the functional, medical/nursing, and financial requirements, but they will not be permitted to receive an AG payment.

D. Services Available

The following services are provided through PACE:

- adult day care that offers nursing, physical, occupational, speech and recreational therapies;
- meals and nutritional counseling; social services;
- medical care provided by a PACE physician; personal care and home health care;
- all necessary prescription drugs;
- access to medical specialists such as dentists, optometrists and podiatrists; respite care;
- hospital and nursing facility care when necessary; and
- transportation.

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E. Assessment and Service Authorization

Participation in PACE is **voluntary**. The nursing home pre-admission screening team will advise the individual of the availability of PACE and will facilitate enrollment if the Medicaid enrollee chooses PACE. The PACE team is responsible for authorizing as well as providing the services.

Eligibility for PACE must begin on the first day of a month and end on the last day of a month.

M1440.200 COVERED SERVICES

A. Introduction

This section provides general information regarding the LTC services provided under the waivers. This is just for your information, understanding, and referral purposes. The information does not impact the Medicaid eligibility decision.

Note: Services covered under the Building Independence, Community Living and Family and Individual Supports Waivers are described separately in M1440, Appendix 3.

B. Waiver Services Information

Information about the services available under a waiver is contained in the following sections:

- M1440.201 Personal Care/Respite Care Services
- M1440.202 Adult Day Health Services
- M1440.*203* Private Duty Nursing Services
- M1440.*204* Nutritional Supplements
- M1440.*205* Personal Emergency Response System (PERS)

M1440.201 PERSONAL CARE/RESPITE CARE SERVICES

A. What Are Personal Care Services

Personal Care services are defined as long term maintenance or support services which are necessary in order to enable the individual to remain at home rather than enter an institution. Personal Care services provide eligible individuals with aides who perform basic health-related services, such as helping with ambulation/exercises, assisting with normally self-administered medications, reporting changes in the recipient's conditions and needs, and providing household services essential to health in the home.

B. What are Respite Care Services

Respite Care services are defined as services specifically designed to provide temporary but periodic or routine relief to the primary caregiver of an individual who is incapacitated or dependent due to frailty or physical disability. To receive this service the individual must meet the same criteria as the individual who is authorized for Personal Care, but the focus in Respite Care is on the needs of the caregiver for temporary relief. This focus on the caregiver differentiates Respite Care from programs which focus on the dependent or disabled care receiver.

C. Relationship to Other Services

An individual may receive Personal Care or Respite Care in conjunction with Adult Day Health Care services as needed.

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When an individual receives Hospice services, the hospice is required to provide the first 21 hours per week of personal care needed and a maximum of an additional 38.5 hours per week.

D. Who May Receive the Service An individual must meet the criteria of the *CCC Plus* Waiver to qualify for Personal/Respite Care services.

M1440.202 ADULT DAY HEALTH CARE SERVICES

A. What Is Adult Day Health Care Adult Day Health Care (ADHC) is a congregate service setting where individuals receive assistance with activities of daily living (e.g., ambulating, transfers, toileting, eating/feeding), oversight of medical conditions, administration of medications, a meal, care coordination including referrals to rehabilitation or other services if needed, and recreation/social activities. A person may attend half or whole days, and from one to seven days a week, depending on the patient's capability, preferences, and available support system.

B. Relationship to Other Services ADHC centers may provide transportation and individuals may receive this service, if needed, to enable their attendance at the center. An individual may receive ADHC services in conjunction with Personal Care or Respite Care services as needed.

C. Who May Receive the Service An individual must meet the criteria of the *CCC Plus* Waiver to qualify for ADHC services.

M1440.203 PRIVATE DUTY NURSING SERVICES

A. What is Private Duty Nursing Private Duty Nursing services are called "nursing services" in the ID/MR waiver. These services are offered to medically fragile patients who require substantial skilled nursing care. Patients receive nursing services from Registered Nurses or Licensed Practical Nurses. Services are offered as needed by the patient, but always exceed what is available through the Home Health program.

For example, in the CCC Plus Waiver, most technology-assisted patients receive 8 hours or more of continuous nursing services at least four times per week.

B. Relationship to Other Services There are no requirements that other waiver services be or not be received.

C. Who May Receive the Service An individual must meet the *CCC Plus* Waiver technology-assisted criteria for nursing services. A Medicaid recipient who qualifies under EPSDT (Early & Periodic Screening, Diagnosis & Treatment) to receive private duty nursing services may also receive private duty nursing.

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M1440.204 NUTRITIONAL SUPPLEMENTS

Nutritional Supplements (enteral nutrition products) are provided through DME (durable medical equipment) providers for patients who have an identified nutritional risk. Nutritional supplements are ordered by the individual's physician to cover a six-month period and Medicaid payment is authorized by the pre-admission screener or DMAS.

M1440.205 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

A. What is PERS

PERS is an electronic device that enables certain recipients who are at high risk of institutionalization to secure help in an emergency through the use of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the recipient's home telephone line. PERS may include medication monitoring to remind certain recipients at high risk of institutionalization to take their medications at the correct dosages and times.

B. Relationship to Other Services

An individual may receive PERS services in conjunction with agency-directed or consumer-directed Personal Care or Respite Care services.

C. Who May Receive the Service

PERS is available only to *CCC Plus* Waiver recipients who live alone or are alone for significant parts of the day, who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

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Developmental Disabilities Waivers – Services and Support Options – Updated *July 2023*

(BI = Building Independence Waiver; FI = Family & Individual Supports Waiver; CL = Community Living Waiver)

	BI	FI	CL	Description
Employment and Day *Services*				
Individual Supported Employment	✓	✓	✓	Individual Supported Employment services is provided one-on-one by a job coach *and offers training and support in a competitive job where persons without disabilities are employed.*
Group Supported Employment	✓	✓	✓	Group Supported Employment services *is* continuous *employment-related* support *in a competitive job where persons* without disabilities *are employed.*
Workplace Assistance		✓	✓	Workplace Assistance *is* provided to someone who requires more than typical job coach services to *maintain individual, competitive employment.*
Community Engagement	✓	✓	✓	Community Engagement Services *provides a wide variety of opportunities relationships and natural support in the community, while utilizing the community as a learning environment.*
Community Coaching	✓	✓	✓	Community Coaching is designed for *people* who need one to one support in order build a specific skill or set of skills to address barrier(s) that prevents *that* person from participating in Community Engagement.
Group Day	✓	✓	✓	Group Day Services *include skill-building and support activities to enhance independence and increase community integration. Can occur in a center and the community.*
Services via *consumer and agency directed models*				
Companion Services		✓	✓	*Provides nonmedical care, socialization, or support to adults, ages 18 and older in person's home and/or in the community.*
Personal Assistance Services		✓	✓	Includes monitoring health status, *assisting with maintaining a clean and safe home and providing direct support with personal care needs, at home, in the community, and at work.*
Respite *Services*		✓	✓	Respite services are specifically designed to provide temporary, *short-term care for a person* when his/her primary caregiver *is unavailable.*

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	BI	FI	CL	Description
Residential Services *(Facilities offering these services are NOT medical institutions)*				
Independent Living Supports	✓			Independent Living Supports are provided to adults (18 and older) and offers skill building and support to secure a self-sustaining, independent living situation in the community and/or may provide the support necessary to maintain those skills.
Shared Living	✓	✓	✓	Shared Living is support to a person who resides in his/her own home/apartment in the community provided by a roommate of the person's choosing. The individual receives a Medicaid reimbursement for the roommate's portion of the total cost of rent, food, and utilities in exchange for the roommate providing minimal supports.
Supported Living		✓	✓	Supported Living services take place in an apartment/house setting operated by a DBHDS licensed provider and provides 24/7 around the clock availability of staff support performed by paid staff who have the ability to respond in a timely manner. May be provided individually or at the same time to more than one individual living in the home, depending on the required support.
In-home Support Services		✓	✓	In-Home Supports take place in the person's and/or family's home or community settings. Services are designed to ensure the health, safety and welfare of the person and expand daily living skills.
Sponsored Residential			✓	Sponsored Residential Services take place in a licensed DBHDS family home where the homeowners are the paid caregivers ("sponsors") who provide support as necessary so that the person can reside successfully in the home and community.
Group Home Residential			✓	Group Home Residential Services are provided in a DBHDS licensed home with staff available 24 hours per day to provide a skill building component, along with the provision of general health and safety supports, as needed.
Crisis Services				
Community-Based Crisis Supports	✓	✓	✓	Community-based crisis supports provided in the individual's home and community setting. Crisis staff work directly with and assist the person and his/her current support provider or family. These services provide temporary intensive support to emergency psychiatric hospitalization, institutional placement or prevent other out-of-home placement.
Center-based Crisis Supports	✓	✓	✓	Center-based crisis supports provide long term crisis prevention and stabilization in a residential setting (Crisis Therapeutic Home) through planned and emergency admissions.
Crisis Support Services	✓	✓	✓	Crisis support services provide intensive supports to stabilize the person who may experience an episodic behavioral or psychiatric crisis in the community which has the potential to jeopardize his/her current community living situation.

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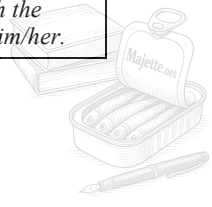
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	BI	FIS	CL	Description
Medical and Behavioral *Services*				
Skilled Nursing		✓	✓	Skilled Nursing is part-time or intermittent care *provided by an LPN or RN to address or delegate needs that require direct support or oversight of a licensed nurse. Nursing service can occur at the same time as other waiver services.*
Private Duty Nursing		✓	✓	Private Duty Nursing is individual and continuous care (in contrast to part-time or intermittent care) for *people* with a medical condition and/or complex health care need, to enable the *person* to remain at home.
Therapeutic Consultation		✓	✓	Therapeutic consultation services *in consultation with a professional* designed to assist the individual's *staff* and*/or* the individual's family/caregiver, as appropriate, *through* assessments, *development of TC supports plan* and teaching for the purpose of assisting the individual enrolled in the waiver with the designated specialty area. The specialty areas are psychology, behavioral consultation, therapeutic recreation, speech and language pathology, occupational therapy, physical therapy, and rehabilitation engineering.
Personal Emergency Response System (PERS)	✓	✓	✓	PERS is a service that monitors individual's safety in *his/her* home, and provides access to emergency assistance for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the *person's* home telephone system.

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	BI	FI	CL	Description
Additional *Services*				
Assistive Technology	✓	✓	✓	Assistive technology is specialized medical equipment, supplies, devices, controls, and appliances*, not covered by insurance* which enable individuals to increase their *independence in* their environment *and community.*
Benefits Planning	✓	✓	✓	*A service that assists recipients of DD Waiver and social security to understand their personal benefits and explore their options regarding employment.*
Community Guide				*Direct assistance (1:1) to persons in navigating and utilizing community resources. Provides information and assistance that help the person in problem solving, decision making, and developing supportive community relationships and other resources that promote implementation of the person-centered plan.*
Electronic Home-Based Services	✓	✓	✓	Electronic Home-Based Services are goods and services based on *current* technology *to enable a person to safely live and participate in the community while decreasing the need for support staff services.* This includes purchases of electronic devices, software, services, and supplies not otherwise provided through this waiver or through the State Plan, that would allow individuals to access greater independence and self-
Environmental Modifications	✓	✓	✓	Environmental modifications physical adaptations to the *person's* primary home *or* primary vehicle that are necessary to ensure the health and welfare of the *person* or enable the individual to function with greater independence.
Individual and Family/Caregiver Training	✓	✓	✓	Training and counseling to individual, families and caregivers to improve supports or educate the person to gain a better understanding of his/her *abilities* or increase his/her self-determination/self-advocacy abilities.
Transition Services	✓	✓	✓	Transition services are nonrecurring set-up expenses for *persons* who are transitioning from an institution or provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.
Employment and Community Transportation	✓	✓	✓	*Promotes the individual's independence and participation in the life of his or her community. Transportation to waiver and other community services or events, activities and resources, inclusive of transportation to employment or volunteer sites, homes of family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities or events as specified by the service plan and when no other means of access is available.*
Peer Mentor Supports	✓	✓	✓	*Designed to foster connections and relationships which build individual resilience. This service is delivered by people with developmental disabilities who are or have received services, have shared experiences with the person, and provide support and guidance to him/her.*



CHAPTER M14
LONG-TERM CARE
SUBCHAPTER 50

TRANSFER OF ASSETS

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M1450 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-35	7/1/25	Table of Contents, Pages 37, 41, 42, 45, 46
TN #DMAS-31	4/1/24	Pages 42 and 46
TN #DMAS-29	10/1/23	Page 37
TN #DMAS-28	7/1/23	Page 35 and Appendix 2
TN #DMAS-27	4/1/23	Page 44
TN #DMAS-26	1/1/23	Page 46
TN #DMAS-25	10/1/22	Page 36
TN #DMAS-17	7/1/20	Page 45
TN #DMAS-15	1/1/20	Page 46
TN #DMAS-14	10/1/19	Pages 19, 41, 42, 46
TN #DMAS-10	10/1/18	Pages 1, 2 Appendix 3, page 2 Page 24a was added back; it was inadvertently removed in a previous transmittal. Page 2a was added as a runover page.
TN #DMAS-9	7/1/18	Page 35-36a, 37-38, 43
TN #DMAS-7	1/1/18	Page 4, 24, 36, 36a, 37, 41, 42 Appendix 1, Page 1.
TN #DMAS-5	7/1/17	Table of Contents Pages 13, 35, 41-44 Page 43a was renumbered. Pages 45 and 46 were added as runover pages.
TN #DMAS-3	1/1/17	Pages 30, 40-42, 44
TN #DMAS-1	6/1/16	Pages 13, 15, 35 Pages 14 and 16 are runover pages.
TN #100	5/1/15	Table of Contents Pages 17-19, 36, 37 Page 35 is a runover page.
TN #99	1/1/14	Page 7, 10, 21
UP #7	6/1/12	Table of Contents Pages 37-43 Page 43a was added.
TN #96	10/1/11	Table of Contents Pages 4-8 Pages 15, 16, 25, 26 Pages 31-38 Page 31a removed.
TN #95	3/1/11	Pages 4, 24, 32, 36, 37, 37a, Pages 39, 42, 43
TN #94	9/1/10	Table of Contents Pages 36-37a, 39-44
TN #93	1/1/10	Table of Contents Pages 3, 17-18, 29 Appendix 2, page 1
TN #91	5/15/09	Pages 41, 42

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M1450.000 TRANSFER OF ASSETS

M1450.001 OVERVIEW

A. Introduction

Individuals who are eligible for Medicaid may NOT be eligible for Medicaid payment of long-term care (LTC) services, *also referred to as long-term services and supports (LTSS),* for a specific period of time (penalty period) if they or their spouses have transferred assets for less than fair market value without receiving adequate compensation. The asset transfer policy applies to all individuals in all types of *LTSS: facility based and community based care (CBC), also referred to as home and community based services (HCBS).*

B. Policy

The EW must evaluate an asset transfer according to the instructions found in the sections below. The applicable policy rules depend on

- when the transfer occurred;
- who transferred the asset;
- to whom the asset was transferred;
- what was transferred.

Information must be obtained from all Medicaid applicants and recipients who require LTC services about transfers of both income and resources that occurred during the **five years** before the Medicaid application date. Whether the transfer will affect LTC services eligibility depends on:

- the date the transfer occurred,
- to whom the asset was transferred,
- the type of asset that was transferred,
- the reason for the transfer,
- the value of the transferred asset
- the amount of compensation received.

M1450.002 LEGAL BASE

A. Public Law 96-611

This federal law established a transfer of property eligibility rule for the SSI program and also permitted states to adopt a transfer eligibility rule for their Medicaid programs which could be, in certain respects, more restrictive than in SSI or the money payment programs. The rule adopted by Virginia was more restrictive than the SSI rule.

B. Public Law 100-360

Public law 100-360 (The Medicare Catastrophic Coverage Act), enacted on July 1, 1988, changed the federal Medicaid law relating to property transfers. Further revisions were made by the Family Support Act of 1988 (Welfare Reform) Public Law 100-485, enacted on October 13, 1988.

C. Public Law 103-66 (OBRA)

Section 13611 of this federal law, enacted on August 10, 1993, revised transfer provisions for the Medicaid Program. It amended section 1917 of the Social Security Act by incorporating in section 1917 new requirements for asset transfers and for trusts.

D. Public Law 109-171 (DRA)

The Deficit Reduction Act (DRA) of 2005, enacted on February 8, 2006, further revised asset transfer provisions for the Medicaid program.



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E. The Code of Virginia

Virginia state law governing the Department of Medical Assistance Services (DMAS) and the Medicaid program in Virginia is contained in sections 32.1-323 through 32.1-330. It includes a definition of assets, and it states that an asset transfer includes a disclaimer of interest(s) in assets.

Section 20-88.01 empowers DMAS to request a court order requiring the transferees of property to reimburse Medicaid for expenses Medicaid paid on behalf of recipients who transferred property.

F. 2018 Appropriations Act

The 2018 Appropriations Act provided funding for New Health Coverage Options for Virginia Adults. Effective January 1, 2019, determination of eligibility for adults between the ages of 19-64 without Medicare will be evaluated using MAGI income methodology. Adults eligible under the expansion of coverage will be referred to as Modified Adjusted Gross Income (MAGI) Adults.

Individuals in the MAGI Adults covered group are not subject to a resource test unless the individual requests Medicaid payment for LTC/LTSS. The resource and home equity requirements for MAGI Adults are contained in M1460. ***The asset transfer policy contained in this subchapter IS fully applicable to the MAGI Adults who are seeking Medicaid payment of LTC services.***

M1450.003 DEFINITION OF TERMS

A. Adequate Compensation

For purposes of asset transfer, an individual is considered to have received "adequate compensation" for an asset when the fair market value of the asset or greater has been received.

B. Assets

For the purposes of asset transfer, assets are all income and resources of the individual and the individual's spouse, including any income and resources to which the individual or the spouse is entitled but does not receive because of an action by:

- the individual or the spouse,
- any person, including a court or administrative body, with legal authority to act in the place of or on behalf of the individual or spouse, or
- a person, including a court or administrative body, acting at the direction or request of the individual or spouse.

The term "asset" may also include:

- life estate (life rights) in another individual's home, and
- the funds used to purchase a promissory note, loan, or mortgage.

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C. Asset Transfer

An **asset transfer** is any action by an individual or other person that reduces or eliminates the individual's ownership or control of an asset(s). Transfers include:

- giving away or selling property
- disclaiming an inheritance or not asserting inheritance rights in court
- clauses in trusts that stop payments to the individual
- putting money in a trust
- payments from a trust for a purpose other than benefit of the individual
- irrevocably waiving pension income
- not accepting or accessing injury settlements
- giving away income during the month it is received
- refusing to take legal action to obtain a court-ordered payment that is not being paid, such as alimony or child support
- placement of lien or judgment against individual's property when not an "arm's length" transaction (see below)
- other similar actions.

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When the placement of a lien or a judgment against an individual's asset is not an "arm's length" transaction, it is an uncompensated transfer of assets. An arm's length transaction, as defined by Black's Law Dictionary, is a transaction negotiated by **unrelated** parties, each acting in his or her own self interest. When an individual's relative has a lien or judgment against the individual's property, the lien or judgment is an asset transfer that must be evaluated.

D. Baseline Date

The **baseline date** is the first date as of which the individual was both

- an institutionalized individual (as defined below) AND
- a Virginia Medicaid applicant.

When an individual is already a Medicaid recipient and becomes institutionalized, the baseline date is the first day of institutionalization.

E. Fair Market Value

Fair market value (FMV) is an estimate of an asset's value if it were sold at the prevailing price at the time it was actually transferred. Value is based on criteria used in determining the value of assets for the purpose of determining Medicaid eligibility.

NOTE: For an asset to be considered transferred for fair market value, or to be considered to be transferred for valuable consideration, the compensation received for the asset must be in tangible form with intrinsic value. A transfer for love and affection is not considered a transfer for fair market value.

Also, while relatives and family members legitimately can be paid for care they provide to the individual, it is presumed that services provided for free at the time were intended to be provided without compensation. Thus, a transfer to a relative for care provided for free in the past is a transfer of assets for less than fair market value. However, an individual can rebut this presumption with tangible evidence that is acceptable. For example, the individual proves that a payback arrangement had been agreed to in writing at the time services were provided.

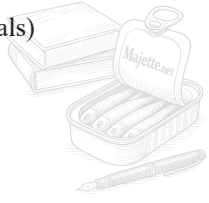
F. Income

Any monies received by an individual or the individual's spouse to meet the individual's basic needs for food or shelter, is **income**. See subchapter M1460 for items that are not income.

G. Institutionalized Individual

For the purposes of asset transfer, an **institutionalized individual** is:

- a person who is an inpatient in a nursing facility;
- a person who is an inpatient in a medical institution and for whom payment for care is based on a level of care provided in a nursing facility. Included are persons in long-stay hospitals (including rehabilitation hospitals and rehabilitation units of general hospitals) and patients in Virginia *Department of Behavioral Health and Developmental Services (DBHDS)* facilities who



are housed in an area certified as a nursing facility or intermediate care facility for the *intellectually disabled*; or

- a Medicaid applicant/enrollee who has been screened and approved for or is receiving Medicaid community-based care (CBC) waiver services, services through the Program of All Inclusive Care for the Elderly (PACE) or hospice services.

H. Legally Binding Contract

Virginia law requires written contracts for the sale of goods (not services) valued over $500, and for transactions involving real estate. Contracts for services may be oral.

To prove a contract is **legally binding**, the individual must show:

***1.* Parties Legally Competent**

The parties to the contract were legally competent to enter into the contract. (Generally, this excludes (1) individuals declared to have mental incapacity or a diminished mental capacity and (2) children less than 18 years of age, who may not enter into a contract under Virginia law. The purpose here is to ensure that both parties knew what they were doing when they entered into the contract).

***2.* Valuable Consideration**

"Valuable consideration" is received by each party when the "adequate compensation" requirement for the asset transfer rule is met.

***3.* Definite Contract Terms**

Contract terms are sufficiently definite so that the contract is not void because of vagueness. Payments under contracts with immediate family members must be at reasonable rates. Those rates must be discernable from the terms of the contract. For example, it is not sufficient for a mother to agree to give her son all the stocks she owns upon her death in exchange for his agreeing to take care of her for an undefined period of time (such a contract might have to be written, depending on the value). The contract must set forth the per diem rate, specify a time period, or in some other manner establish definable and certain terms.

***4.* Mutual Assent**

Contract terms were agreed to by mutual assent. Confirm that both parties understood and agreed upon the same specific terms of the contract when they entered into the contract.

I. Look-Back Date

The look-back date is the date that is 60 months before the first date the individual is both (a) an institutionalized individual and (b) has applied for Medicaid. The look-back date is the earliest date on which a penalty for transferring assets for less than fair market value can be imposed. Penalties can be imposed for transfers that take place on or after the look-back date. Penalties cannot be imposed for transfers that take place before the look-back date.

J. Look-back Period

The **look-back period** is the period of time that begins with the look-back date and ends with the baseline date. The look-back period is 60 months.

K. Other Person

Other person means:

- the individual's spouse or co-owner of an asset;
- 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; and
- a person, including a court or administrative body, acting at the direction, or upon the request, of the individual or the individual's spouse.

L. Payment Foreclosed

Payment to any individual from an irrevocable trust that is not for the benefit of the individual for whom the trust was created is an uncompensated transfer of assets. See M1140.404 B. 4. c. for information regarding when a trust is foreclosed.

M. Penalty Period

The **penalty period** is the period of time during which Medicaid payment for LTC services is denied because of a transfer of assets for less than market value. The length of the penalty period is based on the value of the uncompensated transfer of assets and the average cost of nursing facility care in Virginia.

N. Property/ Resources

"Property" and "resources" both refer to real and personal property legally available to the individual or the individual's spouse.

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O. Uncompensated Value

The uncompensated value is the amount of an asset's fair market value that was not or will not be received as a result of the asset transfer.

The uncompensated value for **real property** at the time of transfer is:

- the difference between the asset's FMV and the Gross Amount Due to Seller, when the lien/other encumbrance against the asset is satisfied from the seller's proceeds, or
- the difference between the asset's equity value (FMV minus the lien) and the Gross Amount Due to Seller, when the lien is assumed by the buyer. Refer to examples in M1450.610 H.

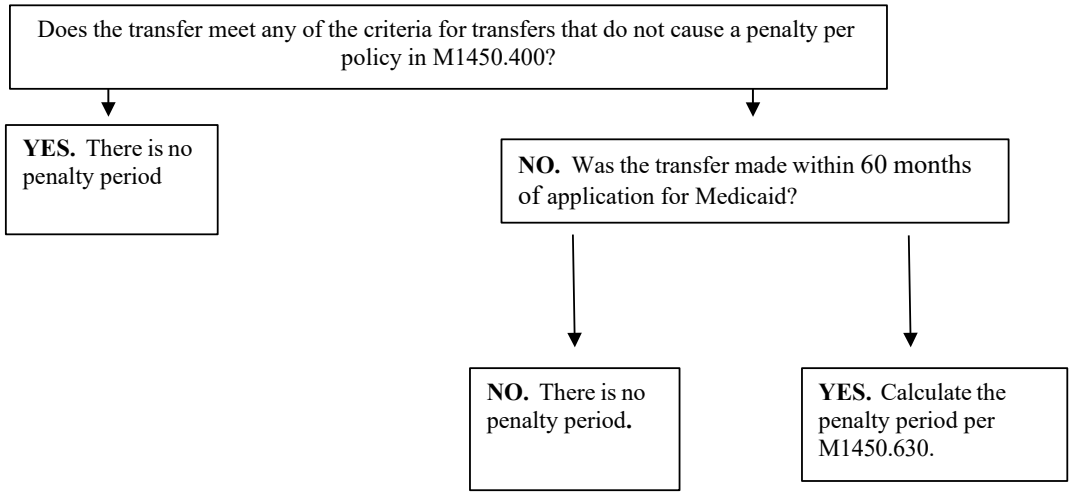
P. Undue Hardship

An undue hardship exists when the imposition of a penalty period would deprive the individual of medical care such that his health or his life would be endangered or be deprived of food, clothing, shelter, or other necessities of life.

M1450.004 TRANSFER OF ASSETS FLOW CHART

The flow chart below illustrates when an asset transfer penalty period is required.

Transfer of Assets Flow Chart



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M1450.100 RESERVED

M1450.200 POLICY PRINCIPLES

A. Policy

An institutionalized individual who transfers (or has transferred), or whose spouse transfers or has transferred, an asset in ways not allowed by policy is not eligible for Medicaid payment of long-term care services. The DRA established new policy for evaluating transfers made on or after February 8, 2006. The look-back period for all transfers is 60 months; there is no distinction between transfers involving trusts and other transfers.

B. Procedures

When a Medicaid enrollee is institutionalized, review the individual's eligibility to determine if an asset transfer occurred within the 60 months prior to institutionalization. When a Medicaid applicant reports an asset transfer, or the worker discovers a transfer, determine if the transfer occurred within 60 months prior to the month in which the individual is both institutionalized and a Medicaid applicant/enrollee.

1. All Transfers

Determine if any assets of the individual or the individual's spouse were transferred during the 60 months (the "look-back period") prior to the first date on which the individual was both an institutionalized individual and a Medicaid applicant/enrollee.

2. Determine Effect

If an asset was transferred during the look-back periods specified above, determine if the transfer affects eligibility for LTC services' payment, using sections *M1450.300* through M1450.550 below.

If the transfer affects eligibility and was for less than market value, determine the uncompensated value (M1450.610) and establish a penalty period (period of ineligibility for Medicaid payment of LTC services, M1450.630).

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M1450.300 ASSETS THAT ARE NOT RESOURCES FOR TRANSFER RULE

A. Policy

The assets listed in this section are NOT resources for asset transfer purposes. Therefore, the transfer of any of the assets listed in this section does NOT affect eligibility for Medicaid payment of LTC services.

B. Personal Effects and Household Items

A transfer of personal effects or household items does not affect eligibility.

C. Certain Vehicles

The transfer of a vehicle that meets the following requirements does not affect Medicaid payment for LTC services:

- a vehicle used by the applicant/enrollee to obtain medical treatment.
- a vehicle used by the applicant/enrollee for employment.
- a vehicle especially equipped for a disabled applicant or enrollee.
- a vehicle necessary because of climate, terrain, distance, or similar factors to provide necessary transportation to perform essential daily activities.

If the vehicle was not used as provided above at the time of transfer, $4,500 of the trade-in value of the vehicle used for basic transportation is excluded. Any value in excess of $4,500 must be evaluated as an asset transfer.

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D. Property Essential to Self Support

The transfer of property essential to the institutionalized individual's self-support (tools, equipment, etc. used by the individual to produce income), including up to $6,000 equity in income-producing real property(ies) owned by the applicant/recipient, does not affect eligibility for LTC services' payment.

To be income-producing, the property(ies) must usually have a net annual return that is:

- 6% of the equity, if the equity is $6,000 or less or
- $360 if the equity is more than $6,000.

If an unusual circumstance caused a temporary reduction in the net annual return and the net annual return is expected to meet the requirements the following year, the property is still considered income-producing.

E. Resources Under PASS

Transfer of resources specifically designated for a disabled or blind SSI recipient's plan of self-support (PASS), as determined by SSI, does not affect eligibility for LTC services' payment.

F. Certain Life Insurance

Transfer of term or group insurance that has no cash value, or transfer of life insurance with a total face value of $1,500 or less (total of all policies) on an individual, does not affect eligibility for LTC services' payment. Life insurance includes policies that presently do not have a cash value but will have a cash value in the future.

G. Certain Cash and In-kind Items

Transfer of cash or in-kind items received to replace/repair lost, damaged, or stolen exempted resources (see M1130.630) does not affect eligibility for LTC services' payment.

H. Burial Spaces or Plots

Transfer of burial spaces or plots held for the use of the individual, the individual's spouse, or the individual's immediate family does not affect eligibility for LTC services' payment.

I. Excluded Burial Funds

Transfer of up to $1,500 in resources excluded under the burial fund exclusion policy does not affect eligibility for LTC services' payment.

J. Cash to Purchase Medical/Social Services

Transfer of cash received from a governmental or nongovernmental program to purchase medical care or social services does not affect eligibility for LTC services' payment IF the cash was transferred in the receipt month or the month following the receipt month.

K. Alaskan Natives' Stock

Transfer of certain shares of stock held by Alaskan natives does not affect eligibility for LTC services' payment.

L. Other Assets That Are Not Resources

The transfer of the following resources, **if they have been kept separate from other resources**, do not affect eligibility for LTC services' payment:

- Payments from the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.



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- Payments from sections 25-239, 25-240, and 25-241 of the Code of Virginia for relocation assistance.
- Payments from sections 404(g) and 418 of the Domestic Volunteer Service Act of 1973.
- Retroactive Supplemental Security Income and/or retroactive Social Security payments for nine (9) months after the month of receipt of the payment(s).
- Retained disaster assistance.

M1450.400 TRANSFERS THAT DO NOT AFFECT ELIGIBILITY

A. Policy

An asset transfer does NOT affect eligibility for Medicaid payment of LTC services if the transfer meets the following criteria:

- the transfer(s) of assets was made for reasons exclusive of becoming or remaining eligible for Medicaid payment of LTC services (M1450.400 B),
- the individual received adequate compensation for the asset(s), or
- the asset transfer meets the criteria in either section B, C or D below.

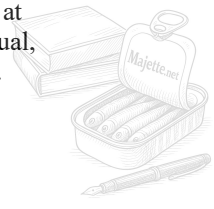
If the transfer **does not** meet the criteria in this section, see section 1450.500 below to evaluate the asset transfer.

B. Reason Exclusive of Becoming or Remaining Medicaid Eligible

Assume that when an institutionalized individual or his community spouse has transferred assets for less than the CMV during the look back period, the transfer is subject to a penalty period. During this penalty period, Medicaid will not pay for LTC services. The institutionalized individual must be given the opportunity to rebut this assumption by showing satisfactorily that he intended to receive CMV or that the reason for the transfer of assets was exclusively for a purpose other than to qualify for Medicaid.

The individual must provide convincing and objective evidence showing that there *was* no reason to believe that Medicaid payment of LTC services might be needed. *The fact the individual had not yet applied for Medicaid, had not been admitted to an institution or was not aware of the asset transfer* provisions *does not meet the evidence requirement*. The sudden loss of income or assets, the sudden onset of a disabling condition or personal injury may provide convincing evidence.

The individual must provide evidence that other assets were available at the time of transfer to meet current and expected needs of that individual, including the cost of nursing home or other medical institutional care.



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C. **Home Property Transferred to Certain Individuals**

Transfer of the individual's home, whether it was excluded or not excluded at the time of transfer, does NOT affect eligibility for LTC services' payment when the home property is transferred to one or more of the individuals listed below.

1. Spouse, Minor Child, Disabled/Blind Child

The transfer of the home property does not affect eligibility when transferred to the individual's

- spouse,
- child(ren) under age 21 years, or
- child(ren) of any age who is blind or disabled as defined by SSI or Medicaid.

2. Sibling

The transfer of the home property does not affect eligibility when transferred to the individual's sibling or half-sibling (not step-sibling) who:

- has an equity interest in the home, and
- who resided in the individual's home for at least one year immediately before the date the individual became an institutionalized individual.

3. Adult Child

The transfer of the home property does not affect eligibility when transferred to the individual's son or daughter (not including step-child) who resided in the home for at least two years immediately before the date the individual became an institutionalized individual, and *all of* the criteria listed in items a. through d. below *are met.*

a. Provided Care for 2 Years

The individual's son or daughter must have been providing care to the individual during the entire two-year period which permitted the individual to reside at home rather than in a medical institution or nursing facility.

b. Physician's Statement

The individual or his/her representative must provide a statement from his/her treating physician which states

- the individual's physical and/or mental condition during this two-year period,
- why the individual needed personal and/or home health care during this period, and
- the specific personal/home health care service needs of the individual.

c. Statement of Services Provided

The son or daughter must provide a statement showing:

1) the specific services and care he/she provided to the individual during the entire two years;
2) how many hours per day he/she provided the service or care;

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3) whether he/she worked outside the home or worked from the home during this period; how the individual's needs were taken care of while he/she worked; and

4) if the son or daughter paid someone to actually give the care to the individual, who was paid, the rate of pay, the specific services, and the length of time the services were provided.

d. Third Party Statement

The individual or his/her representative must provide an objective statement from a third party(ies) who had knowledge of the individual's condition and his/her living and care arrangements during this period which corroborates the son or daughter's statement. The statement must specify the care/services the son or daughter provided and who cared for the individual when the son or daughter was not at home.

***D.* Transfer to Certain Individuals or Trusts**

Transfer of any asset

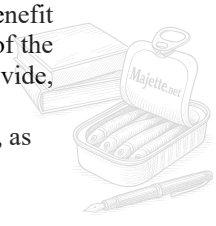
- to the individual's spouse or to another person for the sole benefit of the individual's spouse;
- to another individual by the spouse for the sole benefit of the spouse;
- to the individual's child under 21 or child of any age who is blind or disabled as defined by SSI or Medicaid;
- to a trust that is established solely for the benefit of the individual's
  1) child under age 21, or
  2) child of any age who is blind or disabled as defined by SSI or Medicaid when the trust meets the conditions in M1120.202;
- to a trust established solely for the benefit of an individual under 65 who is disabled as defined by SSI or Medicaid, when the trust meets the conditions in M1120.202;

does not affect eligibility for Medicaid payment of LTC services.

1. For the Sole Benefit of Spouse, Blind/disabled Child, or Disabled Individual

A transfer is for the sole benefit of a spouse, blind or disabled child or a disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child or a disabled individual can benefit from the assets transferred in any way, whether at the time of transfer or at any time in the future. Similarly, a trust is established for the sole benefit of a spouse, blind or disabled child or a disabled individual if no one but the spouse, blind or disabled child or disabled individual can benefit from the assets in the trust, whether at the time of transfer or at any time in the future.

In order to be for the sole benefit of one of these individuals, the instrument or document must provide for the spending of the trust funds for the benefit of the individual that is actuarially sound based on the life expectancy of the individual involved. When the instrument or document does not so provide, any potential exemption from penalty or consideration for eligibility purposes is void. Exception: trusts established for disabled individuals, as described in M1120.202.



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However, the trust may provide for reasonable compensation for a trustee(s) to manage the trust, as well as for reasonable costs associated with investing or otherwise managing the funds or property in the trust. In defining what is reasonable compensation, consider the amount of time and effort involved in managing a trust of the size involved, as well as the prevailing rate of compensation, if any, for managing a trust of similar size and complexity.

2. Not for the Sole Benefit of Spouse, Blind/disabled Child, or Disabled Individual

A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is NOT the spouse, a blind or disabled child or a disabled individual, is NOT considered established for the sole benefit of one of these individuals. Thus, the establishment of such a trust is a transfer of assets that affects eligibility for Medicaid payment of LTC services.

3. Trusts for Disabled Individuals Under Which the State Is Beneficiary

Trusts established for disabled individuals, as described in M1120.202, do not have to provide for an actuarially sound spending of the trust funds for the benefit of the individual involved. However, under these trusts, the trust instrument must provide that any funds remaining in the trust upon the death of the individual must go to the state, up to the amount of Medicaid benefits paid on the individual's behalf.

The trust does not have to provide for an actuarially sound spending of the trust funds for the benefit of the individual involved when:

* the trust instrument designates the state as the recipient of funds from the trust, and

* the trust requirements in M1120.202 require that the trust be for the sole benefit of an individual.

The trust may also provide for disbursal of funds to other beneficiaries provided that the trust does not permit such disbursals until the state's claim is satisfied. "Pooled" trusts may provide that the trust can retain a certain percentage of the funds in the trust account upon the death of the beneficiary.

4. Cross-reference

If the trust is not for the sole benefit of the individual's spouse, blind or disabled child or a disabled individual, and it does not meet the criteria in item M1450.400 D.3 above, go to M1450.*550* to determine if the transfer of assets into the trust affects Medicaid payment for LTC services.

NOTE: Evaluate the trust to determine if it is a resource. See M1120.200, M1120.201 and M1120.202.

E. Other Asset Transfers

For asset transfers other than those described in sections M1450.400 B and C, the transfer does not affect eligibility for Medicaid payment of LTC services if the individual shows that he intended to receive or received adequate compensation for the asset. To show intent to receive adequate compensation, the individual must provide objective evidence according to items 1 through 3 below, and provide evidence that the transfer was made for reasons exclusive of becoming or remaining eligible for Medicaid payment of LTC services.



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1. Evidence of Reasonable Effort to Sell

The individual must provide objective evidence for real property that he/she made an initial and continuing reasonable effort to sell the property. See M1130.140.

2. Evidence of Legally Binding Contract

The individual must provide objective evidence that he/she made a legally binding contract (as defined in M1450.003 above) that provided for his/her receipt of adequate compensation in a specified form (goods, services, money, etc.) in exchange for the transferred asset.

If the goods received include term life insurance, see M1450.510 below.

3. Irrevocable Burial Trust

The individual must provide objective evidence that the asset was transferred into an irrevocable burial trust. The trust is NOT compensation for the transferred money unless the individual provides objective evidence that all the funds in the trust will be used to pay for identifiable funeral services.

Objective evidence is the contract with the funeral home which lists funeral items and services and the price of each, when the total price of all items and services equals the amount of funds in the irrevocable burial trust.

NOTE: Evaluate the trust to determine if it is a resource. See M1120.200, M1120.201 and M1120.202.

F. Post-Eligibility Transfers by the Community Spouse

Post-eligibility transfers of resources owned by the community spouse (institutionalized spouse has no ownership interest) do not affect the institutionalized spouse's continued eligibility for Medicaid payment of LTC services.

Exception: The purchase of annuity by the community spouse on or after February 8, 2006 may be treated as an uncompensated transfer. See G. below.

G. Purchase of an Annuity by Community Spouse

For applications made on or after July 1, 2006, an annuity purchased by the community spouse on or after February 8, 2006, will be treated as an uncompensated transfer unless:

* the state is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant; or
* the state is named the remainder beneficiary in the second position after the community spouse or minor or disabled child. If the spouse or the representative of a minor or disabled child disposes of any remainder for less than fair market value, the state must be named in the first position.

H. Transfers Made on or After February 8, 2006 with Cumulative Value Less Than or Equal to $4,000

The policy in this subsection applies to actions taken on applications, renewals or changes on or after July 1, 2006 for transfers made on or after February 8, 2006.

Asset transfers made on or after February 8, 2006 that have a total cumulative value of less than or equal to $1,000 per calendar year will not be considered a transfer for less than fair market value and no penalty period will be calculated.



Assets transferred on or after February 8, 2006, that have a total cumulative value of more than $1,000 but less than or equal to $4,000 per calendar year may not be considered a transfer for less than fair market value if documentation is provided that such transfers follow a pattern that existed for at least three years prior to applying for Medicaid payment of LTC services. Christmas gifts, birthday gifts, graduation gifts, wedding gifts, etc. meet the criteria for following a pattern that existed prior to applying for Medicaid payment of LTC services.

I. LTC Partnership Policy

The value of assets transferred that were disregarded as a result of an LTC Partnership Policy does not affect an individual's eligibility for Medicaid payment of LTC services. See M1460.160 for more information about LTC Partnership Policies.

J. Return of Asset

The transfer of an asset for less than fair market value does not affect eligibility for Medicaid LTC services' payment if the asset has been returned to the individual.

K. Home Foreclosure

The repossession and/or sale of a home by the mortgage lender for less than fair market value due to foreclosure is not evaluated as an uncompensated transfer. Documentation of the foreclosure must be retained in the case record.

L. *Court-ordered or Approved Sale*

When property is ordered to be sold at a judicial sale or when a court has approved the sale of property for less than FMV, the sale is considered a compensated transfer. The individual or guardian must provide documentation of the court order for the sale and any other documentation needed to verify the sale of the property.

***M.* Transfer of Income Tax Refund or Advance Payment Received After December 31, 2009 but Before January 1, 2013**

Under Section 728 of the Tax Relief, Unemployment Insurance Reauthorization and Job Creation Act of 2010 (P.L. 111-312, the transfer of an income tax refund or advance payment received after December 31, 2009 but Before January 1, 2013, to another individual or to a trust does NOT affect eligibility for Medicaid payment of LTC services. If the funds are given away or placed in a trust, other than a trust established for a disabled individual (see M1120.202), after the end of the exempt period, the transfer is subject to a transfer penalty or being counted under the Medicaid trust provisions, as applicable.

M1450.500 TRANSFERS THAT AFFECT ELIGIBILITY

A. Policy

If an asset transfer does not meet the criteria in sections M1450.300 or M1450.400, the transfer will be considered to have been completed for reasons of becoming or remaining eligible for Medicaid payment of LTC services, unless evidence has been provided to the contrary.

Asset transfers that affect eligibility for Medicaid LTC services payment include, but are not limited to, transfers of the following assets:

- cash, bank accounts, savings certificates,
- stocks or bonds,
- resources **over $1,500** that are excluded under the burial fund exclusion policy,
- cash value of life insurance when the total face values of all policies owned on an individual exceed $1,500
- interests in real property, including mineral rights,
- rights to inherited real or personal property or income**.**

B. Procedures

Use the following sections to evaluate an asset transfer:

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- M1450.510 for a purchase of term life insurance.
- M1450.520 for a purchase of an annuity before February 8, 2006.
- M1450.530 for a purchase of an annuity on or after February 8, 2006.
- M1450.540 for promissory notes, loans, or mortgages.
- M1450.550 for a transfer of assets into or from a trust.
- M1450.560 for a transfer of income.

M1450.510 PURCHASE OF TERM LIFE INSURANCE

A. Policy

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

B. Procedures

1. Policy Funds Pre-need Funeral

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

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

2. Policy Funds Irrevocable Trust

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

***3.* Determine If Transfer Is Uncompen-sated**

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

a. Determine the benefit payable at death. The face value of the policy is the "benefit payable at death."

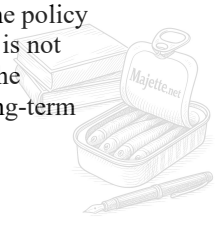
b. From the insurance company, obtain the sum of all premium(s) paid on the policy; multiply this sum by 2. The result is "twice the premium."

c. Compare the result to the term insurance policy's face value.

1) If the term insurance's face value equals or exceeds the result (twice the premium), the purchase of the policy is a transfer for fair market value and does not affect eligibility.

2) If the term insurance's face value is less than the result (twice the premium), the purchase of the policy is an uncompensated transfer for less than fair market value. Determine a penalty period per M1450.620 or M1450.630 below.

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



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M1450.520 PURCHASE OF ANNUITY

A. Introduction

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

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

B. Policy

All annuities purchased by an applicant/recipient or his spouse must be declared on the Medicaid application or renewal form. Annuities purchased by either the institutionalized individual or the community spouse must be evaluated even after initial eligibility as an LTC recipient has been established. In addition to determining if the annuity is a countable resource, the eligibility worker must evaluate the purchase of the annuity to determine if it is a compensated transfer.

The following rules apply to the purchase of an annuity:

1. Purchased by Institutionalized Individual or Community Spouse

An annuity purchased by the institutionalized individual or the community spouse will be treated as an uncompensated transfer unless:

* *the state is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual; or*

* *the state is named the remainder beneficiary in the second position after the community spouse or minor or disabled child. If the spouse or the representative of a minor or disabled child disposes of any remainder for less than fair market value, the state must be named in the first position.*

2. Purchased by Institutionalized Individual

An annuity purchased by the institutionalized individual will be considered an uncompensated transfer unless:

a. *the annuity is described in one of the following subsections of section 408 of the Internal Revenue Service (IRS) Code:*

- *individual retirement account,*
- *accounts established by employers and certain associations of employees,*
- *simple retirement accounts;* ***or***

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b. *the annuity is a simplified employee pension (within the meaning of section 408(k) of the IRS Code; or a Roth Individual Retirement Account (IRA);* ***or***

c. *the annuity is:*

- *irrevocable and non-assignable;*
- *actuarially sound (see M1450.520 C); and*
- *provides for equal payments with no deferral and no balloon payments.*

C. Procedures

1. Determine If Actuarially Sound

Determine if the annuity is actuarially sound. Use the Life Expectancy Table in M1450, Appendix 2:

a. Find the individual's age at the time the annuity was purchased in the "Age" column for the individual's gender ("Male" or "Female").

b. The corresponding number in the "Life Expectancy" column is the average number of years of expected life remaining for the individual.

c. Compare the life expectancy number to the life of the annuity (the period of time over which the annuity benefits will be paid).

d. When the average number of years of expected life remaining for the individual (the "life expectancy" number in the table) equals or exceeds the life of the annuity, the annuity is actuarially sound. When the annuity is actuarially sound, the purchase of the annuity is a compensated transfer for fair market value and does not affect eligibility.

e. When the average number of years of expected life remaining for the individual (the "life expectancy" number in the table) is less than the life of the annuity, the annuity is NOT actuarially sound. The annuity purchase is a transfer for less than fair market value. The transfer occurred at the time the annuity was purchased.

f. When the annuity is not actuarially sound, determine the uncompensated value and the penalty period (sections M1450.610 and M1450.620 below).

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EXAMPLE #2:

A man at age 65 purchases a $10,000 annuity to be paid over the course of 10 years. His life expectancy according to the table is 15.52 years. Thus, the annuity is actuarially sound; the purchase of the annuity is a compensated transfer for fair market value and does not affect eligibility for *LTSS* services payment.

EXAMPLE #3:

A man at age 80 purchases the same $10,000 annuity to be paid over the course of 10 years. His life expectancy according to the table is only 7.16 years. The annuity is not actuarially sound. The purchase of the annuity is a transfer for less than fair market value.

3. **Send Copy to DMAS**

A copy of the annuity agreement must be sent to:

DMAS, *Eligibility & Enrollment Services Division*
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

4. **Maintain Copy of Annuity**

The copy must be maintained by DMAS until the terms of the annuity have expired. A copy of the annuity must also be maintained in agency's case record.

M1450.530 RESERVED

M1450.540 PURCHASE OF A PROMISSORY NOTE, LOAN, OR MORTGAGE ON OR AFTER FEBRUARY 8, 2006

A. Introduction

This policy applies to the purchase of a promissory note, loan, or mortgage on or after February 8, 2006. Subchapter S1140.300 contains explanations of promissory notes, loans, and mortgages.

B. Policy

Funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, must be evaluated as an uncompensated transfer unless the note, loan, or mortgage:

- has a repayment term that is actuarially sound (see M1450.520),
- provides for payments to be made in equal amounts during the term of the loan with no deferral and no balloon payments, and
- prohibits the cancellation of the balance upon the death of the lender.

C. Uncompensated Amount

If the promissory note, loan, or mortgage does not meet the above criteria, the uncompensated amount is the outstanding balance as of the date of the individual's application for Medicaid.

Note: The countable value as a resource is the outstanding principal balance for the month in which a determination is being made.

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M1450.000 TRANSFER OF ASSETS	**M1450.550**	**20**

M1450.545 TRANSFERS INVOLVING LIFE ESTATES

A. Introduction This policy applies to the purchase of a life estate on or after February 8, 2006.

B. Policy Funds used to purchase a life estate in another individual's home on or after February 8, 2006, must be evaluated as an uncompensated transfer unless the purchaser resides in the home for at least 12 consecutive months. If the purchaser resides in the home for less than 12 consecutive months, the entire purchase amount will be considered a transfer for less than fair market value.

For Medicaid purposes, the purchase of a life estate is said to have occurred when an individual acquires or retains a life estate as a result of a single purchase transaction or a series of financial and real estate transactions.

M1450.550 TRANSFERS INVOLVING TRUSTS

A. Introduction A transfer of assets into or from a trust may be a transfer of assets for less than market value. See M1120.200 for trust resource policy, definitions pertaining to trusts, and for instructions for determining if the trust is a resource.

B. Revocable Trust

1. Transfer Into Revocable Trust A transfer of assets **into** a revocable trust does not affect eligibility because the entire principal of a revocable trust is an available resource to the individual.

2. Payments From a Revocable Trust Any payments from the revocable trust which are made to or for the benefit of the individual are counted as income to the individual and are not transfers for less than market value.

Any payments from the revocable trust's principal or income which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value.

3. Look-back Date The look-back date is 60 months for assets transferred (payments made) **from** a revocable trust.

EXAMPLE #4: Mr. B established a revocable trust with a principal of $100,000 on March 1, 1994. He enters a nursing facility on November 15, 1997, and applies for Medicaid on February 15, 1998. The trustee has complete discretion in disbursing funds from the trust. Each month, the trustee disburses $100 to Mr. B and $500 to a property management firm for the upkeep of Mr. B's home. On June 14, 1994, the trustee gave $50,000 of the trust principal to Mr. B's brother.

The $100 and $500 payments are counted as income to Mr. B. Because the trust is revocable, the entire principal is a resource to Mr. B. Because the trustee gave $50,000 away, the countable value of the trust is the remaining $50,000. The transfer of the $50,000 to Mr. B's brother is a transfer for less than fair market value. The look-back date is February 15, 1993, which is 60 months prior to February 15, 1998, the date Mr. B was both in an institution and applied for Medicaid. The transfer occurred on June 14, 1994 which is after the look-back date. The uncompensated value is $50,000. The penalty

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date is June 1, 1994, the first day of the month in which the transfer occurred. The penalty period is 19 months beginning June 1, 1994.

C. Irrevocable Trust

A transfer of funds **into** an irrevocable trust and a transfer of funds **from** an irrevocable trust MAY be asset transfers for less than fair market value, depending on whether the terms of the trust

* allow for payments to or for the benefit of the individual, OR
* do not allow for payments to or for the benefit of the individual.

1. When Payment to Individual Is Allowed

When the trust allows for circumstances under which payment can be made to or for the benefit of the individual from all or a portion of the trust,

1) the portion of the trust principal that could be paid to or for the benefit of the individual is a resource available to the individual;
2) income (produced by the trust principal), which could be paid to or for the benefit of the individual, is a resource available to the individual;
3) payments from the trust income or principal, which are made to or for the benefit of the individual, are counted as income to the individual;
4) payments from income or from the trust principal which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value.

a. Transfer Into Trust

A transfer of assets **into** an irrevocable trust that allows for payment to or for the benefit of the individual does NOT affect eligibility because the irrevocable trust is a resource to the individual.

b. Payments From Trust

Payments from income or from the trust principal which are made to or for the benefit of the individual are counted as income.

Payments from income or from the trust principal which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value.

The date the transfer occurs is the date that the payment to the individual was foreclosed (the date the payment was paid to another person not for the benefit of the individual).

c. Look-back Date When Payment to Individual Is Allowed

The look-back date is ***60*** **months** for assets transferred from an irrevocable trust under which some payment can be made to or for the benefit of the individual.

EXAMPLE #5: Mr. C established an irrevocable trust with a principal of $100,000 on March 1, 1994. He enters a nursing facility on November 15, 1997, and applies for Medicaid on February 15, 1998. The trustee has discretion to disburse the entire principal of the trust and all income from the trust to anyone, including Mr. C, the grantor. Each month, the trustee

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disburses $100 to Mr. C and $500 to a property management firm for the upkeep of Mr. C's home. On June 14, 1994, the trustee gave $50,000 of the trust principal to Mr. C's brother.

The $100 and $500 payments are counted as income to Mr. C. Because the trustee gave $50,000 away, the value of the trust is the remaining $50,000. The $50,000 principal is a resource to Mr. C since the trust allows circumstances under which payment of all the trust principal could be made to Mr. C. The transfer of the $50,000 to Mr. C's brother is a transfer for less than fair market value. The look-back date is February 15, 1995, which is 36 months prior to the baseline date February 15, 1998, the date Mr. C was both in an institution and applied for Medicaid. The transfer occurred on June 14, 1994 which is before the look-back date. No penalty due to this transfer can be imposed; the transfer does not affect eligibility for LTC services payment. Mr. C is not eligible for Medicaid because the $50,000 available trust resource exceeds the Medicaid resource limit.

2. When Payment to Individual Is NOT Allowed

When the trust **DOES NOT allow payment to or for the benefit of the individual** from all or a portion of the trust principal (or income on the trust principal), treat the trust as a transfer of assets for less than fair market value.

a. Transfer Into Trust

A transfer of assets **into** an irrevocable trust that does NOT allow payment to or for the benefit of the individual is a transfer of assets for less than fair market value that affects eligibility.

The date the transfer occurred is

* the date the trust was established.
* the date payment to the individual was foreclosed (the date the exculpatory clause came into effect that made the trust funds no longer payable to the individual), if later.

A transfer of additional funds into an irrevocable trust is a new asset transfer and must be evaluated separately from the asset transfer that established the trust. The date the new transfer occurred is the date the additional funds were placed in the irrevocable trust.

b. Payments From Trust

Payments from the trust cannot be made to or for the benefit of the individual, so any payments from the trust do not affect the individual's eligibility.

c. Look-back Date When Payment to Individual Not Allowed

When the trust states that payment cannot be made to the individual, the look-back date is 60 months before the baseline date.

EXAMPLE #6: Mr. D established an irrevocable trust with a principal of $100,000 on March 1, 1994. He enters a nursing facility on November 15, 1997, and applies for Medicaid on February 15, 1998. The trust does not allow the trustee to disburse any of the principal of the trust to or for the benefit of Mr. D. The trustee disburses $100 to Mr. D and $500 to a property management firm for the upkeep of Mr. D's home each month from the trust income. On June 14, 1994, the trustee gave $50,000 of the trust principal to Mr. D's brother. On July 2, 1996, Mr. D placed another $10,000 of his savings into the trust.



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The $100 and $500 payments are counted as income to Mr. D. Because none of the principal can be disbursed to Mr. D, the entire value of the trust at the time the trust was established ($100,000 in 3-1-94) is a transfer of assets for less than fair market value. The look-back date is February 15, 1993, which is 60 months prior to the baseline date of February 15, 1998, the date Mr. D was both in an institution and applied for Medicaid. The transfer occurred on 3-1-94 which is after the look-back date. The uncompensated value is $100,000.

The 7-2-96 transfer of $10,000 into the trust is another asset transfer for less than fair market value that occurred on 7-2-96. The transfer occurred on 7-2-96 which is after the look-back date. The uncompensated value is $10,000.

D. Pooled Trusts

A pooled trust is a trust that can be established for a disabled individual under the authority of Section 1917(d)(4)(C) of the Social Security Act (see M1120.202). The placement of an individual's funds into a pooled trust when the individual is age 65 years or older must be evaluated as an uncompensated transfer, if the trust is structured such that the individual irrevocably gives up ownership of funds placed in the trusts.

A trust established for a disabled individual under age 65 years is exempt from the transfer of assets provisions. However, any funds placed in the trust after the individual turns 65 must be evaluated as an asset transfer.

M1450.560 INCOME TRANSFERS

A. Policy

Income is an asset. When an individual's income is given or assigned in some manner to another person, such gift or assignment may be a transfer of an asset for less than market value.

B. Procedures

Determine whether the individual has transferred lump sum payments actually received in a month. Such payments are counted as income in the month received for eligibility purposes, and are counted as resources in the following month if retained. Disposal of a lump sum payment before it can be counted as a resource could be an uncompensated asset transfer.

Attempt to determine whether amounts of regularly scheduled income or lump sum payments, which the individual would otherwise have received, have been transferred. Normally, such a transfer takes the form of transferring the right to receive income. For example, a private pension may be diverted to a trust and no longer be paid to the individual. Question the individual concerning sources of income, income levels in the past versus the present, direct questions about giving away income or assigning the right to receive income, to someone else, etc.

In determining whether income has been transferred, do not attempt to ascertain in detail the individual's spending habits during the look-back period. Absent a reason to believe otherwise, assume that the individual's income was legitimately spent on the normal costs of daily living.

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When income or the right to income has been transferred, and none of the criteria in M1450.300 or M1450.400 are met, determine the uncompensated value of the transferred income (M1450.610) and determine a penalty period (M1450.620 or 630).

M1450.570 SERVICES CONTRACTS

A. Policy

Services contracts (i.e. personal care contract, care contracts, etc.) are typically entered into for the completion of tasks such as, but not limited to, grocery shopping, housekeeping, financial management and cooking, that individuals no longer can perform for themselves. For purposes of Medicaid payment of LTC services, payments made under these types of contracts may be considered an uncompensated transfer of assets.

B. Procedures

When a services contract, sometimes referred to as a personal care contract, is presented as the basis for a transfer of assets, the eligibility worker must do the following:

1. **Determine Institutionalization**

Determine when the individual met the requirement for institutionalization.

2. **Verify Contract Terms and Value of Services**

Obtain a copy of the written contract, or written statements verifying the terms of the agreement by all parties. Determine when the agreement was entered into/signed, who entered into/signed the contract, and if the contract is legally binding as defined by policy at M1450.003 H. The terms of the contract must include the types of services, hourly rate of payment and the number of hours for each service. The hourly rate for the services must be the fair market value for such services at the time the services were provided. The terms must be specific and verifiable. Verification of payments made and services provided must be obtained. Any payment for a service which does not have a fair market value is an uncompensated transfer.

3. **Contract Services**

Once an individual begins receipt of Medicaid LTC services, the individual's personal *care* and medical needs are considered to be met by the LTC provider. Payment(s) to other individuals for services received after the individual enters LTC are considered an uncompensated transfer for Medicaid purposes.

4. **Physician Statement Required**

A statement must be provided by the individual's physician that indicates the types of services that were to be provided under the contract, and that these services were necessary to prevent the individual's entrance into LTC.

5. **Contract Made By Individual or Authorized Representative**

The contract must have been made by the applicant/recipient or his authorized representative.

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6. Payments Prior To Contract Date

Any payment(s) made prior to the date the contract was signed (if contract is written) or date the contract was agreed upon (if contract is a legally binding oral contract) by all parties is considered an uncompensated transfer.

7. Advance Lump Sum Payments Made To Contractor

Certain contracts for services provide an advance lump sum payment to the person who is to perform the duties outlined in the contract. Any payment of funds for services that have not been performed is considered an uncompensated transfer of assets. The Medicaid applicant/recipient has not received adequate compensation, as he has yet to receive valuable consideration.

8. Determine Penalty Period

If it is determined that an uncompensated transfer of assets occurred, follow policy in this subchapter to determine the penalty period.

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M1450.600 *APPLYING A* PENALTY PERIOD

A. Introduction

When a transfer of assets was for less than fair market value, the individual is not eligible for Medicaid payment of LTC services for a specific period of time (penalty period) based on the uncompensated value of the transferred asset and the date the transfer occurred. However, if the individual meets all other Medicaid eligibility requirements, the individual is enrolled in Medicaid and is eligible for Medicaid payment of all other Medicaid-covered services.

The asset transfer precludes Medicaid payment for LTC services during the penalty period unless and until the individual receives adequate compensation in return for the transferred asset.

Penalty periods that are imposed cannot overlap or run concurrently. The total cumulative uncompensated value of the assets transferred is used to determine the length of the penalty period.

Once a penalty period begins it does not change or stop. The penalty period continues regardless of whether Medicaid eligibility continues, the institutionalized individual is discharged from LTC, or the individual changes from nursing facility care to community-based care. If the individual is re-admitted to LTC and the penalty period has not expired or ended, Medicaid payment for LTC services will continue to be denied for the remainder of the penalty period. **EXCEPTION:** The penalty period may be shortened if subsequent compensation is received (see M1450.640) or eliminated if an undue hardship is granted (see M1450.700).

B. Determination Procedures

Determine the uncompensated value using policy and procedures in M1450.610 below. Go to M1450. 630 to determine the penalty period.

If the individual subsequently receives compensation in return for the transferred asset, re-evaluate the penalty period using policy and procedures in M1450.640 below.

M1450.610 UNCOMPENSATED VALUE

A. Policy

The uncompensated value is the amount of an asset's fair market value (FMV) that was not or will not be received as a result of the asset transfer. FMV is based on criteria used in determining the value of assets in determining Medicaid eligibility.

The uncompensated value for **real property** at the time of transfer:

- is the difference between the asset's FMV and the Gross Amount Due to Seller, when the lien/other encumbrance against the asset is satisfied from the seller's proceeds, or
- the difference between the asset's equity value (FMV minus the lien) and the Gross Amount Due to Seller, when the lien is assumed by the buyer.

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See M1450.610 H for the procedures for determining the uncompensated value of transferred real property.

Determine the uncompensated value of the transferred asset in this section and go to M1450.630 to determine the penalty period.

B. Term Life Insurance Purchase On or Before April 7, 1993

For term life insurance policies purchased on or before April 7, 1993, the purchase is a compensated transfer of assets and the purchase does not affect eligibility.

C. Term Life Insurance Purchase After April 7, 1993

For term life insurance policies purchased after April 7, 1993, the purchase is a transfer of assets for less than fair market value if the term insurance's face value is less than twice the sum of all premium(s) paid on the policy. The uncompensated value is the total premium(s) paid on the policy.

If more than one premium was paid on the policy, and the premiums were paid in different months, each premium paid on the policy is a separate transfer of assets for less than fair market value. A transfer occurred in the month each premium was paid.

EXAMPLE #7: Mr. C applied for Medicaid on November 2, 1996. On August 13, 1995, Mr. C. used $3,000 from his checking account to pay a $3,000 premium on a $5,000 face value term life insurance policy. On October 5, 1995, he used $2,000 from his checking account to pay up premiums on the same $5,000 face value term life insurance policy. Since the policy was purchased after April 7, 1993, and $5,000 (benefit payable on death) is not twice the $5,000 total premiums, the premium payments are transfers of assets for less than fair market value.

The uncompensated value of the first transfer on 8-13-95 is $3,000. The uncompensated value of the second transfer on 10-5-95 is $2,000. The penalty period for the first transfer is based on the $3,000 uncompensated value and the transfer date of August 1995. The penalty period for the second transfer is based on the $2,000 uncompensated value and the transfer date of October 1995.

D. Annuity Purchase

When the average number of years of expected life remaining for the individual (the “life expectancy” number in the table) *is less than* the life of the annuity, the annuity is NOT actuarially sound. The annuity purchase is a transfer for less than fair market value.

The transfer occurred at the time the annuity was purchased.

To determine the transferred asset's uncompensated value:

1. divide the face value of the annuity by the number of years in the life of the annuity.

2. the result is the yearly payout amount.

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3. from the number of years in the life of the annuity, subtract the individual's life expectancy from table.

4. the result is the uncompensated payout years (number of the annuity's "payout" years that are uncompensated).

5. multiply the uncompensated payout years by the yearly payout amount.

6. the result is the uncompensated value of the assets transferred to purchase the annuity.

EXAMPLE #8: An 80-year old man uses $9,000 from his savings account on May 6, 1996, to purchase a $10,000 annuity to be paid over the course of 10 years. His life expectancy according to the table is only 6.98 years. The annuity is not actuarially sound. The purchase of the annuity is a transfer for less than fair market value.

The uncompensated value is determined:

$10,000 annuity value
÷ 10 years life of annuity
$1,000 yearly payout
10 years life of annuity
- 6.98 life expectancy
3.02 uncompensated payout years
x$1,000 yearly payout
$3,020 uncompensated value

The penalty period is based on the $3,020 uncompensated value and the transfer date of May 1996.

E. Funds From Revocable Trust

Any payments **from** a revocable trust's principal or income which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value. The uncompensated value is the amount of the payment.

EXAMPLE #9: Mr. B established a revocable trust with a principal of $100,000 on March 1, 1994. Each month, the trustee disburses $100 to Mr. B and $500 to a property management firm for the upkeep of Mr. B's home. On June 14, 1994, the trustee gave $50,000 of the trust principal to Mr. B's brother.

The $100 and $500 payments are counted as income to Mr. B. The transfer of the $50,000 to Mr. B's brother is a transfer for less than fair market value. The uncompensated value is $50,000; the penalty period starts on June 1, 1994, the date the transfer occurred.

F. Irrevocable Trust

1. When Payment Is Allowed to Individual

When the irrevocable trust allows payments to the individual from all or a portion of the trust, any payments **from** the trust income or **from** the trust principal which are NOT made to or for the benefit of the individual are

assets transferred for less than fair market value. The uncompensated value is the amount of the payment.

EXAMPLE #10: Mr. C established an irrevocable trust with a principal of $100,000 on March 1, 1994. The trustee has discretion to disburse the entire principal of the trust and all income from the trust to anyone, including Mr. C, the grantor. All of the trust principal ($100,000) could be disbursed to Mr. C under the terms of the trust. Each month, the trustee disburses $100 to Mr. C and $500 to a property management firm for the upkeep of Mr. C's home. On June 14, 1994, the trustee gave $50,000 of the trust principal to Mr. C's brother.

The $100 and $500 payments are counted as income to Mr. C. The transfer of the $50,000 to Mr. C's brother is a transfer for less than fair market value. The transfer occurred in June 1994. The uncompensated value is $50,000.

2. When Payment Is Not Allowed to Individual

When the irrevocable trust does NOT allow payment to the individual from the trust, the transfer of funds into the trust is a transfer of assets for less than fair market value.

a. Trust Value

In determining the value of the trust which cannot be paid to the individual, do not subtract from the trust value any payments made for whatever purpose after the date the trust was established or, if later, the date payment to the individual was foreclosed. The value of the transferred amount is no less than its value on the date the trust is established or the date payment to the individual was foreclosed.

b. Uncompensated value

The uncompensated value is the amount of assets transferred into a trust which cannot be paid to the individual. If payment from the trust was foreclosed after the trust was established, the uncompensated value is the value of the trust as of the date payment was foreclosed.

c. Transfer Date

The date the transfer occurred is the date the trust was established, or, if later, the date payment to the individual was foreclosed.

d. Example #11

EXAMPLE #11: Mr. D established an irrevocable trust with a principal of $100,000 on March 1, 1994. The trust allowed the trustee to disburse any of the principal of the trust to or for the benefit of Mr. D until Mr. D is admitted to a nursing facility. Mr. D was admitted to a nursing facility on May 30, 1996. Each month from the trust income, the trustee disburses $100 to Mr. D and $500 to a property management firm for the upkeep of Mr. D's home. On June 14, 1996, the trustee gave $50,000 of the trust principal to Mr. D's brother. Mr. D applied for Medicaid on February 15, 1998.

The $100 and $500 payments are counted as income to Mr. D. Because none of the principal can be disbursed to Mr. D on or after the date he was admitted to the nursing facility, the value of the trust at the time payment was foreclosed ($100,000 on 5-30-96) is a transfer of assets for less than fair market value. The date the transfer occurred is May 30, 1996, the date payment to Mr. D was foreclosed. The look-back period is 60 months. The look-back date is February 15, 1993, which is 60 months prior to the baseline date of February 15, 1998, the date Mr. D was both in an institution and applied for Medicaid.



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The uncompensated value is $100,000. The fact that $50,000 was paid out of the trust to Mr. D's brother after payment to Mr. D was foreclosed does not alter the uncompensated amount upon which the penalty is based because the value of the transferred asset can be no less than its value on the date payment from the trust was foreclosed.

Mr. D placed an additional $25,000 in the same trust on June 20, 1996. Under the terms of the trust, none of this $25,000 can be disbursed to him. This is a new transfer of assets for less than fair market value. The uncompensated value is $25,000; the transfer date is 6-20-96.

G. Income Transfers

1. Lump Sum Transfer

When a single lump sum, or single amounts of regularly paid income, is transferred for less than fair market value, the uncompensated value is the amount of the lump sum, less any compensation received. For example, an individual gives a $2,000 stock dividend check that is paid once a year to the individual, to another person in the month in which the individual received the check. No compensation was received. The uncompensated value is $2,000.

2. Stream of Income Transfer

When a stream of income (income received regularly) or the right to a stream of income is transferred, determine the total amount of income expected to be transferred during the individual's life, based on an actuarial projection of the individual's life expectancy. The uncompensated value is the amount of the projected income, less any compensation received. Use the Life Expectancy Table in M1450, Appendix 2.

3. Income Transfer Example

EXAMPLE #12: A man aged 65 years, assigns his right to a $500 monthly annuity payment to his brother. He receives no compensation in return. Based on the life expectancy tables for males, the uncompensated value of the transferred income is $*93,120*.

$ 500
x12 months
$6,000 yearly income
x*15.52* life expectancy from table
$*93,120* value
- 0 compensation
$*93,120* uncompensated value

H. Real Property Transfers

The uncompensated value of transferred real property is determined by evaluating the settlement document which outlines the monetary transactions between the individual who sells the property and the individual who buys the property. A copy of the Settlement Document is in **M1450, Appendix 3.**

The eligibility worker must obtain:

- documentation of the tax assessed value of the property at the time of the transfer; and
- a copy of the closing or settlement documents from the client or the financial institution.

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1. **Summary of Seller's Transactions**

Review the summary of the seller's transactions:

- Determine the Gross Amount Due to Seller.
- Is the Gross Amount Due to Seller less than the **tax assessed *or effective 10/4/16, the certified appraised* value**?
  - If **no**, the seller received adequate compensation for the property and there is **no** uncompensated transfer.
  - If **yes**, determine the uncompensated value of the asset transfer.

2. **Real Property Uncompensated Value Calculations**

a. When the lien is satisfied from the proceeds received by the seller, deduct the Gross Amount Due to Seller from the tax assessed *or certified appraised* value to determine the uncompensated amount of the asset transfer.

b. When the lien is assumed by the buyer, deduct the lien amount from the tax assessed *or certified appraised* value of the property, to determine the equity value. From the equity value deduct the Gross Amount Due to Seller for the property to determine the uncompensated amount of the asset transfer.

c. Determine the penalty period. The beginning of the penalty period depends upon whether the transfer took place prior to or on/after 2/08/2006.

Note: Any funds deducted from the Gross Amount Due to Seller that are paid to another individual, such as funds for repair of the property, are not considered usual and customary fees and must be evaluated as a separate asset transfer. If the transfer was uncompensated then the amount of this transfer may be added to any uncompensated value from the sale of property, as the transfer occurred at the same point in time.

Example #13a: Mrs. K. is receiving CBC services. The worker discovers that Mrs. K. has moved in with her daughter and has sold her home to her son. The tax assessed value of her home at the time of transfer was $200,000. The closing documents indicate that she sold her home for $125,000 (the gross amount due to seller). The closing costs were paid by Mrs. K. There was no lien against the property.

The uncompensated value of the transferred real property is calculated as follows:

$200,000 tax assessed value
-125,000 Gross Amount Due to Seller
$ 75,000 uncompensated value

The penalty period is based on the uncompensated value of $75,000.

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Example #13b: On October 20, Mr. B. was admitted to a nursing facility. He transferred his home in July of the same year, which was within the look-back period. His home was assessed at $100,000 in July. The mortgage against his home had a balance due of $16,000 in July.

In reviewing the settlement statement for the sale of the property, it is noted that the sale price of the home was $70,000 (gross amount due to seller), which was less than the tax assessed value of the home. The lien of $16,000 was satisfied at closing from the $70,000 sale price. The other fees deducted were usual and customary and were determined to have been paid by the buyer. Mr. B. received a $54,000 net settlement for the sale of his home.

The uncompensated value of the transferred real property is calculated as follows:

$100,000 tax assessed value
- 70,000 Gross Amount Due to Seller (includes the lien amount)
$ 30,000 uncompensated value

The penalty period is based on the uncompensated transfer value of $30,000. When the penalty period begins depends on whether the transfer took place prior to or after February 8, 2006.

Example #13c: The scenario is the same as in example 13b. However, the lien will be assumed by the purchaser rather than satisfied from the seller's gross settlement amount (Gross Amount Due to Seller). The equity value of the home is used to determine the uncompensated value in this case, because the seller was not responsible for satisfaction of the lien.

$100,000 tax assessed value
-16,000 lien amount
$ 84,000 equity value (EV)

$ 84,000 EV
- 70,000 Gross Amount Due to Seller
$ 14,000 uncompensated value

M1450.620 *RESERVED*

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M1450.630 PENALTY PERIOD CALCULATION

A. Policy

When a transfer of assets affects eligibility, the penalty period begins when the individual would otherwise be eligible for Medicaid payment for LTSS (long term services and support) if not for the penalty period. The penalty period includes the fractional portion of the month, rounded down to a day. Penalty periods for multiple transfers cannot overlap.

As long as an individual in a penalty period meets a full or limited-benefit Medicaid covered group and all nonfinancial and financial requirements for that covered group, he is eligible for all services covered under that group EXCEPT the Medicaid payment of LTSS. Individuals in nursing and other medical facilities or who have been screened and approved for HCBS (home and community based services), meet the 300% SSI covered group during a penalty period because they meet the definition of an institutionalized person.

An individual with a penalty period who does not meet the 300% SSI covered group may meet other covered groups. See M1450.630 B.5.

B. Penalty Begin Date

For individuals not receiving LTSS at the time of transfer, the penalty period begins the first day of the month in which the individual would otherwise be eligible for Medicaid payment for LTSS, except for the imposition of a penalty period. This includes the application retroactive period for nursing facility patients who have been in the facility during the retroactive period.

For individuals who are receiving Medicaid payment for LTSS at the time of transfer, the penalty period begins the month following the month of transfer *unless the transfer took place during the COVID-19 Emergency continuous eligibility period. See M1520.200.*

1. Medicaid LTSS Not Received at Time of Transfer

If the individual is not receiving Medicaid-covered LTSS at the time of the asset transfer, the penalty period begins the first day of the month in which the individual would otherwise be eligible for Medicaid payment for LTSS but for the application of the penalty period, as long as the date does not fall into another period of ineligibility imposed for any reason.

2. Receiving Medicaid LTSS Services at Time of Transfer

If the individual is receiving Medicaid LTSS at the time of the asset transfer, the penalty period begins the first day of the month following the month in which the asset transfer occurred as long as the individual would otherwise be eligible for Medicaid payment for LTSS but for the application of the penalty period.

A referral to the DMAS Enrollee Audit Unit (RAU) must be made for the months in the penalty period during which the individual received Medicaid LTSS services. See Chapter M17 for instructions on RAU referrals.

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3. **Penalty Periods Cannot Overlap**

When multiple asset transfers result in multiple penalty periods, the penalty periods cannot overlap. One penalty period must be completed prior to the beginning of the next penalty period.

4. **Nursing Facility**

If the individual in a nursing facility meets all Medicaid eligibility requirements, he is eligible for Medicaid payment of all other covered services.

5. **HCBS, PACE, Hospice**

a. Transfer Reported at Application

If the individual has been screened and approved for or is receiving Medicaid HCBS, PACE, or hospice services, he cannot be eligible for Medicaid in the 300% of SSI covered group or for the Medicaid payment of LTSS in any other covered group. The individual's Medicaid eligibility in other covered groups must be determined. His penalty period cannot be imposed unless and until he is (1) eligible for Medicaid in a full-benefit covered group other than the 300% of SSI covered group, (2) he meets a spenddown and would otherwise be eligible for the Medicaid payment of LTSS, or (3) he is admitted to a nursing facility.

An individual outside a medical facility (i.e. living in the community) does not meet the definition of an institutionalized person if he is not receiving Medicaid covered HCBS, PACE or hospice services. Therefore, an individual for whom a penalty period is imposed cannot be eligible for Medicaid unless the individual is eligible for Medicaid outside the 300% SSI covered group.

Any penalty periods imposed under the rules effective April 17, 2018 through October 1, 2022 are valid and continue until the penalty period is exhausted.

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b. Transfer Reported After Eligibility is Established

If it is reported or discovered that an individual receiving *HCBS* services in the 300% of SSI covered group made an uncompensated asset transfer prior to beginning *HCBS,* determine a penalty period. Evaluate for another covered group prior to cancelling. His penalty period cannot be imposed unless and until he is (1) eligible for Medicaid in a full-benefit covered group other than the 300% of SSI covered group, (2) he meets a spenddown and would otherwise be eligible for the Medicaid payment of *LTSS*, or (3) he is admitted to a nursing facility.

A referral to the DMAS Enrollee Audit Unit (RAU) must be made for the months in the penalty period during which the individual received Medicaid *LTSS* services. See Chapter M17 for instructions on RAU referrals.

***6.* Penalty Period imposed by another state**

If the individual has completed an asset transfer penalty period in another state, a penalty period is not imposed by Virginia Medicaid for the same uncompensated transfer.

If an individual has relocated to Virginia and reports they have an active asset transfer penalty period in another state, he must complete the penalty period before being eligible for Medicaid payment of *LTSS* services. The eligibility worker must contact the previous state to find out the length of penalty period and time remaining. The remaining penalty period cannot be imposed unless and until the person is: 1) eligible for Medicaid in a full-benefit covered group other than the 300% of SSI covered group or; 2) meets a spenddown and would otherwise be eligible for the Medicaid payment of *LTSS* services or; 3) is admitted to a nursing facility. The individual's Medicaid eligibility in any other covered group(s) must be determined.

C. Penalty Period Calculation

The period is calculated by taking the uncompensated value of the assets transferred on or after the look-back date, divided by the average monthly cost of nursing facility services to a private-pay patient in his locality at the time of the application for Medicaid. The remainder is divided by the daily rate (the monthly rate divided by 31).

When the uncompensated value of an asset transfer is less than the monthly nursing facility rate, go to step #4 in E below to calculate the partial month penalty period.

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D. Average Monthly Nursing Facility Cost (Figures Provided by Virginia Health Information)

Average Monthly Private Nursing Facility Cost

Application Date	Northern Virginia*	All Other Localities
10-1-96 to 9-30-97	$2,564	$2,564
10-1-97 to 12-31-99	$3,315	$2,585
1-1-00 to 12-31-00	$3,275	$2,596
1-1-01 to 12-31-01	$4,502	$3,376
1-1-02 to 12-31-03	$4,684	$3,517
1-1-04 to 9-30-07	$5,403	$4,060
10-1-07 to 12-31-10	$6,654	$4,954
1-1-11 to 12-31-14	$7,734	$5,933
1-1-15 to 6-30-18	$8,367	$5,933
7-1-18 to 12-31-20	$9,032	$6,422
1-1-21 to *12-31-24*	$9,268	$7,023
1-1-25 to present	*$9,703*	*$7,324*

*The northern Virginia localities are: Alexandria, Arlington, Fairfax, Fairfax County, Falls Church, Loudoun County, Manassas, Manassas Park and Prince William County.

See M1450, Appendix 1 for amounts prior to October 1, 1996.

E. Partial Month Transfer

The following example shows how to compute a penalty period for an uncompensated transfer that occurred on or after July 1, 2018 and involves a partial month.

Example #19 (using July 2018 figures): An individual living outside Northern Virginia made an uncompensated asset transfer of $48,294 in July 2018, the same month he applies for Medicaid. The uncompensated value of $48,294 is divided by the average monthly rate of $6,422 which equals 7.52 months. The full 7-month penalty period runs from July 2018, the month of the transfer, through January 2019, with a partial month penalty calculated for February 2019. The partial month penalty is calculated by dividing the partial month penalty amount ($3,340.00) by the daily rate ($207.16, which is the monthly rate of $6,422 divided by 31). The calculations are as follows:

Step #1	$48,294.00	uncompensated value of transferred asset
	÷ 6,422.00	avg. monthly nursing facility rate at time of application
	= 7.52	penalty period (7 full months, plus a partial month)
Step #2	$ 6,422.00	avg. monthly nursing facility rate at time of application
	X 7	seven-month penalty period
	$44,954.00	penalty amount for seven full months

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Step #3 *$48,294.00* *uncompensated value*
- 44,954.00 *penalty amount for seven full months*
$ 3,340.00 *partial month penalty amount*

Step #4 *$3,340.00* *partial penalty amount*
÷ 207.16 *daily rate ($6,422 ÷ 31)*
= 16.12 *number of days for partial month penalty*

For *February 2019,* the partial month penalty of 16 days would be added to the seven (7) month penalty period. *This* means Medicaid would authorize payment for *LTSS* services beginning *February 17, 2019.*

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

When an institutionalized individual is ineligible for Medicaid payment of long-term care services because of a transfer made by the spouse, and the spouse is or becomes institutionalized and eligible for Medicaid, the penalty period must be apportioned between the spouses. The couple may choose to either:

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

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

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

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

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M1450.640 SUBSEQUENT RECEIPT OF COMPENSATION

A. Policy

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

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

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

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

B. Example #20 Full Compensation Received

Example #20 Mr. G., who is in a nursing facility, applied for Medicaid on November 24, *2011*. On October 10, 2011, he transferred his non-home real property worth *$46,404* to his son. The transfer did not meet any of the criteria in M1450.*400*, so a penalty period was imposed from October 1, 2011, through April 30, *2012*.

On December 12, *2011*, Mr. G.'s son paid *some outstanding* medical bills *that were not related to long-term care* for his father totaling $*47,000*. The agency re-evaluated the transfer and determined a penalty period was no longer appropriate since full compensation was received. Mr. G's eligibility for Medicaid payment of long-term care services was re-evaluated, beginning with October 1, *2011*.

C. Example #21 Partial Compensation Received

Example #21: Ms. H. applied for Medicaid on November 2, 2004, after entering a nursing facility on March 15, 2004. On October 10, 2004, she transferred her non-home real property worth $40,000 to her son and received no compensation in return for the property. Ms. H's Medicaid application was approved, but she was ineligible for Medicaid payment of long-term care services for 9 months beginning October 1, 2004 and continuing through June 30, 2005.

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

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

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M1450.700 CLAIM OF UNDUE HARDSHIP

A. Policy

The opportunity to claim an undue hardship must be given when the imposition of a penalty period affects Medicaid payment for LTC services. *The opportunity to claim an undue hardship is in addition to the opportunity to appeal the transfer of assets decision itself.* An undue hardship may exist when the imposition of a transfer of assets penalty period would deprive the individual of medical care such that the individual's health or life would be endangered or he would be deprived of food, clothing, shelter, or other necessities of life. An undue hardship may be granted when documentation is provided that shows:

- that the assets transferred cannot be recovered, and
- that the immediate adverse impact of the denial of Medicaid coverage for payment of LTC services due to the uncompensated transfer would result in the individual being removed from the institution or becoming unable to receive life-sustaining medical care, food, clothing, shelter or other necessities of life.

Applicants, recipients, or authorized representatives may request an undue hardship evaluation. Additionally, the Deficit Reduction Act of 2005 authorized nursing facilities to act on behalf of their patients, when necessary, to submit a request for undue hardship. The nursing facility must have written authorization from the recipient or his authorized representative in order to submit the claim of undue hardship.

A claim of undue hardship:

- can be made for an individual who meets all Medicaid eligibility requirements and is subject to a penalty period,
- cannot be made on a denied or closed Medicaid case *or when the individual is deceased*,
- cannot be made when the penalty period has already expired, and
- cannot be used to dispute the value of a resource.

B. Procedures

If the individual chooses to make a claim of an undue hardship, documentation regarding the transfer and the individual's circumstances must be sent to the Department of Medical Assistance Services (DMAS) for an undue hardship determination **prior** to the eligibility worker taking action to impose a penalty period.

The individual has the burden of proof and must provide written evidence to clearly substantiate what was transferred, the circumstances surrounding the transfer, attempts to recover the asset or receive compensation, and the impact of the denial of Medicaid payment for LTC services.

1. Eligibility Worker

The eligibility worker must inform the individual of the undue hardship provisions and, if an undue hardship is claimed, send the claim and supporting documentation to DMAS for evaluation.

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The eligibility worker must send a letter to the individual informing him of each asset transfer and the corresponding penalty period, as well as the right to claim an undue hardship. An Asset Transfer Undue Hardship Claim form, available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, must be included with the letter. The Asset Transfer Undue Hardship Claim Form serves as the request for an undue hardship evaluation.

a. Undue Hardship Claimed - Required Documentation

When requesting an undue hardship, the individual must provide the following documentation appropriate to the case situation:

- the reason(s) for the transfer;
- attempts made to recover the asset, including legal actions and the results of the attempts;
- notice of pending discharge from the facility, or discharge from PACE, hospice, or CBC services due to denial or cancellation of Medicaid payment for these services and include the actual date discharge will take place;
- medical provider's statement stating the inability to receive nursing facility or CBC services would result in the applicant/recipient's inability to obtain life-sustaining medical care;
- documentation that individual would not be able to obtain food, clothing, shelter, or other necessities of life;
- list of all assets owned and verification of their value at the time of the transfer if the individual claims he did not transfer resources to become Medicaid eligible; and
- documents such as deeds or wills if ownership of real property is an issue.
-

b. *15* Days to Return Undue Hardship Claim

The individual must be given at least *15* calendar days to return the completed form and documentation to the local agency. If the individual requests additional time to provide the form and documentation, the worker shall allow up to 30 calendar days from the date the checklist was sent. If the form and documentation are not returned within 30 calendar days, the penalty period must be imposed.

c. Documentation for DMAS

If an undue hardship is claimed, the eligibility worker must send to DMAS:

- a copy of the undue hardship claim form
- a description of each transfer:
  - what was transferred
  - parties involved and relationship
  - uncompensated amount
  - date of transfer

- calculation and duration of the penalty period(s) being imposed;
- a brief summary of the applicant/recipient's current eligibility status and living arrangements (nursing facility or community); and
- other documentation provided by the applicant/recipient.

Email the documentation to DMAS at DMASEvaluation@dmas.virginia.gov or mail to:

DMAS, Eligibility Policy and Outreach Division
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

A copy of all documentation submitted with the undue hardship claim must be retained in the case record.

Any information the agency receives about the individual's subsequent receipt of compensation which shortens the penalty period must be sent to the DMAS at the above address.

d. When Applicant/Recipient Was Victim

If the applicant/recipient was a victim of an individual who is not the individual's attorney in fact, guardian, conservator or trustee and undue hardship is claimed, the **agency** must provide a statement documenting the facts and what actions were taken by the agency with regard to their findings. If the transfer was by a court-appointed guardian or conservator, documentation of any bond insurance that would cover the loss must be provided.

e. Undue Hardship Not Claimed or Not Granted by DMAS

If undue hardship is not claimed or if a penalty period must be imposed per DMAS, follow the procedures in M1450.800 through M1450.830 for notifying the individual and DMAS of the action. The individual must be informed that a denial of a claim for undue hardship may be appealed in accordance with the provisions of 12 VAC 30-110. If the individual meets all other eligibility requirements, he is eligible for Medicaid payment of all covered services other than LTC.

2. DMAS

DMAS will review the documentation provided with the undue hardship claim to determine if an undue hardship may be granted and send written notification to the eligibility worker. If additional information is needed to clarify the documentation received with the Undue Hardship claim, DMAS will notify the agency and provide a time frame for submitting the documentation. A copy of the decision must be retained in the individual's case record.

3. Subsequent Claims

If DMAS is unable to approve an undue hardship request because sufficient supporting documentation was not submitted, the claim must be denied and the penalty period must begin. Once a claim is denied, no further decision related to the same asset transfer will be made by DMAS unless the individual experiences a change in circumstances **while still in the penalty period**, such as receiving a discharge notice, that would result in the individual being removed from the institution or becoming unable to receive life-sustaining medical care, food, clothing, shelter or other necessities of life.

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If the individual/authorized representative alleges a change in circumstances while still in the penalty period, *a claim of undue hardship can be requested and* will follow the procedures *as found* in M1450.700 B.1. *Once DMAS makes a decision on the claim, the worker will follow the policy as below.*

a. If a subsequent claim is received and penalty period has begun

If DMAS approves the subsequent claim of undue hardship, the penalty period ends effective with the date of the discharge notice or other documentation of undue hardship. The effective date is indicated in the approval letter from DMAS. Medicaid cannot pay for *LTSS* received prior to the end of the penalty period.

b. If a subsequent claim is received and penalty period has not begun

If the individual was screened and approved for Medicaid HCBS, PACE, or hospice services but his penalty period could not be imposed per M1450.630 B.5, and DMAS approves the subsequent claim of undue hardship, the penalty period is waived. However, Medicaid cannot pay for *LTSS* received prior to the date of the documentation of undue hardship, as designated by DMAS.

M1450.800 AGENCY ACTION

A. Policy If an individual's asset transfer is not allowable by policy, the individual is not eligible for Medicaid payment of long-term care services. The individual, the service provider, and the Department of Medical Assistance Services (DMAS) must be notified of his/her ineligibility for the Medicaid payment of long-term care services, as well as his eligibility or ineligibility for Medicaid per M1450.810 below.

B. Procedures The procedures used for notifying the recipient, the provider and DMAS are in sections M1450.810, 820, and 830 below.

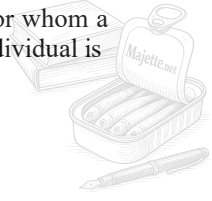
M1450.810 APPLICANT/RECIPIENT NOTICE

A. Policy Whenever an institutionalized individual is not eligible for Medicaid payment of long-term care services because of an asset transfer, the notice to the individual must contain the following:

1. Notice Includes Penalty Period The form which notifies him/her of Medicaid eligibility must include the penalty period during which Medicaid will not cover *LTSS* for the individual.

2. Individual In Facility - Eligible An individual in a nursing or other medical facility continues to meet the definition of an institutionalized person. If the individual meets all other Medicaid eligibility requirements, he is eligible for Medicaid in the 300% SSI covered group, except for payment for *LTSS.*

3. Individual Not in Facility - Not Eligible An individual outside a medical facility (i.e. living in the community) **does not** meet the definition of an institutionalized person if he is not receiving Medicaid covered *HCBS,* PACE or hospice services. Therefore, an individual for whom a penalty period is imposed cannot be eligible for Medicaid unless the individual is eligible for Medicaid outside the 300% SSI covered group.



4. Referral to DMAS Recipient Audit Unit (RAU)

If the individual already received Medicaid long-term care services during a penalty period or made a claim of an undue hardship for imposition of a penalty period and the claim was approved, a referral to the DMAS RAU must be made. The LDSS must make all referrals for recovery.

B. Notice Contents

The Notice of Action on Medicaid sent to the individual must specify that:

- Medicaid will not pay for nursing facility or CBC waiver services for the months (state the begin and end dates of the penalty period) because of the uncompensated asset transfer(s) that occurred on (date/dates);
- the penalty period may be shortened if compensation is received.

The notice must also specify that either:

- the individual is eligible for Medicaid coverage of services other than nursing facility or waiver services beginning (the appropriate date); **or**
- the individual is ineligible for Medicaid in any covered group, citing M1450.810 A.3, above.

If an asset transfer undue hardship claim was approved and the amount of the uncompensated transfer was $25,000 or more and was made within 30 months of the individual becoming eligible for or receiving Medicaid LTC services, the notice must also include the following statement:

"Section 20-88.02 of the Code of Virginia allows DMAS to seek recovery from the transferee (recipient of the transfer) when a Medicaid enrollee transfer assets with an uncompensated value of $25,000 or more within 30 months of receiving or becoming eligible for Medicaid."

C. Advance Notice

When an institutionalized Medicaid recipient is found no longer eligible for Medicaid payment of long-term care services because of an asset transfer, the Advance Notice of Proposed Action must be sent to the individual at least 10 days before cancelling coverage of LTC services, and must specify that either:

- The individual is eligible for Medicaid coverage of services other than nursing facility or waiver services beginning (the appropriate date), **or**
- The individual is ineligible for Medicaid in any covered group, citing M1450.810 A.3, above, **and**
- Medicaid will not pay for long-term care services for the months (state the penalty period begin and end dates) because of the asset transfer(s) that occurred (date/dates), **and**
- The penalty period may be shortened if compensation is received.



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M1450.820 PROVIDER NOTICE

A. Introduction

Use the Medicaid LTSS Communication Form (DMAS-225) to notify the provider of the individual's Medicaid eligibility and ineligibility for Medicaid payment of long-term care services.

B. Medicaid LTC Communication Form (DMAS-225)

The DMAS-225 should include:

- the individual's full name, Medicaid and Social Security numbers;
- the individual's birth date;
- the patient's Medicaid coverage begin date; and
- that the patient is not eligible for Medicaid payment of nursing facility/CBC waiver services for the months (state the penalty period begin and end dates) because of an asset transfer(s).

If the individual reports a change in circumstances to the local DSS, he or his authorized representative must be offered the chance to submit an additional claim of undue hardship. Follow the procedures in M1450.700 B above.

If DMAS grants the claim of undue hardship, the portion of the asset transfer penalty remaining **as of the date of the undue hardship request** is nullified. **Medicaid cannot pay for long-term care services received during the penalty period prior to the undue hardship request.** Nursing facility charges incurred during a penalty period may be evaluated as a patient pay deduction using the policy and procedures in M1470.230.

Once the penalty period has expired, no additional claims of undue hardship may be made.

M1450.830 DMAS NOTICE *section removed 7/1/25*

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Average Monthly Private Nursing Facility Cost
Prior to January 1, 2011

Application Date		Average Monthly Cost
		(All Localities)
7-1-1988 to 6-30-1989		$2,029
7-1-1989 to 12-31-1990		$2,180
1-1-1991 to 9-30-1993		$2,230
10-1-1993 to 9-30-1996		$2,554
10-1-1996 to 9-30-1997		$2,564

Application Date	*Average Monthly Cost*	
	*Northern Virginia**	*All Other Localities*
10-1-97 to 12-31-99	*$3,315*	*$2,585*
1-1-00 to 12-31-00	*$3,275*	*$2,596*
1-1-01 to 12-31-01	*$4,502*	*$3,376*
1-1-02 to 12-31-03	*$4,684*	*$3,517*
1-1-04 to 9-30-07	*$5,403*	*$4,060*
10-1-07 to 12-31-10	*$6,654*	*$4,954*

(Figures Provided by Virginia Health Information)

*The northern Virginia localities are: Alexandria, Arlington, Fairfax, Fairfax County, Falls Church, Loudoun County, Manassas, Manassas Park, and Prince William County.

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LIFE EXPECTANCY TABLE*

If the exact age is not on the chart, use the next lower age. For example, if an individual is age 47 at the time of the asset transfer, use the life expectancy that corresponds to age 40 on the chart.

AGE	Life Expectancy MALE	Life Expectancy FEMALE	AGE	Life Expectancy MALE	Life Expectancy FEMALE
0	*74.12*	*79.78*	74	*11.05*	*12.94*
10	*64.67*	*70.27*	75	*10.46*	*12.26*
20	*54.97*	*60.41*	76	*9.88*	*11.60*
30	*45.86*	*50.79*	77	*9.32*	*10.95*
40	*36.97*	*41.38*	78	*8.77*	*10.31*
50	*28.33*	*32.24*	79	*8.25*	*9.70*
60	*20.47*	*23.67*	80	*7.74*	*9.10*
61	*19.74*	*22.85*	81	*7.25*	*8.53*
62	*19.03*	*21.04*	82	*6.77*	*7.98*
63	*18.32*	*21.24*	83	*6.31*	*7.44*
64	*17.63*	*20.45*	84	*5.88*	*6.93*
65	*16.94*	*19.66*	85	*5.47*	*6.44*
66	*16.26*	*18.88*	86	*5.07*	*5.99*
67	*15.58*	*18.10*	87	*4.70*	*5.55*
68	*14.91*	*17.34*	88	*4.35*	*5.15*
69	*14.24*	*16.58*	89	*4.02*	*4.76*
70	*13.59*	*15.82*	90	*3.72*	*4.41*
71	*12.94*	*15.08*	95	*2.57*	*3.05*
72	*12.30*	*14.36*	100	*1.93*	*2.23*
73	*11.67*	*13.64*	110	*1.05*	*1.12*

**Data from www.ssa.gov Actuarial Life Table, 2020, as used in the 2023 Trustees Report*

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Settlement Statement-

Form HUD-1 follows on pages 2 and 3 of this appendix. This form is frequently used as the settlement statement when closing a real estate transaction or transfer. Note that there is a specific section for the borrower and the seller. The Borrower is the individual(s) who is purchasing the property. The Seller is the owner of the property.

The Gross Amount Due to Seller for the property noted on line 420 of the first page of the statement represents the amount of funds being paid for purchase the property. This amount includes the funds which satisfy any outstanding liens against the property at the time of transfer, which are noted on lines 504 and 505 of the first page.

Usual and customary fees associated with real estate transactions are already indicated on the form, such as the lien amounts, any additional deductions must be added to the form. These types of deductions should be carefully examined by the eligibility worker, as they may represent a separate uncompensated transfer from the seller's portion of the proceeds from the sale of the property.

Any questions regarding this form and any deductions listed should be referred to the appropriate Medical Assistance Program Consultant.

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A. Settlement Statement — U.S. Department of Housing and Urban Development — OMB Approval No. 2502-02 (expires 11/30/200

B. Type of Loan

1. ☐ FHA 2. ☐ FmHA 3. ☐ Conv. Unins. 4. ☐ VA 5. ☐ Conv. Ins.

6. File Number:	7. Loan Number:	8. Mortgage Insurance Case Number:

C. Note: This form is furnished to give you a statement of actual settlement costs. Amounts paid to and by the settlement agent are shown. Items marke "(p.o.c.)" were paid outside the closing; they are shown here for informational purposes and are not included in the totals.

D. Name & Address of Borrower:	E. Name & Address of Seller:	F. Name & Address of Lender:

Buyer

G. Property Location:	H. Settlement Agent:	
	Place of Settlement:	I. Settlement Date:

J. Summary of Borrower's Transaction		K. Summary of Seller's Transaction	
100. Gross Amount Due From Borrower		**400. Gross Amount Due To Seller**	
101. Contract sales price		401. Contract sales price	
102. Personal property		402. Personal property	
103. Settlement charges to borrower (line 1400)		403.	
104.		404.	
105.		405.	
Adjustments for items paid by seller in advance		**Adjustments for items paid by seller in advance**	
106. City/town taxes to		406. City/town taxes to	
107. County taxes to		407. County taxes to	
108. Assessments to		408. Assessments to	
109.		409.	
110.		410.	
111.		411.	
112.		412.	
120. Gross Amount Due From Borrower		**420. Gross Amount Due To Seller**	
200. Amounts Paid By Or In Behalf Of Borrower		**500. Reductions In Amount Due To Seller**	
201. Deposit or earnest money		501. Excess deposit (see instructions)	
202. Principal amount of new loan(s)		502. Settlement charges to seller (line 1400)	
203. Existing loan(s) taken subject to		503. Existing loan(s) taken subject to	
204.		504. Payoff of first mortgage loan	
205.		505. Payoff of second mortgage loan	
206.		506.	
207.		507.	
208.		508.	
209.		509.	
Adjustments for items unpaid by seller		**Adjustments for items unpaid by seller**	
210. City/town taxes to		510. City/town taxes to	
211. County taxes to		511. County taxes to	
212. Assessments to		512. Assessments to	
213.		513.	
214.		514.	
215.		515.	
216.		516.	
217.		517.	
218.		518.	
219.		519.	
220. Total Paid For Borrower		**520. Total Reduction Amount Due Seller**	
300. Cash At Settlement From/To Borrower		**600. Cash At Settlement To/From Seller**	
301. Gross Amount due from borrower (line 120)		601. Gross amount due to seller (line 420)	
302. Less amounts paid by/for borrower (line 220)	( )	602. Less reductions in amt. due seller (line 520)	( )
303. Cash ☐ From ☐ To Borrower		**603. Cash** ☐ To ☐ From Seller	

Gross Amount Due to Seller

Liens paid for by the seller.

Areas not pre-filled are where other transactions are listed.

Section 5 of the Real Estate Settlement Procedures Act (RESPA) requires the following: • HUD must develop a Special Information Booklet to help persons borrowing money to finance the purchase of residential real estate to better understand the nature and costs of real estate settlement services; • Each lender must provide the booklet to all applicants from whom it receives or for whom it prepares a written application to borrow money to finance the purchase of residential real estate; • Lenders must prepare and distribute with the Booklet a Good Faith Estimate of the settlement costs that the borrower is likely to incur in connection with the settlement. These disclosures are mandatory.

Section 4(a) of RESPA mandates that HUD develop and prescribe this standard form to be used at the time of loan settlement to provide full disclosure of all charges imposed upon the borrower and seller. These are third party disclosures that are designed to provide the borrower with pertinent information during the settlement process in order to be a better shopper.

The Public Reporting Burden for this collection of information is estimated to average one hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

This agency may not collect this information, and you are not required to complete this form, unless it displays a currently valid OMB control number.

The information requested does not lend itself to confidentiality.

Previous editions are obsolete — Page 1 of 2 — form **HUD-1** (3/86) ref Handbook 4305.2

A. Settlement Statement

U.S. Department of Housing and Urban Development

OMB Approval No. 2502-02
(expires 11/30/200

B. Type of Loan

1. ☐ FHA 2. ☐ FmHA 3. ☐ Conv. Unins.
4. ☐ VA 5. ☐ Conv. Ins.

6. File Number:	7. Loan Number:	8. Mortgage Insurance Case Number:

C. Note: This form is furnished to give you a statement of actual settlement costs. Amounts paid to and by the settlement agent are shown. Items marke "(p.o.c.)" were paid outside the closing; they are shown here for informational purposes and are not included in the totals.

D. Name & Address of Borrower:	E. Name & Address of Seller:	F. Name & Address of Lender:

G. Property Location:	H. Settlement Agent:	
	Place of Settlement:	I. Settlement Date:

J. Summary of Borrower's Transaction		K. Summary of Seller's Transaction	
100. Gross Amount Due From Borrower		**400. Gross Amount Due To Seller**	
101. Contract sales price		401. Contract sales price	
102. Personal property		402. Personal property	
103. Settlement charges to borrower (line 1400)		403.	
104.		404.	
105.		405.	
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107. County taxes to		407. County taxes to	
108. Assessments to		408. Assessments to	
109.		409.	
110.		410.	
111.		411.	
112.		412.	
120. Gross Amount Due From Borrower		**420. Gross Amount Due To Seller**	
200. Amounts Paid By Or In Behalf Of Borrower		**500. Reductions In Amount Due To Seller**	
201. Deposit or earnest money		501. Excess deposit (see instructions)	
202. Principal amount of new loan(s)		502. Settlement charges to seller (line 1400)	
203. Existing loan(s) taken subject to		503. Existing loan(s) taken subject to	
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205.		505. Payoff of second mortgage loan	
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207.		507.	
208.		508.	
209.		509.	
Adjustments for items unpaid by seller		**Adjustments for items unpaid by seller**	
210. City/town taxes to		510. City/town taxes to	
211. County taxes to		511. County taxes to	
212. Assessments to		512. Assessments to	
213.		513.	
214.		514.	
215.		515.	
216.		516.	
217.		517.	
218.		518.	
219.		519.	
220. Total Paid By/For Borrower		**520. Total Reduction Amount Due Seller**	
300. Cash At Settlement From/To Borrower		**600. Cash At Settlement To/From Seller**	
301. Gross Amount due from borrower (line 120)		601. Gross amount due to seller (line 420)	
302. Less amounts paid by/for borrower (line 220)	( )	602. Less reductions in amt. due seller (line 520)	( )
303. Cash ☐ From ☐ To Borrower		**603. Cash** ☐ To ☐ From Seller	

Section 5 of the Real Estate Settlement Procedures Act (RESPA) requires the following: • HUD must develop a Special Information Booklet to help persons borrowing money to finance the purchase of residential real estate to better understand the nature and costs of real estate settlement services; • Each lender must provide the booklet to all applicants from whom it receives or for whom it prepares a written application to borrow money to finance the purchase of residential real estate; • Lenders must prepare and distribute with the Booklet a Good Faith Estimate of the settlement costs that the borrower is likely to incur in connection with the settlement. These disclosures are mandatory.

Section 4(a) of RESPA mandates that HUD develop and prescribe this standard form to be used at the time of loan settlement to provide full disclosure of all charges imposed upon the borrower and seller. These are third party disclosures that are designed to provide the borrower with pertinent information during the settlement process in order to be a better shopper.

The Public Reporting Burden for this collection of information is estimated to average one hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

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form **HUD-1** (3/86)
ref Handbook 4305.2

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L. Settlement Charges				
700. Total Sales/Broker's Commission based on price $	@	% =	Paid From Borrowers Funds at Settlement	Paid From Seller's Funds at Settlement
Division of Commission (line 700) as follows:				
701. $	to			
702. $	to			
703. Commission paid at Settlement				
704.				
800. Items Payable In Connection With Loan				
801. Loan Origination Fee	%			
802. Loan Discount	%			
803. Appraisal Fee	to			
804. Credit Report	to			
805. Lender's Inspection Fee				
806. Mortgage Insurance Application Fee to				
807. Assumption Fee				
808.				
809.				
810.				
811.				
900. Items Required By Lender To Be Paid In Advance				
901. Interest from to	@$	/day		
902. Mortgage Insurance Premium for		months to		
903. Hazard Insurance Premium for		years to		
904.		years to		
905.				
1000. Reserves Deposited With Lender				
1001. Hazard insurance	months @$	per month		
1002. Mortgage insurance	months @$	per month		
1003. City property taxes	months @$	per month		
1004. County property taxes	months @$	per month		
1005. Annual assessments	months @$	per month		
1006.	months @$	per month		
1007.	months @$	per month		
1008.	months @$	per month		
1100. Title Charges				
1101. Settlement or closing fee	to			
1102. Abstract or title search	to			
1103. Title examination	to			
1104. Title insurance binder	to			
1105. Document preparation	to			
1106. Notary fees	to			
1107. Attorney's fees	to			
(includes above items numbers:		)		
1108. Title insurance	to			
(includes above items numbers:		)		
1109. Lender's coverage	$			
1110. Owner's coverage	$			
1111.				
1112.				
1113.				
1200. Government Recording and Transfer Charges				
1201. Recording fees: Deed $	; Mortgage $	; Releases $		
1202. City/county tax/stamps: Deed $	; Mortgage $			
1203. State tax/stamps: Deed $	; Mortgage $			
1204.				
1205.				
1300. Additional Settlement Charges				
1301. Survey to				
1302. Pest inspection to				
1303.				
1304.				
1305.				
1400. Total Settlement Charges (enter on lines 103, Section J and 502, Section K)				

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ref Handbook 4305.2

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CHAPTER M14
LONG-TERM CARE
SUBCHAPTER 60

LTC FINANCIAL ELIGIBILITY

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M1460 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Pages 3, 35
TN #DMAS-36	10/1/25	Pages 2, 17, 41, 42, 44, 46
TN #DMAS-34	1/1/25	Pages 3, 29, 35 Page 26a is added
TN #DMAS-33	10/1/24	Pages 4, 23, 24
TN #DMAS-32	7/1/24	Page 4a
TN #DMAS-31	4/1/24	Page 3, 35
TN #DMAS-30	1/1/24	Pages 11 and 19
TN #DMAS-26	1/1/23	Pages 3, 35
TN #DMAS-24	7/1/22	Pages 11, 47, 48
TN #DMAS-23	4/1/22	Pages 12, 23
TN #DMAS-22	1/1/22	Pages 3, 35
TN #DMAS-18	1/1/21	Pages 3, 35
TN #DMAS-15	1/1/20	Pages 3, 35
TN #DMAS-14	10/1/19	Pages 4, 29
TN #DMAS-13	7/1/19	Page 42
TN #DMAS-11	1/1/19	Pages 3-5, 10, 26, 31
TN #DMAS-10	10/1/18	Table of Contents, page i Pages 1-3, 4b, 5, 6, 9, 10, 13, 15, 17a, 18, 18a, 26, 27, 30a, 37, 38 Pages 8a, 11, 19, 30, 39 and 40 are runover pages.
TN #DMAS-8	4/1/18	Pages 18a, 32, 35
TN #DMAS-7	1/1/18	Pages 3, 7
TN #DMAS-3	1/1/17	Pages 3, 4, 4b, 24, 25, 29
TN #DMAS-2	10/1/16	Page 35
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 3, 8a, 17, 32
TN #100	5/1/15	Table of Contents, page i Pages 1, 2, 5, 6, 10, 15, 16-17a, 25,41-51
TN #99	1/1/14	Pages 3, 35
UP #9	4/1/13	Table of Contents Pages 3, 35, 38, 41, 42, 50, 51
TN #97	9/1/12	Table of Contents Pages 1, 4-7, 9-17 Page 8a was deleted. Pages 18a-20, 23-27, 29-31 Pages 37-40, 43-51 Pages 52 and 53 were deleted
UP #6	4/1/12	Pages 3, 35
TN #96	10/1/11	Pages 3, 20, 21
TN #95	3/1/11	Pages 3, 4, 35
TN #94	9/1/10	Page 4a
TN #93	1/1/10	Pages 28, 35
TN #91	5/15/09	Pages 23, 24

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M1460.000 LTC FINANCIAL ELIGIBILITY

M1460.001 OVERVIEW

A. Introduction

This subchapter contains the Medicaid financial eligibility requirements for individuals receiving facility or Medicaid waiver long-term care (LTC) services, *also referred to as Long-term Supportive Services (LTSS),* who are not married or who are married but do not have community spouses. **For married individuals *other than Modified Adjusted Gross Income (MAGI) Adults* with community spouses (when both are not in a medical facility), go to subchapter M1480 to determine financial eligibility and patient pay.**

All individuals whose Medicaid eligibility has been determined PRIOR to entering LTC must have their financial eligibility redetermined, including asset transfer evaluation, home ownership and other resource evaluation. First, determine if the individual meets the Medicaid non-financial requirements including covered group in M1410.020. Then determine financial eligibility. Financial eligibility requirements for an individual differ depending on the individual's covered group, marital status and type of long-term care.

This subchapter contains policy and procedures for resources and income eligibility determination for institutionalized individuals. Patient pay (post-eligibility treatment of income) policy and procedures for unmarried individuals or married individuals without community spouses are in subchapter M1470.

B. Related Policies

- *MAGI (MAGI) Adults income rules in Chapter M04*
- ABD resource rules in Chapter S11.
- ABD income rules in Chapter S08.
- Family and Children resource rules in Chapter M06.
- Family and Children Medically Needy (MN) income rules in Chapter M07.
- Married Institutionalized Individuals' Eligibility & Patient Pay rules in subchapter M1480.

M1460.100 DEFINITIONS

A. Purpose

This section provides definitions for terms used in this subchapter.

B. Definitions

1. 300% SSI Group

The 300% SSI group is the short name for the categorically needy (CN) covered groups of Aged, Blind & Disabled (ABD) and Families & Children (F&C) individuals who are institutionalized in medical facilities or Medicaid-covered waiver services, who have resources within the Medicaid resource limits and whose gross income is less than or equal to 300% of the Supplemental Security Income (SSI) income limit for one person.

2. Budget Period

The budget period is the period of time during which an individual's income is calculated to determine eligibility.

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3. Carry-over Expenses Carry-over expenses are the balance due on medical, dental, and remedial care expenses incurred in the retroactive or prospective budget period prior to the current budget period which were not used in establishing eligibility and which may be deducted in a consecutive budget period(s) when there has been no break in spenddown eligibility.

4. Certification Period The certification period is the period of time over which an application or redetermination is valid.

5. Current Payments Current payments are payments made in the current spenddown budget period on expenses incurred before the current spenddown budget period which were not used in establishing eligibility in a previous spenddown budget period and when there has been a break in spenddown eligibility. The payment amount allowed is the actual payment amount paid to the provider and is deducted from the spenddown liability on the date the payment is actually made.

6. Income Determination Period The income determination period is the budget period; for all LTC cases, the budget period is one month.

7. LTC Case A case in which the Medicaid applicant or recipient is an institutionalized individual receiving long-term care services is an LTC case.

8. Lump Sum Payment Income received on a "non-recurring basis" and/or income that is received once a year is a lump sum payment. All lump sum payments are income in the month of receipt and a resource in the following month(s), if retained.

Different types of lump sum payments must be treated differently. Refer to the ABD Income chapter S08 (for both ABD and F&C individuals) for policy specific to the type of lump sum payment that is being evaluated.

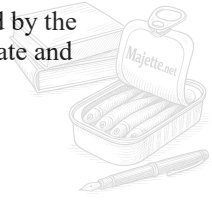
9. MAGI Adults Effective January 1, 2019, MAGI Adults is the CN covered group of individuals between the ages of 19 and 64 with household income at or below 138% of the Federal Poverty Level (FPL) and who are not entitled to or receiving Medicare.

10. Medicaid Rate The Medicaid rate is a monthly rate which is calculated:

- for a facility, by multiplying the individual's daily *Patient-Driven Payment Model (PDPM)* code amount by the number of days in the month. A patient's *PDPM* code amount is based on his room and board and ancillary services. The *PDPM* code amount may differ from facility to facility and from patient to patient within the same facility. Confirmation of the individual's *PDPM* code amount must be obtained by contacting the facility;

  NOTE: When projecting the facility's monthly Medicaid rate, the daily *PDPM* code amount is multiplied by 31 days. *Use of the PDPM is effective as of 10/1/2025.*

- for Medicaid CBC waiver services, by multiplying the provider's Medicaid hourly rate by the number of hours of service received by the patient in the month. Confirm the provider's hourly Medicaid rate and number of service hours by contacting the provider.



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11. Old Bills

Old bills are unpaid medical, dental, or remedial care expenses which:

- were incurred prior to the Medicaid application month and the application's retroactive period,
- were not fully deducted from (counted in) any previous sp3enddown budget period where the spenddown was met, and
- remain a liability to the individual.

EXCEPTION: Bills paid by a state or local program and which meet the definition of "old bills" are treated as old bills even though they are not the individual's liability.

12. Projected Expenses

Expenses for services that have not yet been incurred but are reasonably expected to be incurred are projected expenses.

13. Spenddown Liability

The spenddown liability is the amount by which the individual's countable income exceeds the MNIL for the budget period.

M1460.150 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LTSS

A. Applicability

The policy in this section applies to nursing facility and CBC/PACE patients, including MAGI Adults effective January 1, 2019, who meet the requirements for LTC services, now called long term services and supports (LTSS), on or after January 1, 2006. This includes individuals who filed reapplications after a break in Medicaid eligibility. It does **not apply** to Medicaid recipients who were approved for LTSS prior to January 1, 2006, and who maintain continuous Medicaid eligibility.

For Medicaid applicants or enrollees approved for LTSS on or after July 1, 2006, the amount of equity in the home at the time of the initial LTSS determination and at each renewal must be evaluated.

B. Policy

Individuals with equity value (tax assessed value minus encumbrances) in home property that exceeds the limit are NOT eligible for Medicaid payment of LTSS unless the home is occupied by

- a spouse,
- a dependent child under age 21 years, or
- a blind or disabled child of any age.

If substantial home equity exists, the individual is not evaluated for or eligible for the Medicaid payment of LTSS. Do not evaluate asset transfers.

An individual with excess home equity is not eligible in the 300% of SSI covered group, but may be eligible for Medicaid payment of covered services other than LTSS if he is eligible in another covered group. Evaluate eligibility for an individual with substantial home equity in other covered groups.

***1.* Home Equity Limit**

The applicable home equity limit is based on the date of the application or request for LTC coverage. The home equity limit is:

- Effective January 1, 2024: $713,000
- Effective January 1, 2025: $730,000
- *Effective January 1, 2026: $752,000*

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1. Reverse Mortgages

Reverse mortgages **do not** reduce equity value until payments are being received from the reverse mortgage.

2. Home Equity Credit Lines

A home equity line of credit **does not** reduce the equity value until credit line has been used or payments from the credit line have been received.

C. Verification Required

Verification of the equity value of the home is required.

D. Notice Requirement

If an individual is ineligible for Medicaid payment of LTSS because of substantial home equity exceeding the limit, the Notice of Action must state why he is ineligible for Medicaid payment of LTSS. The notice must also indicate whether the applicant is eligible for other Medicaid covered services.

If the individual is in a nursing facility *or receiving LTSS services in the community*, send the *service provider and the Managed Care Organization (MCO)* a DMAS-225 indicating that the individual is not eligible for the Medicaid payment of LTSS.

E. References

See section M1120.225 for more information about reverse mortgages.

M1460.155 THIRD PARTY & LONG-TERM CARE INSURANCE PAYMENTS

A. Payments Made by Another Individual

Payment of an individual's bills (including Medicare supplementary medical insurance or other medical insurance premiums) by a third party directly to the supplier is not income.

Payments made directly to the service provider by another person for the individual's private room or "sitter" in a medical facility are NOT income to the individual. Refer all cases of Medicaid eligible enrollees in nursing facilities who have a "sitter" to DMAS, Division of *High Needs Supports*, for DMAS review to assure that DMAS is not paying the facility for services provided by the sitter.

B. LTC Insurance Policy Payments

The LTC insurance policy must be entered into the recipient's TPL file. The insurance policy type is "H" and the coverage type is "N." When entered in the Virginia Case Management System (VaCMS) on the TPL screen, Medicaid will not pay the nursing facility's claim unless the claim shows how much the policy paid.

If the patient receives the payment from the insurance company, it is **not** counted as income. The patient should assign it to the provider. If the patient cannot do this, or the policy prohibits assignment, the payment should be given directly to the provider. The provider should report the payment as a third party payment on its claim form.

If the patient received the payment and cannot give it to the provider for some reason, then the patient should send the insurance payment to:

DMAS Fiscal Division, Cashiering Unit
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

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M1460.160 LONG-TERM CARE PARTNERSHIP POLICIES

A. Introduction

A Long-term Care Partnership Policy (Partnership Policy) is a type of LTC insurance. Under section 6021(a)(1)(A) of the Deficit Reduction Act (DRA) of 2005 states were permitted to develop LTC partnerships. In addition to paying for assisted living or long-term care services, a Partnership Policy allows for additional assets to be disregarded in the Medicaid eligibility determination.

The value of assets disregarded in the Medicaid eligibility determination is equal to the dollar amount of benefits paid to or on behalf of the individual as of the month of application, even if additional benefits remain available under the terms of the policy.

The Partnership Policy disregard is not applicable to the resource assessment for married individuals with a community spouse. See M1480 for more information regarding resource assessments and Partnership Policies.

B. LTC Insurance Policy Issued Prior to 9/01/2007

LTC policies issued prior to 9/01/2007 are **not** Partnership Policies. See M1470.230 B.7, *and* M1470.430 B.5 for more information regarding these types of insurance policies.

C. LTC Insurance Policy Issued on or After 9/01/2007

LTC policies issued on or after 9/01/2007 may or may not be Partnership Policies. For a policy to be considered a Partnership Policy, it must meet the following conditions:

- issued on or after 09/01/2007,
- contain a disclosure statement indicating that it meets the requirements under § 7702B(b) of the Internal Revenue Service Code of 1986, and
- provide inflation protection:
  - under 61 years of age, compound annual inflation protection,
  - 61 to 76 years of age, some level of inflation protection, or
  - 76 years or older, inflation protection may be offered, but is not required.

Obtain a copy of the Partnership Disclosure Notice and the LTC Partnership Certification Form (See M1460, Appendices 1 and 2) for verification of the requirements noted above. Also, verification of the amount of benefit paid to or on behalf of an individual as of the month of application must be obtained. This can be found on the Explanation of Benefits statement or by calling the insurance carrier.

Partnership Policies that are issued in other states may or may not meet Virginia's requirements. Please contact your Medicaid Consultant to verify reciprocity with Virginia.

Verifications and documentation regarding a Partnership Policy must be kept with other permanent verifications in the case record.



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M1460.200 DETERMINATION OF COVERED GROUP

A. Overview

An individual in LTC who meets the Medicaid non-financial eligibility requirements in M1410.010 must also meet the requirements of at least one covered group in order to be eligible for Medicaid and Medicaid payment of LTC services.

1. Covered Groups Eligible for LTC Services

The covered groups whose benefit packages include long-term care services are the following groups:

All categorically needy (CN) full benefit covered groups for ABD and F&C:

- SSI Recipients; see M0320.101 and M1460.201
- "Protected" covered Groups; see M0320.200
- *MAGI Adults; see M04*
- ABD 80% FPL; see M0320 and M1460.210
- MEDICAID WORKS; see M0320.400
- 300% SSI; see M0320.500 , M0330.500, and M1460.220
- IV-E Foster Care and Adoption Assistance; see M0330.105
- Individuals Under Age 21; see M0330.107
- Special Medical Needs Adoption Assistance; see M0330.108
- *Former Foster Care Children Under Age 26 Years; see M0330.109*
- Low Income Families With Children (LIFC); see M0330.200
- Child Under Age 19 (FAMIS Plus); see M0330.300
- Pregnant Women and Newborn Children; see M0330.400
- Breast and Cervical Cancer Prevention Treatment Act (BCCPTA); see M0330.700

All medically needy (MN) covered groups

- ABD Individuals; see M0320.701
- December 1973 Eligibles; see M0320.702
- Pregnant Women; see M0330.801
- Newborn Children Under Age 1; see M0330.802
- Children Under Age 18; see M0330.803
- Individuals Under Age 21; see M0330.804
- Special Medical Needs Adoption Assistance; see M0330.805

Medicaid will not pay for the following for MN individuals:

- services in an intermediate care facility for the intellectually disabled (ICF-ID)
- services in an institution for the treatment of mental disease (IMD)
- Community Living Waiver (formerly Intellectual Disabilities Waiver) services, and
- Family and Individual Supports Waiver (formerly Individual and Family Development Disability Support (DD) Waiver) services.

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2. Applicants Who Do Not Receive Cash Assistance

a. Child Under Age 18

MAGI methodology is not applicable to F&C children needing LTC services. If the applicant is a child under age 18, determine the child's eligibility in the F&C 300% SSI group, using the covered group policy in subchapter M0330 and the financial eligibility policy and procedures in this subchapter. The resource requirement for the F&C 300% SSI covered group does **NOT** apply to children under age **18.**

If the child's income exceeds the limit for the F&C 300% SSI group, determine the child's eligibility in an MN covered group.

NOTE: A child who is age 18, 19 or 20 meets an MN covered group if he is blind, disabled, pregnant, in foster care, adoption assistance, or institutionalized in a nursing facility. An individual age 21 or older, must meet the pregnant, aged, blind or disabled definition in order to meet an MN covered group.

b. Individual Age 18 -19

If the individual is age 18 but under age 19, first determine the individual's eligibility in the F&C Child Under 19 or Pregnant Woman covered groups using MAGI income methodology in Chapter M04. If the individual's income exceeds the limits for F&C coverage, he must be determined disabled to meet the ABD 300% SSI covered group. Follow the procedures in M0310.112 for making a disability referral.

c. Individual Age 19 or Older

If the individual is age 19 or older, determine the individual's eligibility in an ABD or F&C covered group, depending on which definition the individual meets, using the financial eligibility policy and procedures in this subchapter.

For ABD individuals, determine the individual's eligibility in the ABD 80% FPL covered group. If not eligible in the ABD 80% FPL covered group, determine the individual's eligibility in the ABD 300% SSI covered group. If not eligible in the either of these covered groups, determine the individual's eligibility in all other groups for which he meets a definition.

For F&C individuals, first determine the individual's eligibility in the LIFC, Pregnant Woman, or MAGI Adult groups. If the individual's income exceeds the limits for the LIFC, Pregnant Woman, or MAGI Adult covered groups, determine the individual's eligibility in the F&C 300% SSI covered group.

To be eligible in the F&C 300% SSI covered group, the individual must be a child under age 18; under age 21 who meets the adoption assistance or foster care definition; under age 21 in an ICF or ICF- ID; a parent or caretaker-relative of a dependent child; or a pregnant woman as defined in M0310.

If the income exceeds the 300% SSI group limit and the individual meets a MN covered group, determine the individual's eligibility in an MN covered group (see M0330). There is no MN covered group for LIFC parents or MAGI Adults.

B. Relation to Income Limits

Determination of the appropriate covered group must be made prior to determination of income because the income limits are determined by the covered group:

1. ABD 80% FPL

The ABD income policy in Chapter S08 is used to determine countable income for the ABD 80% FPL covered group. *However, the income items listed in Sections M1460.610 and M1460.611 are NOT counted as income in determining income eligibility for the ABD 80% FPL covered group.*



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1. MAGI Adults *The MAGI income policy in Chapter M04 is used to determine countable income for MAGI Adults. The income limit is 138% FPL (133% FPL plus a 5% FPL income disregard if needed).*

***3.* 300% SSI** The ABD income policy in Chapter S08 is used to determine income for all individuals (ABD and F&C) in the 300% SSI group. The items found in section M1460.611 ARE counted in determining income eligibility for long-term care. The income items listed in M1460.610 are not counted for the 300% SSI groups (ABD and F&C).

***4.* ABD MN Groups** The ABD income policy in Chapter S08 is used to determine countable income for the ABD MN covered groups. However, the income items listed in "What Is Not Income", Section M1460.610 and in "Countable Income for the 300% SSI Group", Section M1460.611 are NOT counted as income in determining income eligibility for ABD MN groups.

***5.* F&C MN Groups** The F&C income policy in Chapter M07 is used to determine countable income for individuals in F&C MN covered groups. However, the income items listed in "What Is Not Income", section M1460.610 and "Countable Income for the 300% SSI Group", Section M1460.611 are NOT counted when determining income eligibility for F&C MN groups.

C. Ongoing Recipient Enters LTC

1. SSI Recipients SSI recipients who are already enrolled in Medicaid when they enter Medicaid long-term care must have their eligibility reviewed. They already meet a covered group but they must also meet the asset transfer, resource and financial eligibility requirements in order for Medicaid to cover the cost of long-term care services.

2. Other Recipients Recipients who do not receive cash assistance but who are already enrolled in Medicaid when they enter long-term care in a medical facility **must have their eligibility redetermined**. They must meet a covered group and they must meet the asset transfer, resource, and financial eligibility requirements in order for Medicaid to cover the LTC services cost.

For a MAGI Adult, complete a review to evaluate substantial home equity and asset transfers, including transfers of assets into trusts or to purchase annuities.

Review the asset transfer policy in subchapter M1450 with the recipient if he has transferred assets. If the recipient is admitted to a nursing facility, or moves from his home to receive Medicaid CBC in another person's home, review asset transfer, home property and other resource requirements to determine if the individual remains eligible for Medicaid

A married recipient, *other than a MAGI Adult*, who enters LTC must have resource and income eligibility redetermined using the rules in subchapter M1480, if his spouse is a community spouse.



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M1460.201 SSI RECIPIENTS

A. Introduction

An SSI recipient in a nursing facility, or who receives Medicaid CBC waiver services, must meet the Medicaid nonfinancial, asset transfer and resource eligibility requirements to be eligible for Medicaid payment of LTC services. The SSI recipient's resource eligibility must be determined if he owns a real property resource; the receipt of SSI meets the Medicaid income eligibility requirements. An SSI recipient is income-eligible for LTC as long as he is entitled to an SSI payment. *When the SSA record indicates a payment code of "C01" and no payment amount is shown, the individual is considered to be an SSI recipient for Medicaid purposes. If the SSA record indicates a code of "EO1" or "E02" and no SSI payment has been received in more than twelve months, the individual's SSI status must be confirmed.* The covered group eligibility requirements for SSI recipients are in section M0320.101.

1. Medicaid CBC

An SSI recipient who receives Medicaid CBC waiver services in his community residence usually continues to receive SSI with no change. If a recipient moves to another person's home to receive Medicaid CBC, his SSI payment may be affected. When a Medicaid SSI recipient begins receiving Medicaid CBC waiver services, asset transfer and resource eligibility must be evaluated. As long as the individual receives SSI, he is categorically needy if he meets the Medicaid nonfinancial and resource eligibility rules.

2. Facility

SSI recipients in nursing facilities are subject to the reduced SSI benefit rate of $30 for their personal needs. If they have other countable income that exceeds $30, their SSI will be canceled. SSI recipients may continue to receive their regular monthly SSI benefit for 3 months if they are considered temporarily institutionalized. Individuals who receive SSI after admission to a facility are categorically needy if they meet the Medicaid nonfinancial and resource eligibility rules.

B. Policy

1. Nonfinancial

Evaluate the non-financial Medicaid eligibility rules in section M1410.020. An SSI recipient meets an ABD covered group.

2. Asset Transfer

Determine if the recipient meets the asset transfer policy in subchapter M1450.

3. Resources

a. Determine Countable Resources

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

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

2) interest in undivided heir property and the equity value of the individual's share that, when added to all other countable resources, exceeds the appropriate Medicaid resource limit. (The interest in the



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estate must be legally available. If a partition suit is necessary to sell the interest, costs of partition and attorneys' fees may be deducted as described in section M1120.215);

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

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

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

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

When an SSI recipient has no real property resource listed in 1) through 5) previously, do NOT evaluate the SSI recipient's resources. The SSI recipient meets the Medicaid resource requirements because he receives SSI and does not have a countable real property resource listed above.

b. Countable Resources Within Resource Limit

If countable resources are less than or equal to the $2,000 resource limit, go to item 4 below for income eligibility.

c. Countable Resources Exceed the Resource Limit

If current resources exceed the $2,000 resource limit, the individual is NOT eligible in the SSI recipient covered group, nor is he eligible in the 300% SSI group or the medically needy group. He may be eligible for limited Medicaid coverage as medically indigent (which has more liberal resource methods and standards), however, Medicaid will not pay for LTC services for an ABD medically indigent recipient.

4. Income

An SSI recipient in LTC is income-eligible for Medicaid as long as he receives an SSI payment. Verify receipt of the payment. If the SSI recipient meets the nonfinancial and resource eligibility rules for Medicaid, then he is eligible for Medicaid as categorically needy.

a. When an SSI recipient who has no other income enters a nursing facility, the SSI check is usually reduced to $30 for the month following the month of entry. The SSI payment is **NOT** counted as income when determining income eligibility or patient pay.



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b. If the recipient is temporarily in the nursing facility, the SSI check is not reduced or canceled. Temporary institutionalization for SSI purposes means 90 days or less. The SSI payment is **NOT** counted as income when determining eligibility or patient pay.

C. Development

A partial review of the SSI recipient's Medicaid eligibility is required when the recipient is admitted to facility care or Medicaid CBC waiver services. The EW must determine that asset transfer and resource requirements are met, and that the recipient's SSI continues.

If eligible, determine patient pay; see subchapter M1470. If the individual is eligible but is in an asset transfer penalty period, follow the notification instructions in M1450. If not eligible, follow the eligibility notice requirements in M1410.300.

M1460.205 OTHER CATEGORICALLY NEEDY (CN) COVERED GROUPS

A. Description

Categorically needy (CN) individuals receive or are deemed to be receiving public assistance cash benefits.

B. ABD Groups

1. QSII (1619(b))

Qualified Severely Impaired Individuals (QSII) are former SSI recipients who are working but are still disabled, and are eligible under 1619(b) of the Social Security Act. To be eligible for Medicaid, they must have met the more restrictive resource requirements for Medicaid in the month before the month they qualified under 1619(b). See section M0320.105 for details about this covered group.

2. AG Recipients

An Auxiliary Grants (AG) recipient is eligible for Medicaid if he meets the assignment of rights to medical support and third party payments requirements and the asset transfer policy. See section M0320.202 for details about this covered group.

C. F&C Groups

1. Individuals Under 21

a. IV- E Foster Care Recipients

Children who are eligible for foster care payments under Title IV-E of the Social Security Act are eligible for Medicaid. See section M0320.305 for details about this covered group.

b. IV-E Adoption Assistance Recipients

Children who are eligible for adoption assistance under Title IV-E of the Social Security Act are eligible for Medicaid. See section M0320.305 for details about this covered group.

b. If the recipient is temporarily in the nursing facility, the SSI check is not reduced or canceled. Temporary institutionalization for SSI purposes means 90 days or less. The SSI payment is **NOT** counted as income when determining eligibility or patient pay.

C. Development

A partial review of the SSI recipient's Medicaid eligibility is required when the recipient is admitted to facility care or Medicaid CBC waiver services. The EW must determine that asset transfer and resource requirements are met, and that the recipient's SSI continues.

If eligible, determine patient pay; see subchapter M1470. If the individual is eligible but is in an asset transfer penalty period, follow the notification instructions in M1450. If not eligible, follow the eligibility notice requirements in M1410.300.

M1460.207 MAGI ADULTS COVERED GROUP (EFFECTIVE JANUARY 1, 2019)

A. Description

The MAGI Adults covered group includes individuals between 19 and 64 years old who are not eligible for or receiving Medicare.

B. Policy

1. Nonfinancial

Evaluate the non-financial Medicaid eligibility rules in Chapter M02.

2. Asset Transfer

Determine if the recipient meets the asset transfer policy in subchapter M1450.

3. Resources

Although no resource test is applicable for MAGI Adults coverage, the worker must evaluate certain resources for any individuals seeking Medicaid payment for LTSS. These include asset transfers, trusts, annuities, and the home equity limit.

4. Income

Income is determined using the policy in Chapter M04, and countable income must not exceed 138% FPL. Spenddown does not apply to this covered group.

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M1460.210 ABD 80% FPL COVERED GROUP

A. Description The ABD 80% FPL covered group includes aged, blind and disabled individuals who have income less than or equal to 80% FPL and countable resources that do not exceed the SSI resource limits. See M0320.300 for details about this covered group.

B. Policy

1. Nonfinancial Evaluate the non-financial Medicaid eligibility rules in Chapter M02.

2. Asset Transfer Determine if the recipient meets the asset transfer policy in subchapter M1450.

3. Resources Determine countable resources using the policy in chapter S11 and Appendix 2 to chapter S11. The resource limit is $2,000.

The home property resource exclusion for individuals in the ABD 80% FPL covered group includes the home and ALL contiguous property as long as the individual lives in the home or, if absent, intends to return to the home (see Appendix 2 to chapter S11). When the ABD 80% FPL individual leaves his home property, obtain a signed statement from the individual as to:

- when and why he left the home;
- whether he intends to return; and
- if he does not intend to return, when that decision was made.

The limited 6-month home property resource exclusion for institutionalized individuals does NOT apply to this covered group.

4. Income *The ABD income policy in Chapter S08 is used to determine countable income for the ABD 80% FPL covered group. However, the income items listed in Sections M1460.610 and M1460.611 are NOT counted as income in determining income eligibility for the ABD 80% FPL covered group.*

Countable income must not exceed 80% FPL. Spenddown does not apply to this covered group.

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M1460.220 300% of SSI PAYMENT LIMIT GROUP

A. Description

These are ABD or F&C individuals in medical facilities or who receive Medicaid CBC waiver services, who meet the appropriate CN resource requirements and resource limit and whose income is less than or equal to 300% of the SSI payment limit for an individual.

Individuals who have been authorized for Medicaid LTC or Long-term Services and Supports (LTSS) may be evaluated in this covered group. If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has *180* days from the date on the Notice of Action to begin services.

B. ABD Groups

Aged, blind or disabled individuals institutionalized in medical facilities, or who require institutionalization and are approved to receive Medicaid CBC waiver services are those who:

- meet the Medicaid ABD resource requirements; and
- have gross income, determined according to the ABD income requirements, that does not exceed 300% of the SSI individual payment limit.

See sections M0320.501 and M0320.502 for details about these covered groups.

C. F&C Groups

Individuals who meet an F&C definition (foster care or adoption assistance children under age 21, parents or caretaker-relatives of dependent children, and pregnant women) in medical facilities, or who require institutionalization and who are approved to receive Medicaid home and community-based care (CBC) waiver services, are those who:

meet the F&C CN resource requirements if unmarried,
(married individuals over age 18 must meet the ABD resource requirement *unless eligible in a MAGI group*); and

- have gross income, determined according to the ABD income requirements, that does not exceed 300% of the SSI individual payment limit.

Children under age 18 in the 300% of SSI covered group have no resource requirement.

See sections M0330.501 and M0330.502 for details about these covered groups.

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M1460.300 ASSISTANCE UNIT

A. Policy

An institutionalized individual is an assistance unit of one person, considered living separately from his spouse and/or parent(s), beginning the month in which he meets the definition of *an institutionalized individual* in section M1410.010.

EXCEPTION: A pregnant woman's assistance unit includes the number of unborn children with which she is pregnant.

B. Financial Eligibility

The financial eligibility rules in this section apply to **both ABD and F&C individuals.**

1. Resources

The resources of an institutionalized child's parent(s**)** are **NOT** deemed available to the institutionalized child. The resources of an institutionalized individual's spouse are deemed available to the institutionalized individual in the initial eligibility determination (see subchapter M1480).

2. Income

The income of an institutionalized individual's spouse or parent(s) is **NOT** deemed available to the institutionalized individual.

For income eligibility, married institutionalized individuals are considered separated, not living together, and only that income which is voluntarily contributed to the institutionalized spouse by the separated spouse is considered available to the institutionalized spouse.

Institutionalized children are considered separated from, not living with, their parents and only that income which is voluntarily contributed to the child is considered available to the child.

M1460.400 STEPS FOR DETERMINING FINANCIAL ELIGIBILITY

A. Is person an SSI recipient?

Yes: Go to M1460.201 (determine ABD CN resources; if within limit, is eligible as SSI). If resources exceed the limit, does recipient also meet F&C *CN* covered group?

- **Yes:** eligible as F&C *CN*; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay. (Remember to review asset transfer to evaluate whether Medicaid payment may be made for LTC services).
- **No:** ineligible for Medicaid; STOP. Go to section M1460.660 for notice procedures.

No: Does person receive IV-E cash assistance?

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Yes: eligible as CN; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay. (Remember to review asset transfer to evaluate whether Medicaid payment may be made for LTC services).

No: Go to B below.

B. Covered Group

Is person already enrolled in Medicaid in a covered group eligible for LTC services?

Yes: Go to E "Resources" below, *unless the person is a MAGI Adult.*

No: Is person F&C *or an adult 19-64 years old and not receiving Medicare*?

Yes: Determine if he meets F&C *or MAGI Adult group* first (section M0330), go to D "Income" below.

No: Go to C below.

C. Is person ABD?

Yes: Go to D "Income" below.

No: Is person in Hospice?

Yes: Determine as Hospice; see section M0320.503.

No: ineligible for Medicaid, does not meet a covered group; STOP. Go to section M1460.660 for notice procedures.

D. Income (See M1460.600)

1. Person is F&C *or MAGI Adult*

Determine countable income using chapters *M04 and* M07.

Compare income to appropriate M04 income limit.

Is income within limit?

Yes: eligible as F&C*/MAGI Adult*, STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay *for F&C (MAGI Adults do not have a patent pay).*

No: not eligible as F&C, go to item 2 below.

2. Person Is Not F&C

a. Is person ABD and does he meet the definition of institutionalization in M1410.010?

Yes: Determine if gross income is less than or equal to the 80% FPL income limit using chapter S08 and section M1460.600 below to determine gross income.

Is gross income less than or equal to 80% FPL income limit?

Yes: Go to section E "Resources" below.

No: Go to item 3 "Determine 300% SSI income" below.



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No: Does person meet the F&C 300% SSI or Hospice covered group (*does person meet the definition of institutionalization in M1410.010)?*

Yes: Go to item 3 *"*Determine 300% SSI income" *below.*

No: Go to section M1460.410 "Steps for Determining MN Eligibility."

3. Determine if Gross Income is Less Than or Equal to 300% SSI

Determine if gross monthly income is less than or equal to the 300% SSI income limit using chapter S08 and section M1460.600 below for **ABD and F&C** individuals.

Is gross income less than or equal to 300% SSI income limit?

Yes: go to section E "Resources" below.

No: go to section M1460.410 "Steps for Determining MN Eligibility" below.

E. Resources (See M1460.500)

1. Determine CN Resources

a. ABD groups

1) Unmarried Individual or Married Individual with no Community Spouse

a) ABD 80% FPL group: Using chapter S08 and M1460.600, determine if countable income is within the ABD 80% FPL income limit contained in M0810.002.A.5. If countable income is less than or equal to 80% FPL, determine countable resources using chapter S11 and Appendix 2 to chapter S11. **NOTE:** the 6-month home exclusion does not apply to this covered group.

Compare to ABD CN resource limit = $2,000 for 1 person.

b) 300% SSI group: Determine ABD countable resources using chapter S11.

Compare to ABD CN resource limit = $2,000 for 1 person. If the individual is not eligible due to excess resources, evaluate eligibility in the ABD 80% FPL covered group. See item b) below.

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2) Married Individual with Community Spouse

Determine ABD countable resources using chapter S11 and subchapter M1480.

Compare to ABD CN resource limit = $2000 for 1 person

b. F&C groups

1) Unmarried Individual *age 18 or over* or Married Individual *age 18 or over* with no Community Spouse

- Determine F&C CN countable resources using chapter M06 for the unmarried institutionalized individual.
- Compare to F&C CN resource limit = $1,000.

2) Married Individual *age 18 or over* with Community Spouse

- Determine ABD countable resources, Chapter S11, M1480.
- Compare to ABD CN resource limit = $2000 for 1 person.

2. Are resources within CN limit?

Yes: eligible in the covered group whose income limit is met; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

No: go to item 3 below.

3. Does person meet an MN covered group?

Yes: go to section M1460.410 "Steps for Determining MN Eligibility," below.

No: person is not eligible for Medicaid because of excess resources; STOP. Go to section M1460.660 for notice procedures.

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M1460.410 STEPS FOR DETERMINING MN ELIGIBILITY

A. Does person meet an MN covered group?

Yes: go to B below "Determine MN Resources."

No: person is not eligible for Medicaid because his gross income exceeds 300% of SSI and he does not meet a medically needy covered group; STOP, unless he has Medicare Part A. If he has Medicare Part A, determine eligibility for ABD *MSP*. If he does not have Medicare Part A, go to section M1460.660 for notice procedures.

B. Determine MN Resources

1. ABD Groups

Determine ABD countable resources, Chapter S11.

Compare to ABD MN resource limit = $2,000 for 1 person.

2. F&C Groups

a. Unmarried Individual or Married Individual with No Community Spouse

Determine F&C MN countable resources, Chapter M06.

Compare to F&C MN resource limit = $2,000 for 1 person.

b. Married Individual over age 18 with Community Spouse

Determine ABD countable resources, Chapter S11, M1480.

Compare to ABD MN resource limit=$2000

3. Are resources within MN limit?

Yes: go to C "Determine MN Income" below.

No: person not eligible for Medicaid due to excess resources; STOP. Go to section M1460.660 for notice procedures.

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C. Determine MN Income

1. ABD groups

Determine ABD MN countable income, Chapter S08.

Compare to MN income limit for 1 person in individual's home locality - where the individual last resided in Virginia outside of an institution (use Group III MN limit if individual was admitted to Virginia facility from out-of-state).

2. F&C groups

Determine F&C MN income, Chapter M07.

Compare to MN income limit for 1 person in individual's home locality - where the individual last resided in Virginia outside of an institution (use Group III MN limit if individual was admitted to Virginia facility from out-of-state).

3. Is Income Less Than or Equal to MN Income Limit?

NOTE: A person who has gross income exceeding the 300% SSI limit will **always** have countable income that exceeds the MN limit.

Yes: eligible as MN; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

No: Spenddown; excess amount is "spenddown liability." Go to 4. below for facility patients, 5. below for CBC recipients.

4. Spenddown--Facility Patients

The *PDPM* code amount may differ from facility to facility and from patient to patient within the same facility. For MN patients, the nursing facility must be contacted to obtain the *PDPM* code amount.

a. Spenddown Liability Less Than or Equal to the Individual's Medicaid Rate

If the spenddown liability is less than or equal to the individual's Medicaid rate, determine spenddown eligibility by projecting the facility's costs at the individual's Medicaid rate for the month. Spenddown balance after deducting projected costs at the individual's Medicaid rate should be zero or less.

The patient is eligible as MN for the whole month. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

b. Spenddown Liability More Than the Individual's Medicaid Rate

When the spenddown liability is **more than** the individual's Medicaid rate, determine spenddown eligibility AFTER the month has passed, on a daily basis (do not project expenses) by chronologically deducting old bills and carry-over expenses, then deducting the facility daily cost at the **private** daily rate and other medical expenses as they were incurred.

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If the spenddown is met on any date within the month, the patient is eligible effective the first day of the month in which the spenddown was met. Eligibility ends the last day of the month.

Each month must be evaluated separately. These patients will always be enrolled after the month being evaluated has passed.

5. Spenddown--CBC Patients

Do not project CBC waiver services costs. Eligibility is evaluated on a monthly basis. Determine spenddown eligibility AFTER the month has passed, by deducting old bills and carry-over expenses first, then (on a daily basis) chronologically deducting the daily CBC cost at the **private** daily rate and other medical expenses **as they are incurred.** If the spenddown balance is met on a date within the month, the patient is eligible effective the first day of the month in which the spenddown was met. Eligibility ends the last day of the month.

Each month must be evaluated separately. These patients will always be enrolled after the month being evaluated has passed.

M1460.500 RESOURCE DETERMINATION

A. Introduction

The following sections describe the resource eligibility rules that are applicable to individuals in long-term care.

B. Resource Limits

1. ABD Groups

ALL aged, blind and disabled (ABD) covered groups = $2,000 per individual.

2. F&C Groups

F&C 300% SSI and Hospice groups = $1,000 for individuals age 18 and over, regardless of the number of individuals in the assistance unit. Children under age 18 do not have a resource requirement.

There are no resource *limits* for any other F&C covered group. *All LTSS evaluations require evaluation of substantial home equity and asset transfers, including annuities and trusts.*

1. **MN Groups**

MN groups = $2,000 for an individual and $3,000 for 2 persons (pregnant woman with 1 unborn child; add $100 for each additional unborn child).

C. Budget Period

The budget period for determining long-term care resource eligibility is always one month.

M1460.510 DETERMINING COUNTABLE RESOURCES

A. Married Individual

1. Married MAGI Adult

MAGI Adults do not have a resource assessment or resource limit. Evaluate substantial home equity and asset transfers, including annuities and trusts, made by the MAGI Adult and/or the spouse.

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2. With A Community Spouse

See **subchapter M1480** for the rules to determine the **institutionalized individual's resource eligibility** when he is married and his spouse is a community spouse (the spouse is not in a medical institution or nursing facility).

a. Community Spouse Not Receiving Medicaid CBC Waiver Services

When both husband and wife have applied for Medicaid and one is institutionalized, and the community spouse does NOT receive Medicaid CBC waiver services, the community spouse's eligibility is processed as a noninstitutionalized individual.

NOTE: Follow resource determination rules found in chapter S11 for ABD covered groups, and in chapter M06 for F&C covered groups. The community spouse's resource eligibility is determined as a couple in the month the other spouse becomes institutionalized, and as an unmarried individual for the following months.

b. Community Spouse Receives Medicaid CBC Waiver Services

When both husband and wife have applied for Medicaid and one is institutionalized in a medical facility, and the community spouse receives Medicaid CBC waiver services, the community spouse's eligibility is processed as a married institutionalized Medicaid CBC recipient in the initial month of Medicaid CBC and afterwards, using the policy and procedures in subchapter M1480.

2. Both Spouses In A Medical Facility (No Community Spouse)

When the institutionalized individual's spouse is NOT a community spouse (the spouse is in a medical institution or nursing facility), the policy and procedures in subchapter M1460 that apply to an **unmarried individual** apply to the institutionalized individual effective the month of institutionalization and apply to the individual's spouse if the spouse also applies for Medicaid. Do not use subchapter M1480 because the individual is not an "institutionalized spouse" as defined in M1480.

When both husband and wife are institutionalized in a facility, the policy and procedures in subchapter M1460 that apply to **unmarried** individuals apply to each spouse in the initial month of institutionalization and afterwards.

3. Both Spouses Receive Medicaid CBC

When both spouses have applied for Medicaid and both receive Medicaid CBC waiver services, each spouse must be evaluated using policy and procedures in subchapter M1480**.**

B. Unmarried Individual

1. MAGI Adult Group

MAGI Adults do not have a resource assessment or resource limit. Evaluate substantial home equity and asset transfers, including annuities and trusts.

***2.* ABD Covered Groups**

An institutionalized individual is an assistance unit of 1 person, considered living separately from his family. No resources are deemed available from the individual's spouse. To determine the ABD resource eligibility of an unmarried individual, or married individual with no community spouse, use the ABD Resource policy and procedures found in chapter S11 and in section M1460.500.

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For the ABD 80% FPL covered group, use the ABD resource policy and procedures in chapter S11 and Appendix 2 to chapter S11.

The maximum allowable resource limit for an ABD individual is $2,000.

NOTE: If the individual's resources exceed the resource limit, and the individual has Medicare Part A, evaluate for eligibility as QMB, SLMB, or QI (limited coverage) which have a higher resource limit.

3. **F&C Covered Groups**

An institutionalized individual is an assistance unit of 1 person, considered living separately from his family. No resources are deemed available from a child's parent(s).

NOTE: A pregnant woman's assistance unit includes the number of unborn children with which she is pregnant.

Use the resource policy and procedures in chapter M06 for the resource determination.

M1460.520 RETROACTIVE RESOURCE DETERMINATION

A. Policy

When an applicant reports that he received a medical service within the retroactive period, evaluate Medicaid eligibility for that period.

Evaluate resource eligibility for each month using resources available during that month.

B. Reduction of Resources

An individual cannot retroactively reduce resources. If countable resources exceeded the resource limit **throughout** a retroactive month, the individual is **not** eligible for that month. However, if an applicant reduces excess resources **within** a retroactive month, he may be eligible in the month in which the value of his resources is reduced to or below the Medicaid resource limit.

In order to reduce resources, liquid resources such as bank accounts and prepaid burial accounts must actually have been expended. Non-liquid resources must have been liquidated and the money expended.

M1460.530 HOME OWNERSHIP (NOT APPLICABLE TO ABD 80% FPL GROUP *OR MAGI ADULTS*)

A. Policy

The policy in this section does not apply to the ABD 80% FPL group. See Appendix 2 to chapter S11 for home ownership resource policy for the ABD 80% FPL group.

The policy in this section does not apply to MAGI Adults. However, the substantial home equity policy in M1460.160 DOES apply to MAGI Adults.

The institutionalized individual's former home in which he has an ownership interest, and which he occupied as his residence before becoming institutionalized, is not a countable resource for the first six months **following** admission to a medical facility or nursing facility. The former home is excluded indefinitely when it is occupied by a spouse, minor child, disabled adult child, or disabled parent.



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B. Definitions for This Section

1. Dependent

A dependent child or parent is one who may be claimed as a dependent for tax purposes under the Internal Revenue Service's Code by either the institutionalized individual or his spouse.

2. Institutionaliz-ation

a. Definition

Institutionalization means receipt of 30 consecutive days of :

- care in a medical facility (such as a nursing facility), or
- Medicaid waiver services (such as community-based care); or
- a combination of the two.

The definition of institutionalization is also met when an individual has a signed hospice election that has been in effect for 30 consecutive days.

The 30 consecutive days requirement is expected to be met if the pre-admission screening committee provides verbal or written confirmation of its approval for the individual's receipt of long-term care (LTC) services (see M1410.010).

NOTE: For purposes of this definition, continuity is broken by *180* or more consecutive days of:

- absence from a medical institution, or
- non-receipt of Medicaid waiver services.

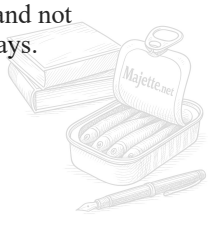
EXCEPTION: When an individual is readmitted in less than 30 days due to a different diagnosis or a change in condition unforeseen at the time of discharge, a new 6-month home exclusion will begin if it was medically documented that the discharge occurred because facility services were no longer required and a physician documents that the change in circumstances could not be anticipated.

b. When Institutionalization Begins

Institutionalization begins the date of admission to a nursing facility or Medicaid waiver services when the pre-admission screening committee provides verbal or written confirmation of its approval for the individual's receipt of long-term care (LTC) services, or when the individual has been in the nursing facility for at least 30 consecutive days.

Institutionalization begins the date of admission to a hospital (acute care) when the individual has actually been a patient in the hospital for 30 consecutive days or more. For example, an individual was admitted to the general hospital on March 5. He applied for Medicaid on March 6. On April 3, he was still a patient in the general hospital. He was in the hospital for 30 consecutive days on April 3; his institutionalization began on the date he was admitted to the hospital, March 5. His eligibility for March is determined as an institutionalized individual.

The date of discharge from a medical institution into the community (and not receiving CBC waiver services) or death is **NOT** included in the 30 days.



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3. Home Property

The home property is defined based on the individual's covered group, except when the individual is married with as community spouse. When the individual is married with a community spouse, **go to subchapter M1480.**

a. ABD Groups

The home property definition in section M1130.100 applies to ABD covered groups. An individual's home is property that serves as his or her principal place of residence. A home shall mean the house and lot used as the principal residence and all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000. If the individual has property contiguous to his home, the value of the non-home contiguous property over $5,000 is a countable resource, unless it can be excluded for another reason listed in subchapter S1130.

b. F&C Groups

The home property definition in section M0630.115 applies to F&C covered groups. Home property is the home used as the principal residence and all contiguous property. Contiguous property is the land, and improvements on that land, which adjoins the home and which is not separated by land owned by others.

4. Former Home

The patient's former home (including a mobile home) is his primary residence:

- which he owns, and
- which he occupied as his residence prior to admission to an LTC facility, or prior to moving out to receive Medicaid CBC waiver services in another person's home.

C. Exclude Former Home Indefinitely

The former home property can be excluded indefinitely when one of the following conditions is met:

1. Occupied By Spouse or Minor Child

The former home is occupied by the individual's spouse, minor dependent child under age 18, or dependent child under age 19 if attending school or vocational training.

2. Occupied By Disabled Adult Child or Disabled Parent

The former home is occupied by the individual's parent or adult child who:

- *has been determined to be* disabled according to the Medicaid disability definition;
- lived in the home with the recipient for at least one year prior to the recipient's institutionalization; and
- is dependent upon the recipient for his shelter needs.

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3. ABD Groups--Home Exclusion Does Not Apply To Contiguous Property

For unmarried individuals and married individuals with no community spouses, the home exclusion for ABD covered groups applies to the home (dwelling) and the plot of land on which the home is located, and to the property contiguous to the home that comes under the home exclusion by using one of the two different calculations in section M1130.100. The home exclusion DOES NOT apply to the property contiguous to the home that does **not** come under the home definition in section M1130.100 A.2.

If the ABD individual owns property contiguous to his home, the value of the non-home contiguous property is a countable resource, regardless of whether the home is occupied by a dependent relative, unless the contiguous property can be excluded for another reason listed in subchapter S1130.

D. 6-Months Home Exclusion

The home is excluded as a primary residence during temporary absences for visits or to obtain medical treatment. The former home property is excluded as a resource for 6 months, beginning with the month **following** the month institutionalization begins.

1. ABD Groups--Exclusion Does Not Apply To Contiguous Property

The 6-month home exclusion for ABD covered groups applies to the home (dwelling) and the plot of land on which the home is located, and to the property contiguous to the home that comes under the home exclusion by using one of the two different calculations in section M1130.100. The 6-month home exclusion DOES NOT apply to the property contiguous to the home that does **not** come under the home definition in section M1130.100 A.2.

Therefore, if the ABD individual owns property contiguous to his home, the value of the non-home contiguous property is a countable resource, regardless of the individual's temporary absence, unless the contiguous property can be excluded for another reason in subchapter S1130.

2. Facility Admission

The former home property is excluded for 6 full months beginning with the month **following** the month of institutionalization in a medical facility. The property is no longer "home property" after 6 months of absence due to institutionalization. An individual who has been receiving Medicaid CBC waiver services in his own home and who then enters a nursing facility receives the six months former home exclusion starting with the month following the month of admission to the facility.

Individuals re-admitted to a medical facility 30 days or more after discharge will have the six-months former home exclusion start over again.

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EXAMPLE #1: Mr. G is an unmarried aged individual who has been receiving Medicaid CBC waiver services in his home since February 2, 1997. He was admitted to a nursing facility on June 20, 1998. He owns his home, which has no contiguous property. His former home property is excluded for 6 months after admission, beginning July 1, 1998 and ending December 31, 1998

3. Medicaid CBC Waiver Services Admission

A Medicaid CBC waiver services recipient who is living away from the home established as his primary place of residence, in order to receive medical care, is entitled to the six months' home exclusion. The six months will start with the month **following** the month in which he left his home.

An individual who is discharged from a nursing facility to go home and receive Medicaid CBC waiver services is considered as living on the home property. The home property, as defined by the appropriate manual section, is excluded while the individual lives there.

EXAMPLE #2: Mr. B is an unmarried aged individual living in his home. He was admitted to Medicaid CBC waiver services on January 20, 1999, the day he moved into his daughter's home. He owns his home, which has no contiguous property. His former home property is excluded for 6 months after the month in which he moved to his daughter's home. The 6-months exclusion begins February 1, 1999 and ends July 31, 1999.

E. After Six Months

At the end of six months of continuous absence due to institutionalization, the former home property must be counted as an available resource if owned by the recipient, unless it can be excluded for another reason.

1. Exclude Indefinitely

The former home property (residence) can be excluded indefinitely when one of the conditions in section M1460.530 C. above is met.

2. Exclude Under Resource Rules

If the former residence is not excluded because it is not occupied by an individual who meets the requirements in section M1460.530 C. above, determine if it can be excluded under the resource rules applicable to the individual's covered group.

a. ABD Covered Groups

1) Reasonable but Unsuccessful Efforts to Sell (section M1130.140).

2) Indians' Interest in Trust or Restricted Lands (section S1130.150).

3) Other Real Property (section M1130.160).

4) Property Essential to Self-support (sections S1130.500 through S1130.510).

b. F&C Covered Groups

1) Excluded Resources (section M0630.100).

2) Reasonable Effort To Sell (CN) (section M0630.105).

3) Reasonable Effort To Sell For the Medically Needy (section M0630.110).

F. Home No Longer Excluded

If the individual's home property is no longer excluded and the individual has excess resources, cancel Medicaid because of excess resources when the individual does not have Medicare Part A. If the individual has Medicare Part A, evaluate the individual's eligibility as ABD Medicare Savings Program (MSP) which has more liberal resource requirements and limits (see M0320.600).

1. Individual Has Medicare Part A

When the individual has Medicare Part A:

a. compare income with the ABD MSP limits; if the income is below one of the ABD MSP income limits, then

b. evaluate the resources using ABD MSP policy as found in Chapter S11, Appendix 2.

c. If eligible as ABD MSP only, Medicaid will not pay for nursing facility or CBC waiver services costs. Do the following:

- prepare and send an Advance Notice of Proposed Action to the recipient;

- cancel the recipient's coverage, then reinstate the recipient to ABD MSP limited coverage;

- send a Medicaid LTC Communication Form (DMAS-225) to the provider *and the MCO*, stating that the recipient is no longer eligible for full Medicaid coverage because of excess resources, but is eligible for limited ABD MSP coverage; beginning (specify the date following the cancel date of the recipient's full coverage), Medicaid will not pay for the individual's care.

d. If NOT eligible as ABD MSP because of resources and/or income, cancel the recipient's Medicaid. Do the following:

- prepare and send an "Advance Notice of Proposed Action" to the recipient;

- cancel the recipient's Medicaid coverage because of excess resources or income;

- send a DMAS-225 to the provider *and the MCO*, stating that the recipient's Medicaid will be canceled because of excess resources (and/or income) and the effective date of cancellation.

2. Individual Does Not Have Medicare Part A

When the individual DOES NOT have Medicare Part A:

a. cancel the recipient's Medicaid coverage because of excess resources;

b. prepare and send an Advance Notice of Proposed Action to the recipient;

c. send a DMAS-225 to the provider, stating that the recipient's Medicaid will be canceled because of excess resources, and the effective date of cancellation.

M1460.540 SUSPENSION PROCEDURES

A. Policy

This section applies ONLY to Medicaid recipients:

- who are enrolled in ongoing Medicaid coverage and
- whose patient pay exceeds the Medicaid rate.

B. Procedures

If a Medicaid recipient's patient pay exceeds the Medicaid rate and his resources go over the Medicaid resource limit, take the following actions:

1. For Recipients Who Have Medicare Part A

a. Resources Less Than or Equal to ABD MSP Resource Limit

If the recipient's resources are less than or equal to the higher ABD **MSP** resource limit, **determine** if the recipient's income is less than or equal to the QMB, SLMB, or QI income limit.

1) When the recipient's income is less than or equal to the QMB, SLMB, or QI income limit:

a) prepare and send an advance notice to reduce the recipient's Medicaid coverage from full benefits to limited benefits (specify the appropriate QMB, SLMB, or QI coverage). Write a note on the notice telling the recipient that:

- the limited (QMB, SLMB, or QI) benefits will NOT pay for long-term care services, and
- if he verifies that his resources are less than or equal to the $2,000 resource limit, he should request reinstatement of full Medicaid benefits.

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b) **cancel** the recipient's full coverage effective the last day of the month in which the 10-day advance notice period expires. Reinstate the recipient's coverage with the begin date as the first day of the month following the cancellation effective date, using the appropriate QMB, SLMB or QI AC.

2) When the recipient's income exceeds the QMB, SLMB and QI income limits, follow the procedures in 2 below (the procedures for recipients who do not have Medicare Part A).

b. Resources Exceed ABD MSP Resource Limit

If resources are greater than the ABD MSP resource limit, follow the procedures in item 2 below (the procedures for recipients who do not have Medicare Part A).

2. For Recipients Who Do NOT Have Medicare Part A

a. Prepare and Send Advance Notice

Prepare and send an advance notice to cancel the recipient's Medicaid eligibility. Specify the effective date, which is the last day of the month in which the 10-day advance notice period expires. Write a note on the notice telling the recipient that if he verifies that his resources are less than or equal to the $2,000 resource limit before the specified date (specify the date which is 3 months from the cancel effective date), he should request reinstatement of Medicaid eligibility.

b. Cancel Medicaid Eligibility

Cancel the recipient's eligibility effective the last day of the month in which the 10-day advance notice period expires.

c. Suspend Case Administratively

Suspend the case administratively for a maximum of 3 months; do not close the case statistically. The suspension effective date is the effective date of the Medicaid cancellation in *VaCMS*. While suspended, the case remains open for a maximum of 3 months.

If, by the end of 3 months from the suspension effective date, the individual provides verification that his resources have been reduced to or below the resource limit, document the reduction in resources in the individual's *VaCMS* case record. Reinstate his Medicaid eligibility effective the first day of the month in which his resources are less than or equal to the resource limit.

If the individual does NOT provide verification within 3 months of the suspension effective date that his resources have been reduced to or below the resource limit, close the case administratively and statistically. Do not take any action on his enrollment in *VaCMS*, because his eligibility has already been canceled. The individual will have to file a new Medicaid application.

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M1460.600 INCOME DETERMINATION

A. Introduction

This section provides the income requirements specific to determinations of eligibility for Medicaid participation in payment of long-term care services.

B. F&C *CN*

If an institutionalized individual meets an F&C *CN* covered group, determine if his income is within the appropriate F&C income limit. The institutionalized individual is an assistance unit of one person; no income is deemed from responsible relatives. Use the policy and procedures in chapters M04 and M07 to determine countable income.

C. MAGI Adult Group

If an individual is between the ages of 19 and 64 and is not entitled to or receiving Medicare, determine if his MAGI household income is less than or equal to 138% of the Federal Poverty Level (FPL). Use the policy in Chapter M04 to determine countable income.

D. ABD 80% FPL Group

If an individual is aged, blind or disabled, determine if his income is less than or equal to 80% of the FPL. See M0810.002 A.5 for the ABD 80% FPL income limits. The ABD income policy in Chapter S08 is used to determine countable income for the ABD 80% FPL covered group. *However, the income items listed in Sections M1460.610 and M1460.611 are NOT counted as income in determining income eligibility as an institutionalized individual for the ABD 80% FPL covered group.*

E. 300% SSI Income Limit Group

For purposes of this section, we refer to the ABD covered group and the F&C covered group of "individuals in medical facilities who have income less than or equal to 300% of the SSI individual payment limit" and "individuals receiving Medicaid waiver services who have income less than or equal to 300% of the SSI individual payment limit" as one covered group. We refer to this one group as "institutionalized individuals who have income within 300% of SSI" or the "300% SSI group."

1. Assistance Unit

The institutionalized individual is an assistance unit of one person; no income is deemed from responsible relatives.

2. Income Limit

The income limit for ABD and F&C individuals in the 300% SSI group is 300% of the SSI individual payment limit (see M0810.002 A. 3).

3. Countable Income

Income sources listed in section M1460.610 are NOT considered income.

Income sources listed in section M1460.611 ARE counted as income.

All other income is counted. The individual's gross income is counted; no exclusions are deducted.

To determine an income type or source and to determine how to count the income, use the policy and procedures in chapter S08 for all individuals (both ABD and F&C) in this covered group.

Income is projected for the month for which eligibility for LTC is being determined. This calculation is based upon the income received in the past month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount expected to be received.



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*To determine if an individual has income within the 300% of SSI limit, use **gross** income, not countable income. Determine what is income according to chapter S08 and subchapter M1460.*

DO NOT subtract the $20 general exclusion or any other income exclusions. The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Effective 12/1/2024, Virginia's state Medicaid plan was updated to disregard Social Security Disability Income (SSDI) when determining eligibility for Long Term Services and Supports (LTSS) for approved Developmental Disability (DD) Waiver recipients. This change does not apply to CCC Plus waiver recipients.

The disregard is not applicable to the post-eligibility calculation of patient pay.

- *SSDI over and above the current SSI payment limit will be disregarded for Medicaid applicants offered a DD waiver slot dependent upon Medicaid eligibility and enrollment.*

- *SSDI over and above the current SSI payment limit will be disregarded at renewal or change for individuals approved for LTSS through a DD waiver.*

- *SSDI will be countable as applicable for the covered group(s) in which the individual is being re-evaluated if they are no longer approved for a DD waiver, for example no longer meeting the level of care (LOC) requirement.*

VaCMS will automatically disregard the SSDI income of a client who meets the above criteria counting only the SSI maximum income limit for one person. Additionally, the MA institutionalized screen and various elements of the Eligibility summary screen have been updated with this change.

Compare the total gross income to the 300% of SSI limit (see M0810.002 A. 3). If countable income is equal to or less than this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in this covered group. Evaluate his/her eligibility as medically needy.

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E. **MN Income - All MN Covered Groups**

The medically needy (MN) individual income limits are listed in Appendix 5 to subchapter M0710 and in section M0810.002 A.4.

1. ABD MN Covered Groups

Evaluate MN resource and income eligibility for ABD individuals who have income over the 300% SSI income limit.

The income sources listed in sections M1460.610 "What is Not Income" and M1460.611 "Countable Income for the 300% SSI Group" are NOT counted. Countable income is determined by the income policy in chapter S08; applicable exclusions are deducted from gross income to calculate the individual's countable income.

The income actually received in the retroactive period is considered for retroactive eligibility. The income expected to be received within the application month is considered when determining eligibility in that month. The income expected to be received within a month is counted in that month for ongoing eligibility.

2. F&C MN Covered Groups

Evaluate MN resource and income eligibility for F&C individuals who have income over the 300% SSI income limit.

Countable income is determined by the income policy in chapter M07, using a monthly budget period; applicable exclusions are deducted from gross income to calculate the individual's countable income. In addition, the income sources listed in sections M1460.610 B and M1460.611 are NOT counted.

Anticipated income is projected for the month for which eligibility is being determined. This calculation is based upon the income received in the prior month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount to be received.

M1460.610 WHAT IS NOT INCOME

A. Introduction

This section contains a list of items that are not considered as income when determining income eligibility for institutionalized individuals in medical facilities or Medicaid CBC waiver services.

NOTE: The income items in C. below ARE COUNTED as income only when determining F&C medically needy eligibility.

B. What Is Not Income - All Covered Groups

Do not consider the types of items in this subsection as income **when determining eligibility or patient pay for all covered groups.**

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1. Federal/State Government Payments & Programs

Benefits provided under the following federal and state government program payments are not income:

a. Supplemental Security Income (SSI) payments.
b. Auxiliary grants (AG) payments.
c. Temporary Assistance to Needy Families (TANF) payments.
d. *Supplemental Nutrition Assistance Program (SNAP) (formerly* Food Stamps*)*.
e. Women, Infants and Children (WIC) coupons.
f. IV-E and Non IV-E Foster Care payments [ref. 1612(b)(10)].
g. IV-E and Non IV-E Adoption Assistance payments.
h. Food and Meal programs with government involvement:

- school breakfasts,
- school lunches,
- milk programs.

2. Medical or Social Services

(S0815.050) Cash or in-kind items received from governmental medical or social services programs, unless it is remuneration for work or activities performed as a participant in a sheltered workshop or an incentive payment to encourage individuals to use specific facilities or to participate in specific medical or social services programs, is not income. For example, Title XX, Title IV-B, Child Welfare Services, Title V, Maternal and Child Health Services, services under the Rehabilitation Act of 1973 are cash or in-kind medical or social services received from a government program and are NOT income.

NOTE: Education in public schools, vocational training and government income maintenance programs such as VA are NOT social services programs. The provision of food, shelter, laundry, or recreation is not a social service.

3. Non-government Medical or Social Services

(S0815.050 F1) Cash received from **non-governmental** medical or social services programs, such as Red Cross or Salvation Army, for medical or social services already received by individuals and approved by the organizations is not income.

4. Personal Services

(S0815.150) Personal services performed for an individual is not income, e.g., mowing the lawn, doing housecleaning, going to the grocery store, babysitting are not counted as income to the individual who receives the personal service.

5. Conversion of a Resource

(S0815.200) Receipts from the sale, exchange, or replacement of a resource are not income; they are a conversion of a resource from one form of resource to another form of resource.

6. Income Tax Refund

(S0815.270) Any amount refunded on income taxes already paid is not income.

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7. Credit Life/Disability Payments

(S0815.300) Payments made under a credit life or credit disability insurance policy on behalf of an individual are not income.

8. Loan Proceeds

(S0815.350) Proceeds of a bona fide loan are not income to the borrower because of the borrower's obligation to repay.

9. Third Party Payments

a. Payments made by another individual

(S0815.400) Payment of an individual's bills (including Medicare supplementary medical insurance or other medical insurance premiums) by a third party directly to the supplier is not income.

Payments made directly to the service provider by another person for the individual's private room or "sitter" in a medical facility are **not** income to the individual.

EXCEPTION: For F&C covered groups **except** the 300% SSI group: If the person paying the bill(s) is the child's absent father and the Division of Child Support Enforcement (DCSE) has not established an obligation for the absent parent, the amount(s) paid by the absent parent for the child is counted as income.

b. Long-term care (LTC) insurance payments

Institutionalized individuals who have LTC insurance coverage must have the LTC insurance coverage information entered into the recipient's TPL file in VaCMS. The insurance policy type is "H" and the coverage type is "N."

If the patient receives the payment from the insurance company, it is not counted as income. The patient should assign it to the provider. If the patient cannot do this, or the policy prohibits assignment, the payment should be given directly to the provider. The provider should report the payment as a third party payment on its claim form. If the patient received the payment and cannot give it to the provider for some reason, then the patient should send the insurance payment to:

This address is for USPS mail only:
Commonwealth of VA COV - DMAS
PO Box 780209
Philadelphia, PA 19178-0209

This address is only for overnight mail by special carriers:
Lockbox Services #780209
Commonwealth of VA COV DMAS
2005 Market Street, 5th Floor
Philadelphia, PA 19103-7042

Along with the check, submit some type of documentation to explain why the funds are being sent to DMAS.

10. Replacement Income

(S0815.450) If an individual's income is lost, stolen, or destroyed and the individual receives a replacement, the replacement is not income if the original payment was counted in determining the individual's Medicaid eligibility.

11. Erroneous Payments

(S0815.460) A payment is not income when the individual is aware that he is not due the money and returns the check uncashed or otherwise refunds all of the erroneously received money.



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12. Weatherization Assistance (S0815.500) Weatherization assistance (e.g., insulation, storm doors, and windows, etc.) is not income.

13. Certain Employer Payments (S0815.600) The following payments by an employer are not income UNLESS the funds for them are deducted from the employee's salary:

a. funds the employer uses to purchase qualified benefits under a "cafeteria" plan;

b. employer contribution to a health insurance or retirement plan;

c. the employer's share of FICA taxes or unemployment compensation taxes in all cases;

d. the employer's share of FICA taxes or unemployment compensation taxes paid by the employer on wages for domestic service in the private home of the employer or for agricultural labor only, to the extent that the employee does not reimburse the employer.

14. Payments to Victims of Nazi Persecution Any payments made to individuals because of their status as victims of Nazi persecution are not income [P.L.103-286 and 1902(r)(1)].

15. Advance Payments That will Be Reimbursed Advance payments made by a person other than the patient which are expected to be reimbursed once Medicaid is approved, and payments made by outside sources to hold the facility bed while the patient is hospitalized, are **not counted as income** in determining eligibility or patient pay.

There are instances when the family of a prospective Medicaid patient, or other interested party(ies), makes an advance payment on the cost of facility care prior to or during the Medicaid application process to assure the Patient's admission and continued care. The individual may have been promised that the advance payment will be refunded if Medicaid eligibility is established. Any monies contributed toward the cost of patient care pending a Medicaid eligibility determination must be reimbursed to the patient or the contributing party by the facility once Medicaid eligibility is established.

16. Medical Expense Reimburse-ment Medical expense reimbursement from either VA or an insurance policy is not income. Medical expense reimbursements are resources.

The income in items 17 through 23 below are not income by other federal statutes or law:

17. Energy Assistance Energy Assistance through Block Grants (Virginia's Fuel Assistance payments) is excluded [P.L. 93-644].

18. Radiation Exposure Trust Fund Radiation Exposure Compensation Trust Fund payments are excluded [P.L. 101-426].



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19. Agent Orange Agent Orange Payments are excluded [P. L. 101-239].

20. Native American Funds The following funds for Native Americans are excluded *for all covered groups:*

a. Alaska Native Claims Settlement Act (cash payments not to exceed $2,000) [P.L. 100-241]

b. Maine Claims Settlement Act [P.L. 96-420]

c. Blackfeet and Gros Ventre [P.L. 92-254]

d. Grand River Band of Ottawa [P.L. 94-540]

e. Red Lake Band of Chippewa [P.L. 98-123]

For MAGI Adults, the following payments to American Indian/Alaska Natives are also not counted as income:

a. distributions received from the Alaska Native Corporations and Settlement Trusts (Public Law 100-241),

b. distributions from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the Supervision of the Interior,

c. distribution and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extractions and harvest from:

- *rights of any lands held in trust located within the most recent boundaries of a prior Federal reservation or under the supervision of the Secretary of the Interior,*
- *federally protected rights regarding off-reservation hunting, fishing, gathering or usage of natural resources,*
- *distributions resulting from real property ownership interests related to natural resources and improvements,*
- *located on or near a reservation of within the most recent boundaries of a prior Federal reservation, or*
- *resulting from the exercise of federally-protected rights relating to such property ownership interests.*

d. payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or right or rights that support subsistence or a traditional lifestyles according to applicable Tribal Law or custom.

e. Student financial assistance provided under the Bureau of Indian Affairs Education Program.



C. What Is NOT Income For All Covered Groups EXCEPT F&C MN

The items below are NOT income when determining eligibility *as an institutionalized individual* for all covered groups EXCEPT for the F&C MN covered groups. Count these income sources in the F&C medically needy income determination, **but NOT in the patient pay calculation.**

1. Specific VA Payments

The following VA payments are NOT income for all covered groups EXCEPT the F&C MN covered groups:

a. Payments for Aid and Attendance or housebound allowances. Refer to section M1470.100 for counting Aid and Attendance payments as income in the patient pay calculation.

NOTE: This applies to all LTC recipients, including those patients who reside in state veterans' care centers.

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b. Payments for unusual medical expenses.

c. Payments made as part of a VA program of vocational rehabilitation.

d. VA clothing allowance.

e. Any pension paid to a nursing facility patient who is

- a veteran with no dependents,
- a veteran's surviving spouse who has no child, or
- *a veteran's dependent child.*

NOTE: Refer to section M1470.100 for counting VA pension payments as income for post-eligibility determinations. This applies to all LTC recipients, including those patients who reside in state veterans' care centers.

f. Any portion of a VA educational benefit which is a withdrawal of the veteran's own contribution is a conversion of a resource and is not income.

2. VA Augmented Benefits

An absent dependent's portion of an augmented VA benefit received by the individual on or after 11-17-94 is NOT income to the individual when determining his eligibility in any covered group EXCEPT an F&C MN covered group.

VA Augmented benefits are COUNTED as income when determining eligibility in the F&C MN covered groups.

3. Return of Money

(S0815.250) A rebate, refund, or other return of money that an individual has already paid is NOT income to the individual when determining his eligibility in any covered group EXCEPT an F&C MN covered group. The key idea is a return of the individual's own money. Some "rebates" do not fit this category, such as a cooperative operating as a jointly owned business pays a "rebate" as a return on a member's investment; this "rebate" is unearned income similar to a dividend.

4. Death Benefits

Death benefits **equal** to cost of last illness and burial are NOT income in all covered groups EXCEPT the F&C MN covered groups.

Any amount of the death benefit that **exceeds** the costs of last illness and burial **is counted as income** for eligibility and patient pay **in all covered groups**.

5. Austrian Social Insurance

Austrian Social Insurance payments that meet the requirements in S0830.715 are NOT income in all covered groups EXCEPT the F&C MN covered groups.

6. Native American Funds

a. Seneca Nation Settlement Act [ref. P.L. 101-503]

b. Yakima Indian Nation [ref. P.L. 99-433]

c. Papago Tribe of Arizona [ref. P.L. 97-408]

d. Shawnee Indians [ref. P.L. 97-372]

e. Miami Tribe of Oklahoma and Indiana [ref. P.L. 97-376]

f. Clallam Tribe [ref. P.L. 97-402]

g. Pembina Chippewa [ref. P.L. 97-403]

h. Confederated Tribes of Warm Springs Reservation [ref. P.L. 97-436].

M1460.611 COUNTABLE INCOME FOR THE 3OO% SSI GROUP

A. Applicability

This section contains a list of income sources and amounts of income that are COUNTED when determining income eligibility for the 300% SSI group, but may be excluded when determining income eligibility for the other covered groups.

B. Items Under 1612(b) and Footnote 57 (counted also as patient pay income)

Count the following income sources in this subsection when determining eligibility for the **300% SSI income limit group**.

DO NOT COUNT the income sources in this section when determining the income eligibility in **all other Medicaid covered groups.**

1. ACTION Program

Action Program. This is the federal domestic volunteer agency which provides programs such as the Special and Demonstration Volunteer Programs. This includes the following programs: [Refer to P.L. 93-113]

- Retired Senior Volunteer Program (RSVP)
- Foster Grandparent Program
- Senior Companion Program
- University Year for Action
- VISTA
- Special and Demonstration Volunteer Programs.

2. BIA Student Assistance

Bureau of Indian Affairs Student Assistance [ref. P.L. 89-329].

3. Disaster Assistance

Presidentially declared disaster assistance. This includes assistance from federal programs and agencies, joint federal and state programs, state or local government programs, and private organizations such as the Red Cross [1612(b) (11)].

4. EITC

Earned income tax credit payments [1612(b) (19)].

5. Federal Relocation

Federal Relocation Assistance [ref. P.L. 91-646].

6. Infrequent or Irregular Income

Any infrequent/irregular income. See Chapter S08 for the ABD policy. See Chapter M07 for the F&C policy.

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7. Native Americans' Funds

Funds for Native Americans, including funds from:

- Indian Tribal Judgment Funds Use or Distribution Act [ref. P.L. 93-134]
- ·Indian Tribes Submarginal Land Act [ref. P.L. 94-114].

8. Specific Restitution

Japanese-American and Aleutian Restitution payments [ref. P.L. 100-383].

9. Grants, Scholarships, Fellowships

Any portion of a grant, scholarship or fellowship that is for the cost of tuition and fees at any educational institution, including those for vocational or technical training [1612(b)(7)].

10. Student Loans & Grants

The following student loans or grants:

a. National Defense Student Loans [ref. P.L. 89-329].
b. Pell Grants [ref. P.L. 89-329].
c. Supplemental Education Opportunity Grants (SEOG) [ref. P.L. 89-329].
d. State Student Incentive Grants [ref. P.L. 89-329].

C. Count for 300% SSI Group; (counted as patient pay income)

Count the income sources in this subsection when determining eligibility and patient pay for the **300% SSI group AND all F&C covered groups**.

Do not count the income sources in this section when determining the Income eligibility of the **ABD MN** covered groups.

1. Interest on Disaster Assistance

Interest income on disaster assistance within first nine months of receipt of the payment [1612(b) (12)].

2. Tax Refund

Tax refund on food or real property.

3. Assistance Payments

State or local assistance payments that are based on need [1612(b) (6)].

4. Energy Assistance

Support or maintenance assistance which is based on need and which is furnished in kind by a nonprofit agency, or furnished by supplier of home heating oil or gas, by an entity providing home energy, or by a municipal utility providing home energy [1612(b)(13)]. Energy assistance that is provided by a source other than the "Block Grants" (Virginia's Fuel Program) [1612(b) (13)].

5. Housing Assistance

Housing assistance (including Farmer's Home Assistance payments) under the U.S. Housing Act of 1937, the National Housing Act, section 101 of the Housing and Urban Development Act of 1965, title V of the Housing Act of 1949, or section 202(h) of the Housing Act of 1959 [1612(b) (14)] *paid directly to the applicant/recipient. Do not count housing assistance payments that are not paid directly to the applicant/recipient.*

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6. **Domestic Travel Tickets** — Gifts of domestic travel tickets [1612(b)(15)].

7. **Victim's Compensation** — Victim's compensation provided by a state.

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

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

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

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

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

    a. *For 2026, up to $2,410 per month, but not more than $9,730 in a calendar year, of the earned income of a blind or disabled Student child.*
    For 2025, up to $2,350 per month, but no more than $9,460 in a calendar year, of the earned income of a blind or disabled child.

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

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

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

    e. One-half of remaining earned income in a month [1612(b) (4)(C)].

    f. BWE - Earned income of blind individuals used to meet work expenses [1612(b) (4)(A)].

    g. Earned income used to fulfill an SSI approved plan to achieve self-support (PASS) [1612(b) (4)(A) & (B)].

12. **Child Support** — Child support payments received from an absent parent for a blind or Disabled child [1612(b) (9)].

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13. **Native American Funds**

The following Native American funds (only exclude for ABD MN groups):

a. Puyallup Tribe [ref. P.L. 101-41]
b. White Earth Reservational Land Settlement [ref. P.L. 99-264]
c. Chippewas of Mississippi [ref. P.L. 99-377]
d. Saginaw Chippewas of Michigan [ref. P.L. 99-346]
e. Shoalwater Bay Indian Tribe [ref. P.L. 98-432]
f. Wyandotte Tribe [ref. P.L. 98-602]
g. Chippewas of Lake Superior [ref. P.L. 99-146]
h. Cow Creek Band of Umpqua [ref. P.L. 100-139]
i. Coushatta Tribe of Louisiana [ref. P.L. 100-411]
j. Wisconsin Band of Potowatomi [ref. P.L. 100-581]
k. Seminole Indians [ref. P.L. 101-277]
l. receipts from land distributed to:

- Pueblo of Santa Ana [ref. P.L. 95-498]
- Pueblo of Zia [ref. P.L. 95-499].

14. **State/Local Relocation**

State or local relocation assistance [1612(b) (18)].

15. **USC Title 37 Section 310**

Special pay received pursuant to section 310 of title 37, United States Code [1612(b)(20)].

NOTE: For additional F&C medically needy (MN) income exclusions, go to Chapter M07. For additional ABD medically needy (MN) income exclusions, go to Chapter S08.

M1460.620 RESERVED

M1460.640 INCOME DETERMINATION PROCESS FOR STAYS LESS THAN 30 DAYS

A. Policy - Individual in An Institution for Less Than 30 Days

This subsection is applicable ONLY if it is known that the time spent in the institution has been, or will be, less than 30 days. If the individual is institutionalized for less than 30 days, Medicaid eligibility is determined as a non-institutionalized individual because the definition of "institutionalization" is not met. If there is no break between a hospital stay and admission to a nursing facility or Medicaid CBC waiver services, the hospital days count toward the 30 days in the "institutionalization" definition.

B. Recipient

If a Medicaid recipient is admitted to a medical institution for less than 30 days, go to subchapter M1470 for patient pay policy and procedures.

C. Applicant

If the individual is NOT a Medicaid recipient and applies for Medicaid determine the individual's income eligibility as a non-institutionalized individual. Go to Chapter M07 for F&C or S08 for ABD to determine the individual's income eligibility.

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M1460.650 RETROACTIVE INCOME DETERMINATION

A. Policy

The retroactive period is the three months immediately prior to the Application month. The three-month retroactive period cannot include a portion of a prior Medicaid medically needy spenddown budget period in which eligibility was established.

1. Institutionalized Individual

For the retroactive months in which the individual was institutionalized in a medical facility, determine income eligibility on a monthly basis using the policy and procedures in this subchapter (M1460). An individual who lived outside of a medical institution during the retroactive period must have retroactive Medicaid eligibility determined as a non-institutionalized individual.

A spenddown must be established for any month(s) during which excess income existed. Go to M1460.700 for spenddown policies and procedures for medically needy institutionalized individuals.

2. Individual Not Institutionalized

For the retroactive months in which the individual was NOT institutionalized, determine income eligibility for the ABD groups using the ABD policy and procedures in chapter S08. Determine income eligibility for the F&C groups using policy and procedures in chapters *M04 and* M07. *Determine income eligibility for MAGI Adults using the policy and procedures in chapter M04.*

If the individual meets a MN covered group, a spenddown must be established for any month(s) during which excess income existed. See Chapter M13 for spenddown policies and procedures. *There is no MN covered group for MAGI Adults.*

3. Retroactive Entitlement

If an applicant meets all eligibility requirements, he is entitled to Medicaid coverage for the month(s) in which all eligibility factors were met.

B. Countable Income

Countable income is that income which was actually received in the retroactive month(s). Count the income received in the months in which the individual meets all other Medicaid eligibility requirements.

If the individual was CN in the retroactive month, the countable income is compared to the appropriate income limit for the retroactive month. **Medicaid income eligibility is determined on a monthly basis for the MN institutionalized individual.**

C. Entitlement

Retroactive coverage cannot begin earlier than the first day of the third month prior to the application month. When an applicant reports that he received a medical service within the retroactive period, entitlement for Medicaid will begin with the first day of the third month prior to the application month, provided all eligibility factors were met in all three months. If the institutionalized applicant had excess income in the retroactive period, entitlement may begin the first day of the month in which the retroactive spenddown was met.

For additional information, refer to section M1510.101.

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D. Retroactive Income Determination Example

EXAMPLE #3: A disabled institutionalized individual applies for Medicaid on June 5 and requests retroactive coverage for unpaid medical bills that he incurred in March, April, and May. His disability onset date was April 10. He was institutionalized on April 10.

The retroactive period is March, April and May. He is not eligible for March because he did not meet a covered group in March. The income he received in April and May is counted monthly because he was institutionalized in each month. He is resource eligible for all three months.

His April income is calculated and compared to the monthly 300% SSI income limit. It exceeds that limit. His May income is calculated and compared to the monthly 300% SSI income limit; it is within the limit. Therefore, he is placed on a one-month retroactive spenddown for April, and is enrolled in the 300% SSI covered group for May.

M1460.660 NOTICES & ENROLLMENT PROCEDURES FOR CATEGORICALLY NEEDY

A. CN Eligible Enrollment

Enroll the recipient with the appropriate CN aid category (AC) as follows:

1. SSI

011 Aged
031 Blind
051 Disabled

2. "Protected" ABD Covered Groups

021 Aged
041 Blind
061 Disabled

3. MAGI Adults

100 *Parent/Caretaker-relative; income at or below 100% FPL*
101 *Parent/Caretaker-relative; income greater than 100% FPL, but less than or equal to 138% FPL (133% + 5% disregard)*
102 *Childless Adult; income at or below 100% FPL (no disregard)*
103 *Childless Adult; income greater than 100% FPL, but less than or equal to 138% FPL (133% + 5% disregard)*
106 *Presumptive Eligible MAGI Adult; income at or below 138% FPL (133% + 5% disregard)*

4. ABD 80% FPL

029 Aged
039 Blind
049 Disabled

5. MEDICAID WORKS

059

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6. 300% SSI

a. ABD

Not dually eligible as a Qualified Medicare Beneficiary (QMB) or Special Low Income Medicare Beneficiary (SLMB); individual does not have Medicare Part A and/or income equal to or greater than 120% FPL:

020 Aged
040 Blind
060 Disabled

Dually eligible; individual has Medicare Part A and income within 100% FPL

022 Aged also QMB
042 Blind also QMB
062 Disabled also QMB

Dually eligible; individual has Medicare Part A and income greater than 100% FPL but less than 120% FPL

- **025** aged individual also SLMB
- **045** blind or disabled also SLMB

b. F&C

060 F&C who does not meet "Individuals Under Age 21 in an ICF or ICR/MR covered group, not blind or disabled

082 Institutionalized child under age 21 in an ICF or ICF/MR, not blind or disabled

NOTE: Children who are eligible in the Child Under Age 19, FAMIS Plus, covered group should be enrolled in the appropriate AC for their age and income (see *M1460.660 A.10* below)

7. All Foster Care and Adoption Assistance

072 Adoption Assistance
076 Foster Care

8. Individuals Under age 21

075 child under supervision of Juvenile Justice Department
082 Child in an ICF or ICF/MR

9. LIFC

081 Parent/caretaker of a dependent child
083 Unemployed parent of a dependent child; 2 parent household

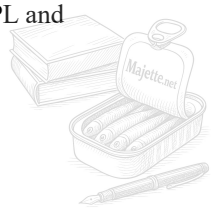
10. Child Under Age 19 FAMIS Plus

091 Child under age 6 w/income less than or equal to the **100% FPL**

090 Child under age 6, income greater than the **100% FPL b**ut less than or equal to the **133% FPL**

092 Child age 6 to 19 **insured or uninsured** w/income less than or equal to the **100% FPL; or insured** w/income greater than 100% and less than or equal to the **133% FPL**

094 Uninsured child age 6 to 19 w/income greater than 100% FPL and less than or equal to the **133% FPL**



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11. Pregnant Women	**091**
12. BCCPTA	**066**

B. CN Eligible Complete & Send Notice

Complete a "Notice of Action on Medicaid and FAMIS to notify the individual of his Medicaid eligibility and coverage begin date. Go to subchapter M1470 to determine the individual's patient pay.

C. Income Exceeds CN Covered Groups Limits

If income exceeds the 300% SSI limit, evaluate as MN. If the individual meets an MN covered group, re-calculate countable income for MN.

Subtract the income exclusions listed in sections M1460.610 and 611 that apply to the individual's MN covered group. Go to section M1460.700 below.

If the individual does NOT meet an MN covered group, he is not eligible for Medicaid; go to subsection D. below.

D. Ineligible--Notice

Complete and send a "Notice of Action on Medicaid and FAMIS" to the individual notifying him that he is not eligible for Medicaid and of his appeal rights.

M1460.700 MEDICALLY NEEDY INCOME & SPENDDOWN

A. Policy

Institutionalized individuals whose income exceeds the 300% SSI income limit must be placed on a monthly medically needy (MN) spenddown if they meet a MN covered group and have countable resources that are less than or equal to the MN resource limit. Countable income for the MN is different than countable income for the 300% SSI covered group. Recalculate income using medically needy income principles.

For individuals who were within a spenddown budget period prior to the month in which they become institutionalized, prorate and shorten the spenddown budget period for the months prior to admission to long-term care services.

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Income for all LTC recipients is determined on a monthly basis. Upon receipt of long term care services, the spenddown budget period is one month. A separate monthly spenddown budget period is established for each month of receipt of LTC services.

A spenddown case is considered denied; however, the application is valid for a certification period of 12 months from the last application or redetermination.

B. Spenddown Procedures

The spenddown procedures for facility patients differ from the spenddown procedures for CBC patients. The expected monthly cost of the facility care is projected at the beginning of the month. The cost of CBC is NOT projected and must be deducted daily as incurred. Specific instructions for determining MN income eligibility for facility and CBC patients are provided in the following sections:

- M1460.710 Spenddown For Facility Patients
- M1460.740 Spenddown For Patients Receiving CBC
- M1460.750 Medically Needy Spenddown Enrollment and Post-eligibility Procedures.

M1460.710 SPENDDOWN FOR FACILITY PATIENTS

A. Policy

Facility patients in the MN classification fall into two distinct subgroups for the purpose of spenddown eligibility determination. These subgroups are:

1. individuals with a spenddown liability less than or equal to the individual's Medicaid rate.

2. individuals with a spenddown liability greater than the individual's Medicaid rate.

The *PDPM* code amount may differ from facility to facility and from patient to patient within the same facility. The nursing facility must be contacted to obtain the *PDPM* code amount whenever a daily facility cost of care is needed to determine eligibility and patient pay for medically needy individuals.

Entitlement and enrollment procedures depend on whether the individual's spenddown liability is less than, equal to or greater than the Medicaid rate.

Applications for individuals who are placed on spenddown are valid for a 12 month period and the cases are subject to annual redetermination.

B. Determine the Spenddown Liability

Calculate the individual's monthly MN income:

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1. ABD MN Groups

a. Start with the gross monthly income for the ABD MN income determination found in section M1460.410 C.

b. Subtract the applicable ABD MN income exclusions. The result is the MN countable income.

c. Subtract the monthly MN income limit for 1 person in the individual's home locality from the MN monthly countable income. The remainder is the ABD individual's spenddown liability.

2. F&C MN Groups

a. Start with the gross monthly income for the F&C MN income determination found in section M1460.410 C.

b. If the individual has earned income, subtract the F&C earned income exclusions in M0720.500 except for the 30 + 1/3 exclusion which is not applicable to this group.

If the individual has child support income, subtract the $50 child support exclusion. See section M0730.400.

a. The remainder is the MN monthly countable income.

d. Subtract the monthly MN income limit appropriate to the individual's home locality from the MN monthly countable income. The remainder is the F&C individual's spenddown liability.

C. Determine the Individual's Projected Medicaid Rate

The individual's projected monthly Medicaid rate is the daily *PDPM* code amount at the time of the spenddown calculation multiplied by 31 days. **For the month of entry, use the actual number of days that care was received or is projected to be received in the facility.**

D. Compare

Compare the individual's spenddown liability to the individual's Medicaid rate.

E. SD Liability Is Less Than or Equal To Medicaid Rate

If the spenddown liability is less than or equal to the individual's Medicaid rate, the individual is income eligible as medically needy for the full month. Individuals with a spenddown liability less than or equal to the individual's Medicaid rate will meet their spenddown based on the Medicaid rate alone. The Medicaid rate is projected and compared to the spenddown liability. Because the spenddown liability is less than the individual's Medicaid rate, eligibility begins the first day of the month.

Go to section M1460.750 below for enrollment procedures.

F. SD Liability Is Greater Than Medicaid Rate

If the spenddown liability is greater than the Medicaid rate, the individual is NOT income eligible as MN. The individual must incur medical expenses, including old bills, carry-over expenses and the facility's cost of care at the private rate, which equal or exceed the spenddown liability for the month. These determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred.

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To determine spenddown eligibility for a medically needy individual whose spenddown liability is greater than the *individual's* Medicaid rate, go to G. below.

G. Facility Spenddown Determination Procedures

To determine spenddown eligibility for a medically needy institutionalized individual whose spenddown liability is greater than the *individual's* Medicaid rate, take the following actions:

1. Calculate Private Cost of Care

Multiply the facility's **private** per diem rate by the number of days the individual was actually in the facility in the month. Do not count any days the individual was in a hospital during the month.

The result is the private cost of care for the month.

2. Compare to Spenddown Liability

Compare the private cost of care to the individual's spenddown liability for the month.

a. Private Cost of Care Greater Than or Equal To Spenddown Liability

If the private cost of care is **greater than or equal to** the individual's spenddown liability, the individual meets the spenddown in the month because of the private cost of care. He is entitled to **full-month coverage** for the month in which the spenddown was met.

Enroll the individual in Medicaid with the begin date of the first of the month, the end date the last day of the month. Go to section M1460.*750* below for enrollment procedures. Determine patient pay according to subchapter M1470.

b. Private Cost of Care Less Than Spenddown Liability

If the private cost of care is less than the individual's spenddown liability, **determine spenddown on a day-by-day basis** in the month by deducting allowable incurred expenses from the spenddown liability.

From the spenddown liability, deduct old bills, carry-over expenses and incurred medical/remedial care expenses per subchapter M1340. When the monthly spenddown liability is reduced to $0, eligibility is established. Eligibility can be established only AFTER the expenses are actually incurred.

If the spenddown is met any time during the month, the individual is eligible for full month coverage. Enroll the individual in Medicaid with the begin date of the first of the month, the end date the last day of the month. Go to section M1460.*750* below for enrollment procedures.

Determine patient pay according to subchapter M1470.

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3. Example - Spenddown Liability Greater than Cost of Care, (using July 2014 figures)

EXAMPLE #4: Mr. Not lives in Group III and applied for Medicaid on April 21 and was determined disabled by Disability Determination Services (DDS). He is in a nursing facility and was admitted on April 1. His income is $2,800 per month disability benefit from a private company. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His resources are within the Medicaid limit in April (application month).

He is not eligible as CN because his $2,800 gross income exceeds the 300% SSI income limit. The individual's Medicaid rate is $100 per day. His MN income eligibility is calculated:

$2,800.00	disability benefit
- 20.00	general income exclusion
$2,780.00	MN countable income
- 457.63	MNIL for 1 month for 1 person in Group III
$2,322.37	spenddown liability

The individual's Medicaid rate for the admission month is calculated as follows:

$100.00	daily *PDPM* code amount
x 30	days
$3,000.00	individual's projected Medicaid rate

The $2,322.37 spenddown liability is less than the individual's Medicaid rate of $3,000.00. Because his spenddown liability is less than the Medicaid rate, his application is approved for ongoing coverage.

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4. Example - On Prior Spenddown, Spenddown Liability Greater Than Cost of Care *(Using July 2014 Figures)*

EXAMPLE #5: Ms. Was, *age 62*, lives in Group I and applied for Medicaid on May 6, *2015*. She is in a nursing facility and was admitted on May 1. She had applied for Medicaid previously and was on a spenddown from December 1, *2013* through May 31, *2014*, which she met on May 2, *2014*. She did not re-apply until May *2015*. She verifies that she has an unpaid $2,300 hospital bill and a $1,500 physician's bill for September 10 to September 12, *2014* (total = $3,800) on which she pays $50 a month. She also has a retroactive incurred expense - a $678 outpatient hospital bill for services dated February 13, *2015*. She has no health insurance and is not eligible for Medicare.

She was not institutionalized in the retroactive period. Her income in the retroactive spenddown budget period was $1,600 per month Civil Service Annuity (CSA) disability. The retroactive spenddown budget period is February, March and April; the income limit is *$915.27*.

Her retroactive spenddown liability is *$3,824.73*.

$1,600.00	CSA disability
- 20.00	general income exclusion
1,580.00	countable income
x 3	months
4,740.00	countable income for retroactive spenddown budget period
- *915.27*	MNIL for retroactive spenddown budget period
$3,824.73	retroactive spenddown liability

Her May 2015 application is a re-application. The September *2014* medical expenses are old bills based on her May *2015* re-application because they were incurred prior to the re-application's retroactive period, were not incurred during a prior spenddown budget period in which eligibility was established. These old bills, totaling $3,800, are deducted from the retroactive spenddown liability. Her retroactive spenddown eligibility is calculated:

$3,824.73	retroactive spenddown liability
- 3,800.00	September *2014* old bills (hospital & physician bills)
24.73	spenddown balance on February *1*, *2015*
- 678.00	February 13, 2015 outpatient expense
0	spenddown balance on February 13, *2015*

The retroactive spenddown was met on February 13, *2015*. Ms. Was is enrolled in retroactive Medicaid for the period February 13, *2015* through April 30, *2015*.

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Her income starting May 1, 2015 increased. Her Civil Service Annuity is $1,620 per month and she began to receive Social Security of $600 per month; total income is $2,220 per month. Because this exceeds the 300% SSI income limit, her medically needy income eligibility is calculated as follows:

$2,220.00	total monthly income
- 20.00	general income exclusion
2,200.00	countable income
- 305.09	MNIL for 1 month for 1 person in Group I
$1,894.91	spenddown liability

Ms. Was' daily *PDPM* code amount is $45. The projected Medicaid rate for the month is calculated as follows:

$ 45	daily *PDPM* code amount
x 31	days
$1,395	individual's projected Medicaid rate

The $1,894.91 spenddown liability is greater than her Medicaid rate of $1,395. Because her spenddown liability is greater than the Medicaid rate, her May application is denied and she is placed on a monthly spenddown for the certification period of May 1, 2015 through April 30, 2016.

On June 3, her authorized representative requests re-evaluation of her spenddown for May. She was in the facility for 31 days in May. The private cost of care for May is calculated:

$ 53	private per diem cost
x 31	days in May
$1,643	private cost of care

The private cost of care, $1,643, is less than her spenddown liability of $1,894.91. Therefore, her spenddown eligibility in May must be determined on a daily basis. The prospective budget period is May 1 through May 31, 2015. Since all of her old bills were used to meet her retroactive spenddown, they cannot be deducted from her current spenddown. The only incurred medical expenses which can be deducted are the medical expenses she incurred in May. In addition to the facility care, she incurred a doctor's expense on May 30 of $400. Her spenddown eligibility for May is determined:

$1,894.91	spenddown liability
- 1,590.00	30 days @ $53 per day (5-1 through 5-30)
- 400.00	noncovered doctor's expense 5-30-2015
0	spenddown balance on 5-30-2015

Because the spenddown was met on May 30, Ms. Was is entitled to Medicaid coverage beginning May 1, 2015 and ending May 31, 2015.

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M1460.740 SPENDDOWN FOR PATIENTS RECEIVING CBC

A. Policy

An individual meets the definition of "institutionalized" when he is *authorized* for Medicaid waiver services and the services are being provided. An individual who has been *authorized* for Medicaid waiver services and whose income exceeds the 300% SSI income limit is not eligible for Medicaid until he meets the monthly spenddown liability. These determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred. The private cost of his home-based medical care is deducted as a noncovered medical expense.

For an individual on spenddown **before** starting Medicaid CBC waiver services, the spenddown budget period and the spenddown liability are prorated and recalculated to include the months prior to the receipt of Medicaid CBC services. A separate monthly spenddown budget period is calculated for each month of receipt of Medicaid CBC services.

A MN CBC patient must incur medical expenses, including old bills, carry-over expenses and the cost of CBC at the private rate, which equal or exceed the spenddown liability for the month. From the spenddown liability, deduct old bills, carry-over expenses and incurred medical/remedial care expenses per section M1340.210. When the monthly spenddown liability is reduced to $0, eligibility is established. Eligibility can be established only AFTER the expenses are actually incurred. Do not project CBC expenses. The eligibility begin date is the first day of the month in which the spenddown was met and the end date is the last day of the month.

B. CBC Spenddown Eligibility Procedures

To determine spenddown eligibility for a CBC institutionalized individual, take the following actions:

1. Calculate Private Cost of Care

Multiply the CBC provider's (or providers' if the individual has multiple CBC providers) **private** hourly rate by the number of hours of service the individual actually received from the provider in the month.

The result is the private cost of care for the month.

2. Compare to Spenddown Liability

Compare the private cost of care to the individual's spenddown liability for the month.

3. Spenddown Liability Less Than Private Cost of Care

If the individual's spenddown liability is less than or equal to the private cost of care, the individual meets the spenddown in the month because of the private cost of care. He is entitled to **full-month coverage** for the month in which the spenddown was met.

Enroll the individual in Medicaid with the begin date of the first of the month, the end date the last day of the month. Go to section M1460.750 below for enrollment procedures. Determine patient pay according to subchapter M1470.



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4. Spenddown Liability Greater Than Private Cost of Care

If the individual's spenddown liability is greater than the private cost of care, **determine spenddown on a day-by-day basis** in the month by deducting allowable incurred expenses from the spenddown liability. Refer to section M1340.210 to determine allowable deductions from the individual's spenddown liability.

If the spenddown is met any time in the month, the individual is eligible for full-month Medicaid coverage beginning the first day of the month in which the spenddown was met and ending the last day of the month.

5. Example - No Prior Spenddown, Spenddown Liability Greater than Private Cost of Care (Using July 2014 Figures)

EXAMPLE #6: Mr. May lives in Group III and applied for Medicaid on April 21, 2015. He was *authorized* for the EDCD waiver on April 10, 2015. The DDS determined that he is disabled. He has no health insurance. His income is $2,800 per month disability benefit from a private company. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His resources are within the Medicaid limit in April 2015 (application month).

He is not eligible as CN because his $2,800 gross income exceeds the 300% SSI income limit. His MN income is calculated:

$2,800.00	disability benefit
- 20.00	general income exclusion
$2,780.00	MN countable income
- 457.63	MNIL for 1 month for 1 person in Group III
$2,322.37	spenddown liability

His CBC costs cannot be projected. Eligibility can be established only after the expenses are actually incurred. He received 20 days of CBC services in April.

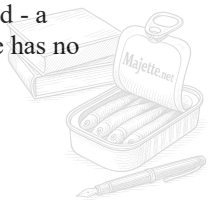
His April application is denied and he is placed on a monthly spenddown for the certification period of 4-1-2015 through 3-31-2016.

$ 8	per hour private rate
x 6	hours per day
$ 48	private per diem cost
x 20	days in April
$ 960	private cost of care

Mr. May's spenddown liability of $2,322.37 is greater than the private cost of care, $960. His Medicaid eligibility was not established in April.

6. Example - On Prior Spenddown, Spenddown Liability Less Than Private Cost of Care (Using July 2014 Figures)

EXAMPLE #7: Ms. Gray lives in Group I and applied for Medicaid on May 6, 2015. She was *authorized* for Medicaid EDCD waiver services on May 2, 2015; the services started on May 4, 2015. She had applied for Medicaid previously and was on a spenddown from December 1, 2013 through May 31, 2014, which she met on May 2, 2014. She did not re-apply until May 2015. She verifies that she has an unpaid $2,300 hospital bill and a $1,500 physician's bill for September 10 to September 12, 2014 (total = $3,800) on which she pays $50 a month. She also has an incurred expense in the retroactive period - a $678 outpatient hospital bill for services dated February 13, 2015. She has no health insurance and is not eligible for Medicare.



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She was not institutionalized in the retroactive period. Her income in the retroactive spenddown budget period was $1,600 per month CSA disability. The retroactive spenddown budget period is February, March and April, 2015; the income limit is *$915.27*.

Mrs. Gray's retroactive spenddown liability is $4,090:

$1,600.00	CSA disability
- 20.00	general income exclusion
1,580.00	countable income
x 3	months
4,740.00	countable income for retroactive spenddown budget period
- *915.27*	MNIL for retroactive spenddown budget period
$3,824.73	retroactive spenddown liability

There was a break between spenddown budget periods (June, July, August, September, October, November and December *2014* and January *2015*). The September *2014* medical expenses are old bills based on her May *2015* re-application because they were incurred prior to the re-application's retroactive period and were not incurred during a prior spenddown budget period in which eligibility was established. These old bills, totaling $3,800, are deducted from the retroactive spenddown liability. Her retroactive spenddown eligibility is calculated:

$3,824.73	retroactive spenddown liability
- 3,800.00	September *2014* old bills (hospital & physician bills)
24.73	spenddown balance on February 1, *2015*
- 678.00	February 13, *2015* outpatient expense
0	spenddown balance on February 13, *2015*
	(*$653.27* carry over balance)

A balance of *$653.27* ($678-24.73) on the 2-13-*2015* outpatient expense remains and can be used as a carry-over expense for the first prospective budget period.

The retroactive spenddown was met on 2-13-*2015*. Ms. Gray is enrolled in retroactive Medicaid for the period 2-13-2015 through 4-30-2015.

Her income starting May 1, 2015 increased. Her CSA is $1,620 per month and she began to receive Social Security of *$630* per month; total income is *$2,250* per month. Because this exceeds the 300% SSI income limit, her medically needy income eligibility is calculated as follows:

$2,250.00	total monthly income
- 20.00	general income exclusion
2,230.00	countable income
- *305.09*	MNIL for 1 month for 1 person in Group I
$1,924.91	spenddown liability
- *653.27*	carry-over expense from retroactive period
$1,271.64	spenddown liability balance

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Her May application is denied and she is placed on a monthly spenddown for the certification period of May 1, 2015 through April 30, 2016.

On June 3, she submits verification of expenses for May. In May, she received CBC services from one provider for 28 days, 6 hours per day, at the private hourly rate of $10. The private cost of care for May is calculated:

$ 10	per hour private rate
x 6	hours per day
$ 60	private per diem cost
x 28	days received services in May
$1,680	private cost of care

The spenddown liability of *$1,271.64 is less than* the private cost of care, $1,680. Therefore, she is eligible for the period 5-1-*2015* through 5-31-*2015.*

M1460.750 MEDICALLY NEEDY ENROLLMENT *AND POST-ELIGIBILITY* PROCEDURES

A. AC

1. Use Appropriate MN AC

- Aged = **018**
- Blind = **038**
- Disabled = **058**
- Child Under 21 in ICF/ICF-MR = **098**
- Child Under 18 = **088**
- Juvenile Justice Child = **085**
- Foster Care/ Adoption Assistance Child = **086**
- Pregnant Woman = **097**

B. Patient Pay

Determine patient pay according to subchapter M1470.

C. MN Post-eligibility Requirements

1. *Facility Patient with* Spenddown Liability Less Than or Equal to Medicaid Rate

When the spenddown liability for *an* individual *who is in a facility* is less than or equal to the *individual's* Medicaid rate, the individual has ongoing eligibility for the 12-month certification period. The individual must file a redetermination after the 12-month certification period ends.

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2. ***All CBC Patients and Facility Patients with* Spenddown Liability Greater Than Medicaid Rate**

When an individual (1) receives CBC or (2) an individual in a facility has a spenddown liability that exceeds *individual's Medicaid rate and meets* a spenddown, the individual does NOT have ongoing eligibility. Therefore, the individual will need to submit monthly reports of actual expenses and changes in income and resources so that spenddown eligibility can be determined each month. This report, "Medical Expense Record - Medicaid" (form # 032-03-023) is found in subchapter M1330, Appendix 1. Instructions for use and completion are also in subchapter M1330, Appendix 1.

The notification to the applicant (and his representative) approving the application with spenddown must include a copy of the "Medical Expense Record - Medicaid" for the individual to use to provide verification of the expenses used to meet the spenddown.

a. When Spenddown Liability is Met

When expenses have been incurred, the individual must submit the "Medical Expense Record - Medicaid" with bills or receipts for medical services either paid or incurred, and evidence of third party payment or denial of payment if applicable. Entitlement begins the first day of the month in which the spenddown is met, and ends on the last day of the month.

Appropriate notice of action must be sent to the applicant every time spenddown eligibility is evaluated. After eligibility is established, the usual reporting and notification processes apply. The individual must provide verification of income and resources for any month for which bills are presented.

b. Certification Period

The certification period is 12 months; therefore, a new application is not required each month. However, the applicant must file a redetermination for Medicaid when the 12-month certification period ends. If the redetermination is not filed, the individual's Medicaid must be canceled, the case must be closed and the individual will have to file a new application.

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Form 200-B
(eff. 9/07)

Partnership Disclosure Notice

[Company Name]
[Company Address]

[Policyholder/Certificateholder] Name:
[Policy/Certificate] Number/Identifier:
Effective Date:

Important Information Regarding Your Policy's [Certificate's]
Long-Term Care Insurance Partnership Status

NOTE: Please keep this Notice with Your Long-Term Care Insurance Policy

Partnership Policy [Certificate] Status. Your long-term care insurance policy [certificate] is intended to qualify as a Partnership Policy [Certificate] under the Virginia Long-Term Care Partnership Program as of your Policy's [Certificate's] effective date.

The long-term care insurance policy [certificate] recently purchased and enclosed qualifies for the Virginia Long-Term Care Insurance Partnership Program. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance policies [certificates] that qualify as Partnership Policies [Certificates] may protect your assets through a feature known as "Asset Disregard" under Virginia's Medicaid program.

Asset Disregard means that an amount of the policyholder's [certificateholder's] assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy [Certificate] will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership Policy [Certificate] without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply and special rules may apply to persons whose home equity exceeds $500,000. **In addition, the purchase of this Partnership Policy does not automatically qualify you for Medicaid.**

What Could Disqualify Your Policy [Certificate] as a Partnership Policy. If you make any changes to your policy [certificate], such changes could affect whether your policy [certificate] continues to be a Partnership Policy. ***Before you make any changes, you should consult with [carrier name] to determine the effect of a proposed change.*** In addition, if you move to a state that does not maintain a Partnership Program or does not recognize your policy [certificate] as a Partnership Policy [Certificate], you would not receive beneficial treatment of your policy [certificate] under the Medicaid program of that state. The information contained in this Notice is based on current Virginia and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your policy [certificate] under Virginia's Medicaid program.

Additional Information. If you have questions regarding your insurance policy [certificate], please contact [carrier name]. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Virginia Department of Medical Assistance Services.

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M1460.000 LTC FINANCIAL ELIGIBILITY	**Appendix 2**	**1**

Form 200-C
(eff. 9/07)

LONG-TERM CARE PARTNERSHIP
CERTIFICATION FORM

Note: This Form must be completed and submitted with each long-term care policy or certificate form for which the insurer is seeking Partnership qualification. A separate form must be completed for each policy form and a specimen copy of the form, including all riders and endorsements, must be attached. A long-term care policy or certificate form may not be issued in Virginia as a partnership policy or certificate unless and until this form has been submitted to and approved by the Bureau of Insurance.

Under § 1917(b)(5)(B)(iii) of the Social Security Act (42 U.S.C. 1396p(b)(5)(B)(iii)) and in accordance with the 14 VAC 5-200-205 D, the insurer hereby submits information relating to policy or certificate form _____ (form number) to substantiate that the form includes all required consumer protection requirements set forth in § 1917(b)(5)(A) of the Social Security Act (42 U.S.C. 1396p(b)(5)(A)) and that it includes certain specified provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act promulgated by the National Association of Insurance Commissioners (adopted as of October 2000) (referred to herein as the "2000 Model Regulation" and "2000 Model Act," respectively).

Part I:

Name of Insurer _____

Company NAIC # _____

Address _____

_____

_____

Telephone _____

Company Contact Name _____

Title _____

Telephone _____

E-Mail _____

CHAPTER M14
LONG-TERM CARE
SUBCHAPTER 70

PATIENT PAY — POST-ELIGIBILITY TREATMENT OF INCOME

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Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Page 19
TN #DMAS-36	10/1/25	Pages 26, 32, 54
TN #DMAS-35	7/1/25	Pages 1 and 48
TN #DMAS-34	1/1/25	Pages 1, 2, 10, 11, 19, 20, 24
TN #DMAS-33	10/1/24	Pages 1, 2, 2a
TN #DMAS-32	7/1/24	Pages 1, 2, 5, 12, 15, 18-20, 28-30, 44, 54, and 55
TN #DMAS-31	4/1/24	Page 10, 12a, 14 and 14a
TN #DMAS-30	1/1/24	Page 20
TN #DMAS-29	10/1/23	Pages 46-48
TN #DMAS-28	7/1/23	Page 19, Appendix 1
TN #DMAS-27	4/1/23	Page 15
TN #DMAS-26	1/1/23	Pages 19, 20
TN #DMAS-25	10/1/22	Page 20
TN #DMAS-24	7/1/22	Pages 1, 15, 28a, 44, 48-50 Page 14a is a runover page.
TN #DMAS-22	1/1/22	Pages 19, 20
TN #DMAS-21	10/1/21	Page 17
TN #DMAS-20	7/1/21	Pages 11, 20, 26
TN #DMAS-19	4/1/21	Pages 7, 8, 22, 23
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TN #DMAS-3	1/1/17	Table of Contents, page ii Pages 1, 14, 17, 19, 20, 28a, 45-47, 50 Appendix 1, pages 1 and 2
TN #DMAS-2	10/1/16	Pages 12, 27, 28 Pages 12a and 28a were added as runover pages.
UP #11	7/1/15	Pages 43-46 Page 46a was deleted.
TN #100	5/1/15	Pages 2a, 4, 29, 31, 32, 34, 43, 44, 45, 53, 54 Pages 1a, 2, 3a and 4 were renumbered for clarity. Pages 3, 4a, 46 and 46a are runover pages. Pages 1 and 3 are reprinted.
TN #99	1/1/14	Pages 9, 19, 20, 23, 24, 40
TN #98	10/1/13	Pages 9, 24
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APPENDIX

Sample Notice of *Patient Pay Responsibility* from VaCMS ..... Appendix 1 1

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M1470.000 PATIENT PAY-POST-ELIGIBILITY TREATMENT OF INCOME

M1470.001 OVERVIEW

A. Introduction

"Patient pay" is the amount of the long-term care (LTC) patient's income which must be paid as the share of the LTC services cost. This subchapter provides basic rules regarding the post-eligibility determination of the amount of the LTC patient's income which must be paid toward the cost of care. **MAGI Adults, *Hospice recipients receiving services outside a facility and individuals participating in the Medicaid Works program* have no responsibility for patient pay *(see M03 for more information).*** If an individual receiving LTC, also called long-term services and supports (LTSS), loses eligibility in *one of these* covered group*s* and is eligible in *a different* full coverage group, patient pay policy will apply.

B. Policy

The state's Medicaid program must reduce its payment to the LTC provider by the amount of the eligible patient's monthly income, after allowable deductions. Patient pay is calculated using actual verified income after an individual has been determined eligible for Medicaid and for Medicaid LTC services. A *non-Medically Needy* Medicaid recipient who is admitted to a nursing facility, facility for individuals with intellectual disability (ICF-ID) or Medicaid waiver services for less than 30 calendar days must have a patient pay determined for the month(s) in which the recipient is in the facility or waiver services**.** *Medically Needy Medicaid does not cover services in ICF-ID or other facilities for less than 30 days. See M1470.320.* The provider collects the patient pay from the patient or the authorized representative. Patient pay information is fed to the Automated Response System (ARS) and the MediCall Systems for provider verification of patient pay. These systems report the amount of patient pay and the date of service to the provider responsible for collecting patient pay.

C. VaCMS Patient Pay Process

The patient pay calculation is completed in VaCMS. Refer to the VaCMS Help feature for information regarding data entry. The patient pay must be updated in the system whenever the patient pay changes, but at least once every 12 months. If VaCMS is not able to process required transactions, a Patient Pay Correction form (DMAS 9PP), available at https://fusion.dss.virginia.gov/bp/BP- Home/Medical-Assistance/Forms, should be submitted to patientpay@dmas.virginia.gov. If attested income was used to determine eligibility, actual income must be verified to calculate patient pay. If actual income was not obtained while determining eligibility the worker must request income verification to calculate patient pay by adding a comment on the notice. If the verified income affects eligibility for the individual, process as a change. If no additional verification is received, the estimated patient pay remains a liability for the individual.

D. Patient Notification

The patient or the authorized representative is notified of the patient pay amount on the Notice of Patient Pay Responsibility. VaCMS will generate and send the Notice of Patient Pay Responsibility. M1470, Appendix 1 contains a sample Notice of Patient Pay Responsibility generated by VaCMS. DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into the Medicaid Enterprise System (MES, formerly MMIS).

The provider is the only entity with the authority to take action when residents do not pay their patient pay amount. If a resident, or his authorized representative is negligent in paying his patient pay amount to the provider, the provider will provide written documentation regarding the requirement to pay the patient pay amount to the resident or authorized representative and follow the provider's collection procedures to collect the funds. The provider will report the resident's negligence in paying the patient pay amount to the LDSS.

The provider's failure to collect the patient pay, or the patient's failure to pay the patient pay, does not itself affect the patient's Medicaid eligibility. However, the

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EW must review the patient's resources each month to determine if the resources are within the Medicaid limit.

If the individual resides in a nursing facility and the above attempts to collect the patient pay amount are unsuccessful, DMAS has advised that the facility may take one of the following options:

1. Facility Option #1

The facility will notify the LDSS no later than 120 calendar days from the due date of the payment. The facility will include in this notification a copy of the third collection statement, a written notification of the situation, documentation of contacts made with the resident or authorized representative, and the reasons why payment has not been made.

The LDSS will take the following steps:

- Upon receipt of the written notice from the facility, the local DSS will review the case to determine if the individual's resources are within Medicaid eligibility limits or if a transfer of assets has occurred.

- If the individual alleges that he does not receive sufficient income to pay his patient pay, the eligibility worker will review the patient pay amount and make any necessary adjustments.

2. Facility Option #2

Discharge or transfer the resident, including transferring the resident within the facility, except as prohibited by the Virginia State Plan for Medical Assistance Services.

Prior to discharge or transfer, the facility must provide reasonable and appropriate notice of the required patient pay, and the resident or authorized representative must be given at least 30 *calendar* days written notice prior to the discharge or transfer, which shall include appeal rights. If the resident or authorized representative does not agree with this action, *they* may submit an appeal request to DMAS. The individual will be allowed to continue residing in the facility during the appeal process.

M1470.100 AVAILABLE INCOME FOR PATIENT PAY

A. Gross Income

Eligibility can be determined using reasonable compatibility, but income must be verified to establish patient pay. Gross monthly income is considered available for patient pay. Gross monthly income includes the same income sources used to determine an individual's eligibility in the 300% SSI income group. It includes types and amounts of income which are excluded when determining medically needy eligibility. Patient pay is a post-eligibility determination. If actual income was not obtained while determining eligibility the worker *must add a* request *for income* verification *to calculate patient pay* by adding a comment on the notice. If the verified income affects eligibility for the individual, process as a change. *If no additional verification is received, the estimated patient pay remains a liability for the individual.*



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1. 300% SSI Group

If the individual is eligible in the 300% SSI group, to determine patient pay start with the gross monthly income *from the sources used* for eligibility. Then add and deduct any amounts that are listed in subsection C. below.

2. Groups Other Than 300% SSI Group

If the individual is eligible in a covered group other than the 300% SSI group, determine the individual's patient pay income using subsections B. and C. below.

B. Income Counted For Patient Pay

All countable sources of income for the 300% SSI group listed in section M1460.611 are considered income in determining patient pay. Any other income NOT specified in C. below is counted as income for patient pay.

1. Aid & Attendance and VA Pension Payments

Count the total VA Aid & Attendance payments and/or VA pension payments in excess of $90.00 per month as income for patient pay when the patient is:

- a veteran who does not have a community spouse or dependent child,
- a deceased veteran's surviving spouse who does not have a dependent child, or
- a veteran's dependent child.

Do not count any VA Aid & Attendance payments and/or VA pension payments when the patient is:

- a veteran who has a community spouse or dependent child, or
- a deceased veteran's surviving spouse who has a dependent child.

NOTE: This applies to all LTC recipients, including patients who reside in a Veterans Care Center.

2. Non-Refundable Advance Payments To *LTSS* Providers

Advance payments and pre-payments paid by a recipient to the *LTSS* provider that will not be refunded are counted as income for patient pay. M1470.1100 contains instructions for calculating the patient pay when an advance payment has been made to reduce resources within a month.

C. Income Excluded For Patient Pay

Income from sources listed in subchapter M1460.610 "What is Not Income" is not counted when determining patient pay, **EXCEPT** for the VA Aid & Attendance and VA pension payments to veterans which are counted in the patient pay calculation (see B. above). Additional types of income excluded from patient pay are listed below.

1. SSI & AG Payments

All SSI and Auxiliary Grants (AG) payments are excluded from income when determining patient pay.

2. Certain Interest Income

a. Interest or dividends accrued on excluded funds which are set aside for burial are not income for patient pay.

b. Interest income when the total interest accrued on all interest-bearing accounts is less than or equal to $10 monthly is not income for patient pay. Interest income that is not accrued monthly must be converted to a monthly amount to make the determination of whether it is excluded.

- Verify interest income at application and each scheduled redetermination.



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- If average interest income per month exceeds $10.00 and is received less often than monthly, it must be treated as a lump sum payment for patient pay purposes. Refer to Section M1470.1000 of this subchapter for procedures and instructions.

3. Repayments

Amounts withheld from monthly benefit payments to repay prior overpayments ***are*** income for patient pay *unless the exception in S0830.110 is met*. The patient or his representative should be advised to appeal the withholding *with the benefit source.*

4. CBC Additional Care

Additional care purchased outside of a CBC recipient's plan of care is not counted as income available for patient pay if it is purchased by someone other than the recipient. This additional care may be purchased from any source including the agency providing the CBC.

5. Refundable Payments to LTC Facilities

The family of a prospective Medicaid patient or other interested party may make an advance payment on the cost of facility care prior to or during the Medicaid application process to assure the patient's admission and continued care. The individual may have been promised that the advance payment will be refunded if Medicaid eligibility is established.

Advance payments made by a person other than the patient and which are expected to be reimbursed once Medicaid is approved, as well as payments made by outside sources to hold the facility bed while the patient is hospitalized, are **not counted as income** in determining eligibility or patient pay.

The facility must reimburse any payment contributed toward the cost of patient care pending a Medicaid eligibility determination once Medicaid eligibility is established.

6. Survivor's Benefit Plan Deductions from Military Pensions

Any portion of a military retiree's pension that is withheld as a contribution to participate in the Survivor's Benefit Plan (SBP) is not income for patient pay. To participate in SBP in conjunction with their retirement, military members must elect to receive reduced retirement pay for their lifetime so that a percentage of their retirement pay can continue to be paid to their survivors following their death. Once SBP is elected, retirees cannot discontinue the deductions from their pensions.

M1470.200 FACILITY PATIENTS - ALLOWABLE DEDUCTIONS FROM INCOME

A. Introduction

Sections M1470.210 through 240 are the only allowable deductions from a facility patient's gross monthly income when calculating patient pay in the month of entry and subsequent months when the patient does not have a community spouse.

If the individual is married and his spouse is in a nursing facility, then there is no community spouse and each spouse is treated as an unmarried individual for patient pay purposes. When the patient is an institutionalized spouse with a community spouse, as defined in subchapter M1480, go to subchapter M1480 to determine the institutionalized spouse's patient pay.



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B. Order of Patient Pay Deductions

Deductions from gross monthly income are subtracted in the order presented below. Deductions are made only to the extent that income remains after a prior deduction has been subtracted. Therefore, if the patient has no income remaining after a deduction, no additional deductions can be made.

1. Personal Needs

See section M1470.210 "Facility Personal Needs Allowance."

2. Dependent Child Allowance

See section M1470.220 "Dependent Child Allowance."

3. Noncovered Medical Expenses

See section M1470.230 "Facility - Noncovered Medical Expenses."

4. Home Maintenance Deduction

See section M1470.240 "Facility - Home Maintenance Deduction."

C. Appeal Rights

The patient or his representative has the right to appeal the patient pay determination, the amounts used in the calculation and denial of any request for adjustment. If a recipient or his representative appeals the patient pay, the EW or Medicaid Technician who made the decision prepares the appeal summary and attends the hearing.

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M1470.210 FACILITY PERSONAL NEEDS ALLOWANCE

A. Policy

The personal needs allowance is calculated according to the instructions in this section for the month of entry and subsequent months. The amount of the personal needs allowance depends on whether or not:

- the patient has a guardian or conservator who charges a fee; or
- the patient has earnings from employment that is part of the treatment plan.

The personal needs allowance is the sum of the basic personal allowance plus the guardianship fee and/or special earnings allowance, if applicable.

1. Basic Personal Allowance

Deduct $40 per individual.

2. Guardianship Fee

Deduct an amount up to 5% of the patient's gross monthly income (including amounts not counted as income and excluded income) for guardianship fees, if the patient has a legally appointed guardian or conservator AND the guardian or conservator charges a fee. The guardianship filing fees CANNOT be deducted from the individual's income. Document how it was determined that the guardian/conservator charges a fee and the amount of the fee.

No deduction is allowed if the patient’s guardian receives a payment for providing guardianship services from a public agency or organization that receives funding for guardianship services.

No deduction is allowed for representative payee or "power of attorney" fees or expenses.

3. Special Earnings Allowance

Working patients are allowed a higher personal needs allowance if they meet the following criteria. These patients will be identified by the facility. The patient must regularly participate in vocational activity which is a planned habilitation program and is carried out as a therapeutic work program, such as:

- sheltered workshops
- vocational training
- pre-vocational training.

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Deduct a special earnings allowance if the patient participates in a work program as part of treatment. The special earnings allowance is deducted from earned income only. Subtract:

- the first $75 of gross monthly earnings, PLUS
- ½ the remaining gross earnings,
- up to a maximum of $190 per month.

The special earnings allowance cannot exceed $190 per month.

4. Example - Calculation of Personal Needs Allowance

A patient in the nursing facility is employed as a telephone salesperson as part of *the* plan of care in the facility. Has a legally appointed guardian who charges a 2% fee. *The* only income is gross earnings of $875 per month. The patient receives deductions for the basic allowance, the guardianship fee, and the special earning allowance.

Special earnings allowance is calculated first:

$875 gross earned income
- 75 first $75 per month 800 remainder
□ 2
400 ½ remainder
+ 75 first $75 per month
$475 which is > $190

Personal needs allowance is computed as follows:

$ 40.00	basic allowance
+190.00	special earnings allowance
+ 17.50	guardian fee (2% of $875)
$247.50	personal needs allowance

M1470.220 DEPENDENT CHILD ALLOWANCE

A. Unmarried Individual or Married Individual With No Community Spouse

An unmarried individual, or married individual without a community spouse, who has a minor dependent child(ren) under age 21 in the community, can have a dependent child allowance**.** When the individual verifies a dependent child(ren) in the community:

- Calculate the difference between the appropriate monthly medically needy income limit (MNIL) for the child's locality for the number of minor dependent children in the home, and the child(ren)'s gross monthly income. If the child lives outside of Virginia, use the Group III MNIL.

- The result is the dependent child allowance. If the result is greater than $0, deduct it from the patient's monthly income as the dependent child allowance. If the result is $0 or less, there is NO dependent child allowance.

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The dependent child allowance *cannot be given when* the dependent child(ren)'s gross monthly income exceeds the monthly MNIL for the number of children in the child(ren)'s locality, if money is not made available or he does not accept the monthly income allowance.

Do NOT deduct any allowance for other family member(s).

1. Example--One Dependent Child (Based on July 2008 figures)

Mrs. K is a married individual who is now residing in a nursing facility. Her spouse is in another medical facility. Their dependent child lives with her sister in a Group II locality. The child receives a $95.00 of Social Security income per month.

The allowance for the dependent child is calculated as follows:

$ 265.39	MN limit for 1 (Group II)
- 95.00	child's SSA income
$ 170.39	dependent child's allowance

NOTE: If Mrs. K's institutionalized spouse is eligible for Medicaid, an allowance for their child may also be deducted from his income in determining his patient pay. However, the income the child receives from Mrs. K will be counted in the child's gross income when determining any allowance from Mr. K.

2. Example--Two Dependent Children (Based on July 2008 figures)

Mr. H is a single individual with gross monthly income of $920, living in a nursing facility. He is divorced and has two children under age 21 who live with his ex-wife in Group I. His two children each receive $75 of monthly Social Security income.

The allowance for the dependent children is calculated as follows:

$ 337.92	MN limit for 2 (Group I)
- 150.00	children's total monthly SSA income
$ 187.92	dependent children's allowance

M1470.230 FACILITY - NONCOVERED MEDICAL EXPENSES

A. Policy

Amounts for incurred medical and dental expenses not covered by Medicaid or another third party are deducted from the patient's gross monthly income when determining patient pay.

B. Health Insurance Premiums

1. *Private or Commercial Insurance*

Payments for medical/health insurance, *including dental insurance*, which meet the definition of a health benefit plan are deducted from patient pay when:

- the premium amount is deducted from the patient's benefit check;
- the premium is paid from the patient's own funds; OR
- the premium is paid by a relative (other than a spouse or parent for minor child) when that relative receives a benefit payment (income) which includes a benefit amount for the patient.



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The amount deducted is the amount of the **monthly** premium. If the patient pays the premium less often than monthly, such as quarterly, prorate the amount paid by the number of months covered by the payment to obtain the monthly amount to deduct in the patient pay calculation.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA (Multiple Employer Welfare Arrangement) or plan provided by another benefit arrangement.

Health benefit plan does not mean accident only, credit, or disability insurance; long-term care insurance; vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance (14VAC5-234-30).

Income protection insurance (indemnity) policy premiums are not medical expenses and are not deducted from the patient pay.

Membership fees for an organization that sponsors or provides the health insurance are not part of the premium and are not deductible.

2. Medicare Part A and/or B Premiums

Medicare Part B premiums and/or Medicare Part A premiums are paid by Medicaid for eligible individuals. The premiums are paid by Medicaid via the "buy-in" and are not usually deducted from patient pay. However, Medicaid does not start paying the premiums immediately for all eligible patients, so the Medicare premium(s) must be deducted from patient pay in those months for which Medicaid does not pay the premium.

For Categorically Needy (CN) individuals enrolled in the 300% SSI covered group in Aid Categories (ACs) 020, 040, and 060 and Medically Needy (MN)-*only individuals in ACs 018, 038, and 058*, the Medicare buy-in is effective **2 months after the begin date** of Medicaid coverage. If the begin date of coverage is other than the first day of a month, the buy-in is effective the first of the month in which the 60th day occurs. Part B premiums (and Part A premiums if the recipient must pay the Part A premium) must be deducted from patient pay in the month(s) in which the buy-in is not effective.

Deduct the Medicare premium(s) for the first two months of coverage for *individuals in the following ACs:*

- *CN 300% SSI and not dually eligible as a Qualified Medicare Beneficiary (QMB) or a Special Low-income Medicare Beneficiary (SLMB) Plus - ACs 020, 040, 060*
- *MN and not also QMB or SLMB - ACs 018, 038, 058.*

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For individuals *in other ACs*, the buy-in is effective with the begin date of Medicaid coverage. Therefore, do NOT deduct Medicare premiums in the patient pay determination for months in the retroactive and ongoing coverage periods.

The Medicaid Medicare buy-in does NOT pay for Medicare premiums in closed periods of coverage for LTC patients who are on spenddown and whose eligibility is for a closed period. Deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from patient pay in the month(s) in which the buy-in is NOT effective.

The Medicaid Medicare buy-in pays for Medicare premiums in retroactive coverage and closed periods of coverage EXCEPT for LTC patients who are on spenddown. DO NOT deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from the patient pay in the month(s) in which the buy-in is effective for LTC patients who are NOT on spenddowns.

3. Example--Dual Eligible QMB

Mrs. Q has Medicare coverage and SSA income of $580 per month. Her Medicare premiums are deducted from her SSA check. She was admitted to the nursing facility on September 9. Her daughter filed a Medicaid application for her on September 10.

Mrs. Q is eligible in the *CN* 300% SSI group in September and is eligible as QMB. Her Medicare premiums are not deducted for September because they will be paid by Medicaid.

4. Example--Not Dual Eligible QMB

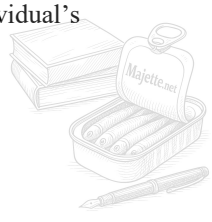
Mr. A was admitted to a nursing facility on March 5. He applied for Medicaid on June 2. His monthly income is $1,295, and his Medicare Part B premium is deducted from his SSA check. He is determined to be eligible in the *CN* 300% SSI covered group effective March 1.

His patient pay for March (the month of entry) includes a deduction for the Medicare premium. Because he is not QMB eligible, the buy-in is effective in May, the second month following the month in which his ongoing Medicaid coverage began. The cost of his Medicare Part B premium is deducted from his patient pay for the months of March and April, as his buy-in will be in effect beginning with the month of May.

If the buy-in is delayed for any reason, the individual will be reimbursed by SSA for premiums deducted after the second month.

5. Medicare Advantage (Part C) Premiums

Medicare Advantage plans, also referred to as Medicare Part C, are voluntary managed-care Medicare plans. In addition to Medicare Part B premiums, some individuals may pay an extra Medicare Advantage premium. The Medicaid Medicare buy-in is initiated for individuals with Medicare Advantage ; however, the buy-in covers only the allowable Medicare Part A and/or B premiums. The individual is responsible for any additional Medicare Advantage monthly premium. The Medicare Advantage monthly premium remains the individual's responsibility and is an allowable deduction from patient pay.



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6. **Medicare Part D Premiums**

An individual who is eligible for Medicare and Medicaid is entitled to enrollment in a basic Medicare Part D prescription drug plan (PDP) *at no cost*. However, the individual may elect enrollment in a plan with a premium.

When a full-benefit Medicaid enrollee is enrolled in *a Medicare Part D* PDP, *any* premium that is the individual's responsibility is an allowable deduction from patient pay.

7. LTC Insurance

a. Deduct LTC premium in admission month only

When an individual has an LTC insurance policy, the individual stops paying premiums beginning the month after he is admitted to LTC. The premium paid for the policy in the admission month can be deducted from the admission month's patient pay only. The LTC insurance premium is not deducted from patient pay for the months following the admission month.

b. LTC insurance benefits

LTC insurance benefits are treated as *Third Party Liability* (TPL). If the individual receives the payment from the insurance company, the payment is not income for patient pay or eligibility determinations. The individual should assign it to the nursing facility. If the individual cannot do this, or the policy prohibits assignment, the LTC insurance payment should be given directly to the nursing facility. The facility should report the payment as a third party payment on its claim form.

If the provider is unable to accept payment directly from the individual, the individual must send the insurance payment to:

DMAS Fiscal Division, Accounts Receivable
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

C. Non-covered Medical/Dental Services

Deductions for the cost of a patient's medically necessary medical or dental services not covered by Medicaid, other insurance (such as Medicare), or another person are subtracted from income to determine patient pay. Some deductions for noncovered services must be approved by DMAS before they can be subtracted from the patient's income.

Services that are covered by Medicaid in the facility's per diem rate cannot be deducted from patient pay as a noncovered service. See M1470.230 C.3 for examples of services that are included in the facility per diem rate.

1. Zero Patient Pay Procedures

If deductions from patient pay cannot be allowed because the recipient has no income remaining after deducting the personal needs allowance, dependent child allowance(s) and health insurance premiums, or the recipient has no income available for patient pay, deny the request.

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Notify the patient or the patient' authorized representative of the denial of the request using the Notice of Action.

If a noncovered service is already being deducted, leaving no patient pay, and a new deduction for another noncovered service has been approved, notify the patient or his authorized representative that the deduction for the new noncovered service will be made after the first noncovered service deductions are completed.

2. Allowable Non-covered Expenses

When a patient has income available for patient pay, the following can be deducted as noncovered expenses:

a. Old Bills

"Old bills" are deducted from patient pay as noncovered expenses. "Old bills" are unpaid medical, dental, or remedial care expenses which:

- were incurred prior to the Medicaid full coverage effective date, or the service was not a Medicaid- covered service;
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met; **and**
- remain a liability to the individual.
- **"Old bills" do not require approval from DMAS in order to be deducted in the patient pay calculation even when the amount of the "old bill" exceeds $500.**

b. Services Provided By A Non-participating Provider

Medical and dental services that are covered by Medicaid, but that the Medicaid enrollee receives from a provider who does not participate in Virginia Medicaid, *CAN* be deducted from patient pay as non-covered services.

c. Covered Services Outside of Medicaid's Scope

Medically necessary medical and dental services exceeding Medicaid's amount, duration, or scope can be deducted from patient pay. Scope includes benefits or services provided by the enrollee's MCO (managed care organization).

d. Other Allowable Noncovered Services

1) The following medically necessary medical and dental services that are NOT covered by Medicaid or by benefits provided by the enrollee's MCO can be deducted from patient pay by the local department of social services without DMAS approval when the cost does NOT exceed $500. **If the service is not identified in the list below and/or the cost of the service exceeds $500, send the request**



and the documentation to DMAS for approval (see M1470.230 C.5). DMAS will advise the eligibility worker if the adjustment is allowable and the amount that is to be allowed.

- dental services **not *provided by a Medicaid provider or*** **covered by Medicaid.** Effective July 1, 2021, Medicaid covers dental services for full-benefit adults, as well as children (see M1850.100.D). **Pre-approval for dental services that exceed $500 must be obtained from DMAS prior to receipt of the service;**
- routine eye exams, eyeglasses and eyeglass repair;
- hearing aids (when medically necessary), hearing aid batteries and hearing aid repair;
- batteries for power wheelchairs or other power mobility items owned by the recipient, not to exceed four batteries in a 12-month period;
- chiropractor services, except for Medicare recipients (Medicare covers chiropractor services and Medicaid covers the Medicare deductible and coinsurance amounts);
- dipyridamole (Persantine) and other prescription medications not covered by Medicaid but ordered by the recipient's physician;
- **transportation to medical, dental or remedial services not covered by Medicaid.**

2) Services received by a Medicaid enrollee during a period of limited Medicaid eligibility (e.g., LTC services not covered because of a property transfer) can be deducted in the patient pay calculation by the local agency without DMAS approval even when the amount of the service exceeds $500.

e. Medicare Part D

Individuals who:

- qualify for Medicare Part D,
- are NOT enrolled in a Medicare Prescription Drug Plan (PDP), and
- are NOT Medicaid eligible at the time of admission to a nursing facility,

will be fully responsible for their drug costs until Medicaid eligibility is determined and the Medicare Part D PDP enrollment process is completed. The individual remains responsible for any drugs purchased prior to the effective date of the PDP enrollment; Medicaid cannot pay for these drugs. The cost of drugs purchased before the PDP begin date can be deducted from patient pay.

Medicaid-enrolled nursing facility patients who are enrolled in a Medicare Part D PDP are **not** responsible for the payment of deductibles or co-pays, nor will



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they be subject to a coverage gap in their Part D benefits. Do NOT deduct from patient pay any Medicare PDP deductibles, co-pays or coverage gap costs beyond the month of admission into the nursing facility.

If a full-benefit Medicaid/Medicare recipient was subject to PDP co-pays prior to *the* admission to a nursing facility, *the individual* may continue to be assessed co-pays until the PDP is notified of *the* admission to the nursing facility. Deduct PDP co-pays incurred during the month of admission to the nursing facility only.

If an individual is enrolled in Part D and is in a nursing facility but was not eligible for Medicaid at the time of admission to the nursing facility, *the individual* may continue to be charged co-pays or deductibles until the PDP is notified of his eligibility as a full-benefit Medicaid enrollee. Deduct PDP co-pays incurred during first month of Medicaid eligibility in the nursing facility only.

3. Services NOT Allowed

Types of services that CANNOT be deducted from patient pay include:

a. medical supplies and equipment that are part of the routine facility care and are included in the Medicaid per diem, such as:

- diabetic and blood/urine testing strips,
- bandages and wound dressings,
- standard wheelchairs,
- air or egg-crate mattresses,
- IV treatment,
- splints,
- certain prescription drugs (placebos).

b. TED stockings (billed separately as durable medical supplies),
c. acupuncture treatment,
d. massage therapy,
e. personal care items, such as special soaps and shampoos,
f. ancillary services, such as physical therapy, speech therapy and occupational therapy provided by the facility or under arrangements made by the facility.

i. services that are NOT medical/remedial care services, even if ordered by a physician:

- air conditioners or humidifiers,
- refrigerators, whole house generators and other non-medical equipment,
- assisted living facility (ALF) room & board and services**,**
- personal comfort items, such as reclining chairs or special pillows,
- health club memberships and costs,
- animal expenses such as for seeing eye dogs,
- cosmetic procedures.

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3a. Managed Care Organizations and *Cardinal Care* (effective *October 1, 2023*)

As of *October 1, 2023*, the majority of Medicaid-eligible individuals who receive long-term service and support (LTSS) are covered under *Cardinal Care* through one of *five (5)* managed care organizations (MCOs). As part of *Cardinal Care*, each health plan offers enhanced benefits, such as adult dental services or hearing aids, outside of the required contracted Medicaid services. Some of these enhanced benefits are frequently submitted to the LDSS as patient pay adjustment.

If there are other coverage sources available for these services or items, Medicaid policy requires the request for coverage first be submitted to those sources and exhausted there, before the LDSS/DMAS may consider or approve a patient pay adjustment.

A process is in development to develop a procedure for distinguishing MCO enhanced benefit services from allowable patient pay deductions. Until further notice, providers and nursing facilities will continue sending all patient pay adjustment requests to the patient's LDSS eligibility worker.

Eligibility workers will review and process patient pay adjustment requests without requiring submission of the request to the individual's CCC Plus plan.

4. Documentation Required

a. Requests For Adjustments From A Patient or Authorized Representative

Request the following documentation from the patient or his representative:

- a copy of the bill;
- if applicable, the amount owed that was not covered by the patient's insurance;
- proof that the service was medically necessary. Proof may be the prescription, doctor's referral**,** or a statement from the patient's doctor or dentist. Proof applies to a physician, doctor, or dentist's current, and not "standing", order(s).

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The local agency can make the adjustment for services identified in subsection C. 2. b. through d.1), above providing the cost of the service does not exceed $500. If the cost of the service is not identified in subsection C. 2. b. through d. 1), or exceeds $500, send the documentation to DMAS to obtain approval and the allowable amount of the adjustment (reimbursement is limited to the prevailing Medicaid or Medicare rate).

b. Requests For Adjustments From LTC Providers

If the request for an adjustment to patient pay to deduct one of the above expenses is made by a nursing facility, ICF-MR, long-stay hospital, or *Department of Behavioral Health and Developmental Services (DBHDS)* facility, the request must be accompanied by:

1) the recipient's correct Medicaid ID number;

2) the current physician's order for the non-covered service (not required for replacement of hearing aid batteries or eyeglass frames or for repair of hearing aids or eyeglasses);

3) actual cost information;

4) documentation that the recipient continues to need the equipment for which repair, replacement, or battery is requested; and

5) a statement of denial or non-coverage by other insurance. The denial may be from the insurance carrier or may be a written statement from the facility that the insurance company was contacted and the item/service is not covered.

If the request from a facility does not include all the above documentation, return the request to the facility asking for the required documentation.

When the cost of the service cannot be authorized by the local department of social services and/or exceeds $500, send the request and the documentation to DMAS to obtain approval for the adjustment and the allowable amount of the adjustment (reimbursement is limited to the prevailing Medicaid or Medicare rate). DMAS must be notified of the name and address of the recipient's spouse, POA or guardian so that proper notification of the decision can be given.

5. Procedures

a. DMAS Approval Required

Requests for adjustments to patient pay for services not included in subsection C.2. b. through d.1) above, or for any service which exceeds $500, must be submitted by the provider to the DSS worker. The DSS worker sends the request and documentation to:

Health Care Compliance Program Analyst
Division of Program Operations, Customer Service Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

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Do not send requests for adjustments to DMAS when the patient has no available income for patient pay. Refer to M1470.230 C.5.c for notification procedures to be followed by the local worker.

When a request for an adjustment is approved or denied by DMAS, the local DSS worker will receive a copy of the letter sent to the recipient by DMAS:

1) If approved, adjust the patient pay using the VaCMS Patient Pay process.

2) If the adjustment request is denied, DMAS prepares the notification.

b. DMAS Approval Not Required

Determine if the expense is deducted from patient pay using the following sequential steps:

1) Upon receipt of the requested documentation, determine the amount of the bill that is a valid deduction. Do not deduct more than the available income that remains after the personal needs, dependent child allowance(s), and health insurance premiums are deducted.

   If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service is requested, deduct the new noncovered services after the first noncovered service deductions have been completed.

2) Subtract the deduction for the month following the month the change is reported. If the deduction exceeds the available income, the remaining balance can be carried over to the following month(s).

c. Notice Procedures

Upon the final decision to allow the deduction, use the VaCMS Patient Pay process to adjust the patient pay. VaCMS will generate and send the Notice of *Patient Pay Responsibility*.

6. *Cardinal Care* Managed Care Organizations (effective *October 1,2023*)

As of *October 1, 2023*, the majority of Medicaid-eligible individuals who receive long-term care (LTC) services are covered under *Cardinal Care* through one of six (6) managed care organizations (MCOs). As part of *Cardinal Care*, each health plan offers enhanced benefits outside of the required contracted Medicaid services. Some of these enhanced benefits are frequently submitted to the LDSS as patient pay adjustment.

If there are other coverage sources available for these services or items, Medicaid policy requires the request for coverage first be submitted to those sources and exhausted there, before the LDSS/DMAS may consider or approve a patient pay adjustment.

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A process is in development to develop a process for distinguishing MCO enhanced benefit services from allowable patient pay deductions. Until further notice, providers and nursing facilities will continue sending all patient pay adjustment requests to the patient's LDSS eligibility worker.

Eligibility workers will review and process patient pay adjustment requests without requiring submission of the request to the individual's *Cardinal Care* plan.

M1470.240 FACILITY - HOME MAINTENANCE DEDUCTION

A. Policy

A single institutionalized individual can be allowed a deduction for the cost of maintaining a home for not more than six months, if a physician has certified he or she is likely to return home within that period.

Home maintenance means that the individual has the responsibility to pay shelter costs on his former place of residence in Virginia, such as rent, mortgage, utilities, taxes, room and board, or assisted living facility (ALF) payments, and that the home, apartment, room or bed is being held for the individual's return to his former residence in Virginia. Individuals who have no responsibility to pay shelter costs are not permitted a home maintenance deduction. If responsibility for shelter costs is questionable, documentation must be requested and provided.

EXCEPTION: For an individual admitted to a nursing facility from an ALF, deduct a home maintenance allowance for the month of entry even if the admission to the nursing facility is not temporary.

Only one spouse of an institutionalized married couple (both spouses are in a medical facility) is allowed the deduction to maintain a home for up to six months, if a physician certifies that he is likely to return home within that period.

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B. Temporary Care

Temporary care is defined as not exceeding 6 months of institutionalization, beginning the **month** of admission to the medical facility. A physician's written statement or a DMAS 225 from the individuals managed care plan indicating that the individual is expected to return to his home within 6 months of admission is required to certify temporary care. If the individual is in the facility less than 6 months and returns to a community living arrangement, temporary care status is assumed and patient pay should be adjusted with the home maintenance allowance for the entire period of institutionalization. When the temporary care period ends, the home maintenance deduction must be discontinued.

The DMAS 96 no longer relays information about the expected length of stay. Assume that the stay is not temporary unless notified by the individual, authorized representative, or managed care plan. A written statement from a physician or a DMAS 225 notification from the managed care plan that the individual is expected to return home within 6 months is acceptable in lieu of a physician's statement.

C. Amount Deducted

The home maintenance deduction is the MNIL for one person in the individual's locality of residence. See Appendix 5 to subchapter M0710 or section M0810.002 A. 4 for the MN income limits.

M1470.300 FACILITY PATIENTS

A. Overview

This section provides policy and procedures for calculating patient pay for the facility patient.

B. Policy and Procedures

Policy and procedures for determining patient pay in the most common admission situations are contained in the following sections:

- Facility Admission From A Community Living Arrangement (M1470.310)
- Patient pay for facility stay of less than 30 *calendar* days (M1470.320)

M1470.310 FACILITY ADMISSION FROM A COMMUNITY LIVING ARRANGEMENT

A. Policy

The policy in this section describes the procedures for calculating patient pay for the month of admission and ongoing months for all persons admitted to an LTC facility except:

- persons who received Medicaid CBC in the community during the admission month;
- persons who were admitted from another facility;
- persons admitted to a facility from a state institution.

B. Procedures

To determine patient pay for the admission month, use the procedures in this subsection.



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1. All Covered Groups Except MN Spenddown

For an individual admitted to a facility (except an individual who meets a spenddown), take the following steps in the order presented, to the extent that income remains:

a. Count all income received in the admission month (M1470.100).

b. Deduct a personal needs allowance:

- $40.00 basic personal needs;
- additional amount for guardianship fees, if appropriate;
- additional amount for special earnings allowance, if working.

c. Deduct a dependent child allowance, if appropriate (M1470.220).

d. Deduct the Medicare premium withheld if the applicant is a Medicare recipient and was not receiving Medicaid prior to admission (see M1470.230).

e. Deduct other health insurance premiums, deductibles or co-insurance charges, if appropriate (M1470.230).

f. Deduct other allowable noncovered medical expenses, if appropriate (M1470.230).

g. Deduct the home maintenance (MNIL) deduction **if appropriate**, if a doctor has certified that the individual is likely to return home within a six-month period (see M1470.240). For recipients who are admitted for a stay that has been for less than 30 days, a physician certification of length of stay is NOT required.

h. Any remainder is the patient pay for the month(s).

2. MN Spenddown Individual in Facility for Less than 30 Days

For a medically needy individual on a spenddown who is in a facility for less than 30 days, see section M1470.320 B. for procedures.

3. MN Spenddown Individual In Facility For More Than 30 Days

For an institutionalized medically needy individual, see Section M1470.600 for procedures.

M1470.320 PATIENT PAY FOR FACILITY STAY OF LESS THAN 30 DAYS

A. All *Full Coverage* Groups Except MN Spenddown

To determine patient pay for a non-institutionalized individual *with full Medicaid coverage* admitted to a facility for less than 30 days (except an individual who meets a spenddown), use the procedures in subsection M1470.310 B.1 for the admission month and for the subsequent month when the facility stay continues into the month after admission. *Individuals with limited-coverage Medicaid do not have a patient pay since facility care is not covered.*



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B. Non-Institutionalized Individuals on MN Spenddown

A non-institutionalized MN individual who is on a spenddown is not eligible for Medicaid until the spenddown is met. Non-institutionalized MN individuals are either on a three-month retroactive or six-month ongoing spenddown.

1. Individual Who Meets the Spenddown

For a non-institutionalized MN individual who meets the spenddown on a date that is within the dates of facility service, take the following steps to determine patient pay:

a. Add together the number of days in the facility stay that are NOT covered by Medicaid. Multiply the result by the facility's private pay daily rate.

b. Determine the remaining balance of the spenddown prior to applying the bill that caused the spenddown to be met.

c. Add the amount in a. above to the figure obtained in b. above. The total is the individual's patient pay for the part of the facility stay that occurs in the spenddown coverage period.

d. Enter patient pay *using* VaCMS.

2. Example – Spenddown Met

Mr. B, an unmarried 70 year-old individual living in a Group II locality, filed an initial application for Medicaid on October 5, 1999. He had excess income and was placed on a spenddown of $2000 for the period October 1, 1999 through March 31, 2000. On October 8, 1999, he was admitted to a nursing facility for temporary care that is expected to be less than 30 days.

On November 10, 1999, his authorized representative asks for his spenddown to be re-evaluated due to his admission to the nursing facility. The representative also submits medical bills incurred before October 8, 1999, that the worker determines leave a spenddown balance of $500 as of October 8, 1999. The nursing facility charges him $120 per day; the Medicaid per diem is $85. His spenddown is determined:

$2000	spenddown liability October 1, 1999-March 31, 2000
- 1500	old bills incurred prior to October 1, 1999
500	spenddown balance on October 1, 1999
- 50	doctor's charge on October 5, 1999 (after TPL pays)
- 120	private pay rate on October 8, 1999
330	spenddown balance beginning October 9, 1999
- 120	private pay rate on October 9,1999
210	spenddown balance beginning October 10, 1999
- 120	private pay rate on October 10, 1999
90	spenddown balance beginning October 11, 1999
- 120	private pay rate on October 11, 1999
$ 0	spenddown met on October 11, 1999

Mr. B met his spenddown on October 11, 1999. Medicaid coverage begins on October 11, 1999 and ends on March 31, 2000, the end of the six month spenddown budget period.

He is discharged from the nursing facility to his home without CBC on November 1, 1999. He was in the nursing facility for less than 30 days. His patient pay for the October 8, 1999 through November 1, 1999 stay is determined:



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a) 3 number of days in the nursing facility that are NOT covered by the individual's Medicaid coverage period (October 8 through October 10)
x 120 facility private pay daily rate
$ 360 amount of the spenddown liability for which the individual is responsible.

b) $90 is the spenddown balance on the date the spenddown was met, therefore, the individual is responsible to pay the $90 to the nursing facility. Medicaid will pay the remainder of the cost.

c) $360 amount of the spenddown liability for which the individual is responsible (October 8 - October 10)
+ 90 spenddown balance on October 11; begin date of coverage
$450 individual's patient pay for October 11 through October 31

If his dates in the nursing facility include part of a second month, his patient pay for the second month would be $0.

3. Individual Who Does Not Meet Spenddown

An individual who meets the spenddown on a date after the *discharge* date has full responsibility for the days in the facility. Send the individual a Notice of Action showing the dates of Medicaid coverage and that the facility care was not covered by Medicaid. Send the provider a DMAS-225 regarding the individual's eligibility status.

M1470.400 MEDICAID CBC PATIENTS - ALLOWABLE DEDUCTIONS FROM INCOME

A. Introduction

Sections M1470.410 through 430 are the only allowable deductions from a Medicaid CBC patient's gross monthly income when calculating patient pay when the patient does not have a community spouse. If the patient has a community spouse, go to subchapter M1480 to determine patient pay.

Medicaid CBC patients are not allowed a home maintenance deduction because shelter costs are included in the personal maintenance allowance.

B. Procedure

Subtract the deduction(s) from gross monthly income in the order presented below:

1. Medicaid CBC Personal Maintenance Allowance (M1470.410)

2. Dependent Child Allowance (M1470.420)

3. Medicaid CBC - Incurred Medical Expenses (M1470.430)

C. Appeal Rights

The patient or *the* representative has the right to appeal the patient pay determination, the amounts used in the calculation and denial of any request for adjustment. If a recipient or his representative appeals the patient pay, the EW who made the decision prepares the appeal summary and attends the hearing.



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M1470.410 MEDICAID CBC – PERSONAL MAINTENANCE ALLOWANCE

A. Individuals

For the month of entry and subsequent months, deduct from the patient's gross monthly countable income a personal maintenance allowance (PMA). The amount of the allowance depends upon under which Medicaid CBC waiver the patient receives LTC services.

The total amount of the PMA cannot exceed 300% SSI.

1. Basic Maintenance Allowance

Patients receiving Medicaid CBC under the following waivers are allowed a monthly basic PMA:

- Commonwealth Coordinated Care Plus (CCC Plus) Waiver (formerly the Elderly or Disabled with Consumer-Direction Waiver and the Technology-Assisted Individuals Waiver),
- Community Living (CL) Waiver (formerly Intellectual Disabilities Waiver),
- Family and Individual Supports (IS) Waiver (formerly Individual and Family Developmental Disabilities Support Waiver), and
- Building Independence (BI) Waiver (formerly Day Support Waiver).

Individuals enrolled in the Program for All Inclusive Care for the Elderly (PACE) are also allowed the basic PMA.

The PMA is:

- January 1, 2022 through December 31, 2022: $1,388
- January 1, 2023 through December 31, 2023: $1,509
- January 1, 2024 through December 31, 2024: $1,556
- January 1, 2025 through December 31, 2025: $1,596
- *January 1, 2026 through December 31, 2026: $1,641*

Contact a Medical Assistance Program Consultant for the PMA in effect for years prior to 202*3.*

2. Guardianship Fee

Deduct an amount up to 5% of the patient's gross monthly income (including amounts not counted as income and excluded income) for guardianship fees, if the patient has a legally appointed guardian or conservator AND the guardian or conservator charges a fee. The guardianship **filing** fees CANNOT be deducted from the individual's income. Document how it was determined that the guardian/conservator charges a fee and the amount of the fee.

No deduction is allowed if the patient's guardian receives a payment for providing guardianship services from a public agency or organization that receives funding for guardianship services.

No deduction is allowed for representative payee or "power of attorney" fees or expenses.

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3. Special Earnings Allowance for Recipients in CCC Plus, CL, IS and BI Waivers

Deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

a. for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (*$2,901 in 2025*) per month.

b. for individuals employed at least 4 but less than 20 hours per week, all earned income up to 200% of SSI (*$1,934 in 2025*) per month.

4. Example – Special Earnings Allowance (Using January 2018 figures)

A working patient receiving CCC Plus Waiver services is employed 18 hours per week. Income is gross earnings of $1228.80 per month and SSA of $300 monthly. Special earnings allowance is calculated by comparing gross earned income ($1128.80) to the 200% of SSI maximum ($1,500.00). Gross earned income is less than 200% of SSI; therefore, entitled to a special earnings allowance. Personal maintenance allowance is computed as follows:

$ 1,238.00 CBC basic maintenance allowance
+ 1,128.80 special earnings allowance
$ 2,360.80 PMA

Because the PMA may not exceed 300% of SSI, the PMA for the patient in this example must be reduced to $2,250.00.

B. Couples

The Medicaid CBC waivers do not specify personal maintenance allowances for a married couple living together when both spouses receive Medicaid CBC because each spouse is considered an individual for patient pay purposes. The individual maintenance allowance in section M1470.410 applies to each spouse in a couple when each receives Medicaid CBC.

M1470.420 DEPENDENT CHILD ALLOWANCE

A. Unmarried Individual, or Married Individual With No Community Spouse

For an unmarried Medicaid CBC patient, or a married Medicaid CBC patient without a community spouse, who has a dependent child(ren) under age 21 years in the community:

- Calculate the difference between the appropriate MN income limit for the **child's** home locality for the number of children in the home and the child(ren)'s gross monthly income. If the children are living in different homes, the children's allowances are calculated separately using the MN

- The result is the dependent child allowance. If the result is greater than $0, deduct it from the patient's income as the dependent child allowance. If the result is $0 or less, do not deduct a dependent child allowance.

Do not deduct an allowance if the child(ren)'s monthly income exceeds the MN income limit in the child's home locality for the number of dependent children in the home. Do not deduct an allowance for any other family member.

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1. Example--Two Dependent Children In One Home (Using January 2009 Figures)

Mr. H is a single individual with gross monthly income of $920, living in the community in Group II and receiving Medicaid CBC. He is divorced and has two children under age 18 who live with his ex-wife in Group I. His two children each receive $75 SSA.

The allowance for his dependent children is calculated as follows:

$ 337.92	MN limit for 2 (Group I)
- 150.00	children's SSA income
$ 187.92	dependent children's allowance

2. Example--Three Dependent Children In Two Homes (Using January 2009 Figures)

Mrs. K is a married individual who lives at home in a Group II locality and receives Medicaid CBC. Her spouse is in a medical facility and is not a community spouse. One of their three dependent children lives with Mrs. K. The other two children live with her sister in a Group III locality. The children each receive $95.00 per month SSA.

The allowance for the dependent children is calculated as follows:

$ 306.23	MN limit for 1 (Group II)
- 95.00	child's SSA income
$ 211.23	child's allowance

$ 480.00	MN limit for 2 (Group III)
- 190.00	children's SSA income
$ 290.00	children’s allowance

$ 211.23	child's allowance
+ 290.00	children's allowance
$ 501.23	total dependent children’s allowance

NOTE: If Mrs. K’s institutionalized spouse is eligible for Medicaid, an allowance for their children may also be deducted from his income in determining his patient pay. However, the allowance the children receive from Mrs. K will be counted as part of their income when determining any allowance from Mr. K’s income.

M1470.430 MEDICAID CBC - NONCOVERED MEDICAL EXPENSES

A. Policy

Amounts for incurred medical and dental expenses not covered by Medicaid or another third party, *including services or benefits provided as part of an enrollee’s managed care organization,* are deducted from the patient’s gross monthly income when determining patient pay.

B. Health Insurance Premiums

Payments for medical/health insurance which meet the definition of a health benefit plan, *including dental insurance*, are deducted from patient pay when:

- the premium amount is deducted from the patient's benefit check;

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- the premium is paid from the patient's own funds; OR
- the premium is paid by a relative (other than a spouse or parent for minor child) when that relative receives a benefit payment (income) which includes a benefit amount for the patient.

The amount deducted is the amount of the monthly premium. If the patient pays the premium less often than monthly, such as quarterly, prorate the amount paid by the number of months covered by the payment to obtain the monthly amount to deduct in the patient pay calculation.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA (Multiple Employer Welfare Arrangement) or plan provided by another benefit arrangement.

Health benefit plan does not mean accident only, credit, or disability insurance; long-term care insurance; vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance (14VAC5-234-30).

Income protection insurance (indemnity) policy premiums are not medical expenses and are not deducted from the patient pay.

Membership fees for an organization that sponsors or provides the health insurance are not part of the premium and are not deductible.

1. Medicare Part A and/or Part B Premiums

Medicare Part B premiums and/or Medicare Part A premiums are paid by Medicaid for eligible individuals. The premiums are paid by Medicaid via the "buy-in" and are not usually deducted from patient pay. However, Medicaid does not start paying the premiums immediately for all eligible patients, so the Medicare premium(s) must be deducted from patient pay in those months for which Medicaid does not pay the premium.

For CN individuals enrolled in the 300% SSI covered group in ACs 020, 040, and 060 and MN-*only individuals in ACs 018, 038, and 058*, the Medicare buy-in is effective **2 months after the begin date** of Medicaid coverage. If the begin date of coverage is other than the first day of a month, the buy-in is effective the first of the month in which the 60th day occurs. Part B premiums (and Part A premiums if the recipient must pay the Part A premium) must be deducted from patient pay in the month(s) in which the buy-in is not effective.

Deduct the Medicare premium(s) for the first two months of coverage for *individuals in the following ACs:*

- *CN 300% SSI and not dually eligible as QMB or SLMB Plus - ACs 020, 040, 060*
- *MN and not also QMB or SLMB - ACs 018, 038, 058.*



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For individuals *in other ACs*, the buy-in is effective with the begin date of Medicaid coverage. Therefore, do NOT deduct Medicare premiums in the patient pay determination for months in the retroactive and ongoing coverage periods.

The Medicaid Medicare buy-in does NOT pay for Medicare premiums in closed periods of coverage for LTC patients who are on spenddown and whose eligibility is for a closed period. Deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from patient pay in the month(s) in which the buy-in is NOT effective.

The Medicaid Medicare buy-in pays for Medicare premiums in retroactive coverage and closed periods of coverage EXCEPT for LTC patients who are on spenddown. DO NOT deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from the patient pay in the month(s) in which the buy-in is effective for LTC patients who are NOT on spenddowns.

2. Example - Medicare Buy-in (Using January 2009 Figures)

Mr. A is 80 years old and started receiving CBC on February 15. He applied for Medicaid on February 2. His only income is $1500 per month. He has no Medicare Part A premium. His Part B premium is withheld from his SSA benefit. Therefore, his gross SSA entitlement is actually $1596.40. He is CN eligible, but he is not dually-eligible as QMB.

Mr. A submitted bills for January and met a retroactive spenddown in January. Ongoing Medicaid began in February because he began receiving Medicaid CBC in February and became CN. The Medicare Buy-in begins on April 1.

His Medicare Part B premium is deducted in February's and March's patient pay. April and subsequent months will not include a deduction for the Medicare premium.

3. Medicare Advantage (Part C) Premiums

Medicare Advantage plans, also referred to as Medicare Part C, are voluntary managed-care Medicare plans. In addition to Medicare Part B premiums, some individuals may pay an extra Medicare Advantage premium. The Medicaid Medicare buy-in is initiated for individuals with Medicare Advantage; however, the buy-in covers only the allowable Medicare Part A and/or B premiums. The individual is responsible for any additional Medicare Advantage monthly premium. The Medicare Advantage monthly premium remains the individual's responsibility and is an allowable deduction from patient pay.

4. Medicare Part D Premiums

An individual who is eligible for Medicare and Medicaid is entitled to enrollment in a basic Medicare Part D prescription drug plan (PDP) at no cost. However, the individual may elect enrollment in a plan with a premium.

When a full-benefit Medicaid enrollee is enrolled in a Medicare Part D PDP, *any* premium that is the individual's responsibility is an allowable deduction from patient pay.

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5. **LTC Insurance**

a. Deduct LTC premium in admission month only

When an individual has an LTC insurance policy that covers long-term care services received in the home, the individual stops paying premiums beginning the month after he is admitted to the home-based LTC. The premium paid for the policy in the LTC admission month can be deducted from the admission month's patient pay only. The LTC insurance premium is not deducted from patient pay for the months following the admission month.

b. LTC insurance benefits

LTC insurance benefits are treated as TPL. If the individual receives the payment from the insurance company, the payment is not income for patient pay or eligibility determinations. The individual should assign it to the waiver services provider. If the individual cannot do this, or the policy prohibits assignment, the LTC insurance payment should be given directly to the provider. The provider should report the payment as a third party payment on its claim form.

If the provider is unable to accept payment directly from the individual, the individual must send the insurance payment to:

This address is for USPS mail only:
Commonwealth of VA COV - DMAS
PO Box 780209
Philadelphia, PA 19178-0209

This address is only for overnight mail by special carriers:
Lockbox Services #780209
Commonwealth of VA COV DMAS
2005 Market Street, 5th Floor
Philadelphia, PA 19103-7042

Along with the check, submit some type of documentation to explain why the funds are being sent to DMAS.

C. Noncovered Medical/Dental Services

Deductions for the cost of a patient's medically necessary medical or dental services not covered by Medicaid, other insurance (such as Medicare), or another person are subtracted from income to determine patient pay.

See M1470.430 B.3 for the procedures used to deduct Medicare Part D prescription drug co-pays for patients who have Medicare.

DMAS approval **is not** required for deductions of noncovered services from patient pay when the individual receives CBC services, regardless of the amount of the deduction.

1. Zero Patient Pay Procedures

If deductions from patient pay cannot be allowed because the recipient has no income remaining after deducting the personal maintenance allowance, dependent child allowance(s) and health insurance premiums, or the recipient has no income available for patient pay, deny the request.

Notify the patient or the patient's representative using the Notice of Action.

If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service has been approved, notify the patient or his authorized representative that the deduction for the new non-covered service will be made after the first noncovered service deductions are completed.

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2. Allowable Non-covered Expenses

When a patient has income available for patient pay, the following can be deducted as noncovered expenses:

a. Old Bills

Old bills are deducted from patient pay as non-covered expenses. Old Bills are unpaid medical, dental or remedial care expenses which:

- were incurred prior to the Medicaid application's retroactive period, or during the retroactive period if the individual was not eligible for Medicaid in the retroactive period or the service was not a Medicaid-covered service;
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and
- remain a liability to the individual.

b. Medically Necessary Covered Services Provided By A Non-participating Provider

Medically necessary medical and dental services that are covered by Medicaid, but that the recipient received from a provider who does not participate in Virginia Medicaid, are deducted from patient pay as non-covered services.

c. Covered Services Outside of Medicaid's Scope

Medically necessary medical and dental services that can be deducted from patient pay are:

- services exceeding Medicaid's amount, duration, or scope;
- services rendered during a prior period of Medicaid eligibility (i.e., LTC services not covered because of a property transfer).

d. Other Allowable Non-covered Services

Medically necessary medical and dental services that are NOT covered by Medicaid and can be deducted from patient pay include:

1) medical supplies, such as antiseptic solutions, incontinent supplies (adult diapers, pads, etc.), dressings, EXCEPT for patients under the Technology-assisted Individuals Waiver (Medicaid covers these services for Technology-assisted Individuals Waiver patients). For Medicaid CBC recipients who have Medicare Part B, do not deduct the cost of supplies/equipment obtained from a Medicare/Medicaid supplier since the supplier receives direct payment from Medicare and Medicaid.

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2) dental services *not provided by a Medicaid provider or covered byMedicaid*. Effective July 1, 2021, Medicaid covers dental services for full-benefit adults, as well as children (see M1850.100.D);

3) routine eye exams, eyeglasses and eyeglass repair;

4) hearing aids (when medically necessary), hearing aid batteries and hearing aid repair;

5) batteries for power wheelchairs or other power mobility items owned by the recipient, not to exceed four batteries in a 12-month period;

6) chiropractor services, except for Medicare recipients (Medicare covers chiropractor services and Medicaid covers the Medicare deductible and coinsurance amounts);

7) dipyridamole (Persantine) and other prescription medications not covered by Medicaid but ordered by the recipient's physician;

8) copayments for prescription drugs obtained under Medicare Part D.

e. Medicare Part D copays

Individuals who:

- qualify for Medicare Part D,
- are NOT enrolled in a Medicare PDP, and
- are NOT Medicaid eligible at the time of admission to CBC

will be fully responsible for their drug costs until Medicaid eligibility is determined and the Medicare Part D PDP enrollment process is completed. The individual remains responsible for any drugs purchased prior to the effective date of the PDP enrollment; Medicaid cannot pay for these drugs. The cost of drugs purchased before the PDP begin date can be deducted from patient pay.

Full benefit Medicaid enrollees who have Medicare, are receiving Medicaid CBC services, and are enrolled in a Medicare Part D PDP were responsible for the payment of co-pays for prescriptions filled prior to January 1, 2012. Effective January 1, 2012, individuals receiving Medicaid CBC services are not responsible for co-pays for prescriptions covered under their Medicare Part D PDP. CBC recipients are not subject to payment of deductibles or a coverage gap in their Part D benefits.

1) Monthly Statements

PDPs must issue a periodic (at least monthly) statement to the beneficiary explaining all benefits paid and denied. Part D drugs that are not covered by the PDP may not be covered by Medicaid and, absent other drug coverage, remain the responsibility of the individual. When a PDP denies coverage of a prescription, the beneficiary has the right to request an exception for coverage of the drug. The beneficiary is notified in writing of the decision on any exception requested.



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2) Verifying Allowable Co-pays

To determine whether or not prescription expenses can be deducted from patient pay, apply the following rules:

- *If the drug expense appears on the statement as a denial, and no exception was requested, **do not** allow the expense.*
- *If the drug expense appears on the statement as a denial, and an exception was requested and denied, allow the expense.*

Enrollees should be advised to maintain these monthly statements if they wish to request patient pay adjustments for Medicare Part D co-pays and for drugs for which the PDP denied coverage.

3. Services NOT Allowed

a. medical supplies covered by Medicaid, or Medicare when the recipient has Medicare, such as:

- diabetic and blood/urine testing strips,
- bandages and wound dressings,
- standard wheelchairs,
- air or egg-crate mattresses,
- IV treatment,
- splints,
- certain prescription drugs (placebos).

b. TED stockings (billed separately as durable medical supplies),
c. acupuncture treatment,
d. massage therapy,
e. personal care items, such as special soaps and shampoos,
f. physical therapy,
g. speech therapy,
h. occupational therapy.

ii. services that are NOT medical/remedial care services, even if ordered by a physician:

- *air conditioners or humidifiers,*
- *refrigerators, whole house generators and other non-medical equipment,*
- *assisted living facility (ALF) room & board and services,*
- *personal comfort items, such as reclining chairs or special pillows,*
- *health club memberships and costs,*
- *animal expenses such as for seeing eye dogs,*
- *cosmetic procedures.*

j. personal care or other waiver services in excess of the number of hours authorized by DMAS (i.e. private pay).

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4. Documentation Required

a. Requests For Adjustments From A Patient or An Authorized Representative

Request the following documentation from the patient or representative:

- a copy of the bill;
- the amount still owed by the patient;
- if applicable, the amount owed that was not covered by the patient's insurance;
- proof that the service was medically necessary. Proof may be the prescription, doctor's referral or a statement from the patient's doctor or dentist. Proof applies to a physician, doctor, or dentist's current, and not "standing", order(s).

b. Requests For Adjustments From CBC Providers

If the request for an adjustment to patient pay to deduct a noncovered expense is made by a Medicaid CBC waiver service provider or case manager, the request must be accompanied by:

1) the recipient's correct Medicaid ID number;

2) the current physician's order for the non-covered service (not required for replacement of hearing aid batteries or eyeglass frames or for repair of hearing aids or eyeglasses);

3) actual cost information;

4) documentation that the recipient continues to need the equipment for which repair, replacement, or battery is requested; and

5) a statement of denial or non-coverage by other insurance. The denial may be from the insurance carrier or may be a written statement from the facility that the insurance company was contacted and the item/service is not covered.

If the request from a provider or case manager does not include all the above documentation, return the request to the provider or case manager asking for the required documentation.

5. Procedures

a. Determine Deduction

When the individual receives CBC services, DMAS approval **is not required** for deductions of noncovered services from patient pay, regardless of the amount of the deduction.

Determine if the expense is deducted from patient pay using the following sequential steps:



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1) Upon receipt of the requested documentation, determine the amount of the bill that is a valid deduction. Do not deduct more than the available income that remains after the personal needs, dependent child allowance(s), and health insurance premiums are deducted.

   If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service is requested, deduct the new noncovered services after the first noncovered service deductions have been completed.

2) Subtract the deduction for the current month. If the deduction exceeds the available income, the remaining balance can be carried over to the following month(s).

b. Notice Procedures

Upon the final decision to allow the deduction, use the VaCMS Patient Pay process to adjust the patient pay. VaCMS will generate and send the Notice of Patient Pay Responsibility If VaCMS is not able to process required transactions, a Patient Pay Correction form (DMAS 9PP), available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, should be submitted to patientpay@dmas.virginia.gov. DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into *MES*.

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6. ***Managed Care Organizations and CCC Plus (effective January. 1, 2018)***

As of January 1, 2018, the majority of Medicaid-eligible individuals who receive long-term care (LTC) services are covered under the CCC Plus program through one of six (6) managed care organizations (MCO). As part of the CCC Plus program, each health plan offers enhanced benefits, such as adult dental services or hearing aids, outside of the required contracted Medicaid services. Some of these enhanced benefits are frequently submitted to the LDSS as patient pay adjustment.

If there are other coverage sources available for these services or items, Medicaid policy requires the request for coverage first be submitted to those sources and exhausted there, before the LDSS/DMAS may consider or approve a patient pay adjustment.

A process is in development to develop a process for distinguishing MCO enhanced benefit services from allowable patient pay deductions. Until further notice, providers and nursing facilities will continue sending all patient pay adjustment requests to the patient's LDSS eligibility worker.

Eligibility workers will review and process patient pay adjustment requests without requiring submission of the request to the individual's CCC Plus plan.

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D. Example--CBC Deduction of Noncovered Services (Using January 2009 Figures)

An aged, single individual, with no dependent child and no guardian or conservator, who lives in Group II, applied for Medicaid for the first time in June. I s approved by the screener for long-term care under the *EDCD* waiver. Gross income is $950 Civil Service Annuity (CSA) and $500 SSA. Resources are within the Medicaid limit. Has Medicare and federal employee's health insurance (Medicare is withheld from the SSA check at the rate of $96.40 per month and $80 is withheld from his CSA for the Health Insurance). Because income is less than 300% of the SSI income limit, *the individual* meets the 300% SSI group.

Retroactive eligibility *is denied* because *there were* no Medicaid covered service*s* in the retroactive period. *The individual* owes $1,500 on a hospital bill incurred the prior September and is making payments. Patient pay for June is determined in the following steps:

Step 1. gross income:

$ 950	CSA
+ 500	SSA
$1,450	total gross income

Step 2. deduct the correct personal maintenance allowance:

$ 1,450	total gross income
- 1,112	personal maintenance allowance
$ 338	remaining income

Step 3. deduct the appropriate medical expense deductions in the correct sequential order:

$ 338.00	remaining income
- 176.40	96.40 Medicare + 80.00 health insurance premium
161.60	remaining income
- 161.60	non-covered medical expenses ($1,500-161.60=$1,338.40)
$ 0	patient pay for June

The $1,338.40 balance remaining from the $1,500 hospital bill that was not deducted from the June patient pay can be deducted in subsequent month(s) *if* it remains a liability.

M1470.500 MEDICAID CBC PATIENTS

A. Overview

This section is only for unmarried individuals and or married individuals who have no community spouse. For married patients who have a community spouse, go to subchapter M1480 for patient pay determination.

This section provides policy and procedures for calculating Medicaid CBC recipients' patient pay.

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B. Policy and Procedures

Policy and procedures for determining Medicaid CBC admission month patient pay in the most common admission situations are contained in the following sections:

- Community Living Arrangement Admission to Medicaid CBC (M1470.510)
- PACE (M1470.520)

M1470.510 COMMUNITY LIVING ARRANGEMENT ADMISSION TO MEDICAID CBC WAIVER SERVICES

A. Policy

The policy in this section describes the procedures for calculating patient pay for the month of admission and ongoing months for **all** persons residing in the community who are screened and approved for Medicaid CBC waiver services.

B. Procedures

1. All Covered Groups Except MN Spenddown

For an individual admitted to Medicaid CBC waiver services (EXCEPT an individual who meets a spenddown**),** use these procedures:

a. Count all income received in the admission month (M1470.100).
b. Deduct a personal needs allowance (M1470.410):

- basic maintenance allowance based on the waiver;
- guardianship fees, if any;
- special earnings allowance, if any.

c. Deduct a dependent child allowance, if any (M1470.420).
d. Deduct the Medicare premium withheld if the individual is a Medicare recipient and was not receiving Medicaid prior to admission, if any (see M1470.430).
e. Deduct other health insurance premiums, deductibles or co-insurance charges, if any (M1470.430).
f. Deduct other allowable noncovered medical expenses, if any (M1470.430).

Any remainder is the patient pay for the month(s).

2. MN Individual Who Meets Spenddown

An MN individual who is on a spenddown is not eligible for Medicaid until the spenddown is met. If an individual is screened and approved for Medicaid waiver services, is considered "institutionalized" and eligibility for Medicaid is determined as an institutionalized individual. If the individual's income exceeds the 300% SSI income limit, must meet an MN institutionalized individual monthly spenddown.

Go to section M1470.600 below to determine patient pay for a CBC patient who is on a spenddown.



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M1470.520 PACE

A. Policy

The Program of All-inclusive Care for the Elderly (PACE) serves individuals aged 55 and older who (1) meet the nursing facility level of care criteria and (2) reside in their own communities. PACE provides all of an individual's health care and long-term care medical needs. PACE is not a CBC Waiver; individuals who meet the criteria for the EDCD Waiver may be enrolled in PACE in lieu of the EDCD Waiver. Individuals who are enrolled in Medicaid as *AG* recipients (Aid Categories 012, 032, and 052) are not eligible for PACE. See M1440.108 for additional information about PACE.

Individuals enrolled in PACE have a patient pay obligation.

B. Procedures

The patient pay for an individual enrolled in PACE who is not Medically Needy is calculated using the procedures in M1470.400 through M1470.520 for an individual in CBC, with the exceptions listed below.

1. Medicare Part D Premiums

PACE recipients are not responsible for Medicare Part D premiums because their prescriptions are provided through PACE and they are eligible for the full Medicare Part D subsidy. Therefore, the cost of the Medicare Part D premium is not allowable as a deduction from patient pay.

2. Covered Medical Expenses

Because PACE includes most medically-necessary services the individual needs, the allowable medical expense deductions differ from the allowable medical expense deductions for CBC.

The following services are provided through PACE:

- adult day care that offers nursing, physical, occupational, speech and recreational therapies;
- meals and nutritional counseling; social services;
- medical care provided by a PACE physician; personal care and home health care;
- all necessary prescription drugs;
- access to medical specialists such as dentists, optometrists and podiatrists;
- respite care;
- hospital and nursing facility care when necessary; and
- transportation.

Any medical expenses incurred by the individual for the services listed above are not allowable patient pay deductions. With the exception of the services listed above, the noncovered expenses listed in M1470.430 C.2 are allowable for PACE recipients. DMAS approval **is not required** for deductions of noncovered services from patient pay for PACE recipients, regardless of the amount of the deduction.

3. PACE Recipient Enters a Nursing Facility

Because PACE is a program of all-inclusive care, nursing facility services are part of the benefit package for PACE recipients who can no longer reside in the community. *PACE recipients may be placed in a nursing facility while still enrolled in PACE.* When a PACE recipient *is placed in* a nursing facility, the PACE provider has 60 days from the date of *placement* to notify the eligibility worker of the individual's placement in the nursing facility and the need for a recalculation of the patient pay.



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Do not change the personal needs allowance to the facility amount unless notification is received from PACE. After notification from PACE of the individual's placement in a nursing facility, the eligibility worker will take action to recalculate the individual's patient pay prospectively for the month following the month the 10 day advance notice period ends. There is NO retroactive calculation of patient pay back to the date the individual entered the facility. Do not refer to the Recipient Audit Unit. When the change is made, the individual is entitled to a personal needs allowance of $40 per month.

M1470.600 MN PATIENTS - SPENDDOWN LIABILITY

A. Policy

This section is for unmarried individuals or married individuals who have no community spouse. **DO NOT USE this section** for a married individual with a community spouse, go to subchapter M1480.

MN individuals have a spenddown liability that must be met before they are eligible for Medicaid because their monthly income exceeds 300% of SSI, which exceeds the MN income limits. When an MN individual meets the spenddown, he is eligible for Medicaid (see section M1460.700 for spenddown determination policy and procedures). Patient pay for **each** month in which the individual meets the spenddown must be determined.

A patient under 22 years of age receiving inpatient psychiatric services in an IMD (Institution for Treatment of Mental Diseases) whose income exceeds 300% of SSI may be eligible for Medicaid as MN if he meets the spenddown liability.

Coverage in an IMD is not part of the Medicaid benefit package for any other MN individuals who are eligible for Medicaid while in an IMD, including individuals age 65 years or older. Individuals under age 22 years who are not receiving inpatient psychiatric services and all individuals over age 22 years but under age 64 years are not eligible for Medicaid while in an IMD (see M0280.201).

B. Definitions

The following definitions are used in this section and subsequent sections of this subchapter:

1. Medicaid Rate

The Medicaid rate for facility patients is the patient's daily *Patient-Driven Payment Model (PDPM)* code amount multiplied by the number of days in the month. A patient's *PDPM* code amount is based on his room and board and ancillary services. The *PDPM* code amount may differ from facility to facility and from patient to patient within the same facility. Confirmation of the individual's *PDPM* code amount must be obtained by contacting the facility. For the month of entry, use the actual number of days that care was received or is projected to be received. For ongoing months, multiply the daily *PDPM* code amount by 31 days.

The Medicaid rate for CBC patients is the number of hours per month actually provided by the CBC provider multiplied by the Medicaid hourly rate.

PACE has a capitated monthly rate that is due and payable on the first day of the month. The monthly PACE rate is available from the PACE provider.

2. Remaining Income

Remaining income is the amount of the patient's total monthly countable income for patient pay minus all allowable patient pay deductions.

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3. Spenddown Liability The spenddown liability is the amount by which the individual's countable income exceeds the medically needy income limit.

C. Procedures The subsections identified below contain the procedures for determining patient pay when an LTC patient meets a spenddown liability and is determined eligible for Medicaid.

1. Facility Patients Patient pay determination procedures are different for medically needy facility patients, depending on whether the spenddown liability is less than or equal to or greater than the Medicaid rate. To determine patient pay for MN facility patients:

a. Determine the individual's spenddown liability using the policy and procedures in subchapter M1460.

b. Compare the spenddown liability to the Medicaid rate.

c. If the spenddown liability is less than or equal to the Medicaid rate, go to section M1470.610 below to determine patient pay.

d. If the spenddown liability is greater than the Medicaid rate, go to section M1470.620 to determine patient pay.

2. Medicaid CBC Patients Medicaid CBC patient pay determination procedures are different from facility procedures. For CBC patients with a spenddown liability, go to section M1470.630.

3. PACE Recipients For PACE recipients with a spenddown liability, go to section M1470.640.

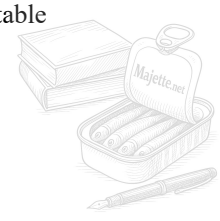
M1470.610 FACILITY PATIENTS--SPENDDOWN LIABILITY LESS THAN OR EQUAL TO MEDICAID RATE

A. Policy This section is applicable ONLY to an unmarried individual, or a married individual without a community spouse. **DO NOT USE this section** for a married individual with a community spouse; go to subchapter M1480.

An MN facility patient whose spenddown liability is less than or equal to the Medicaid rate is eligible for Medicaid effective the first day of the month, based on the projected Medicaid rate for the month.
Medicaid must NOT pay any of the recipient's spenddown liability to the provider. In order to prevent any Medicaid payment of the spenddown liability, the spenddown liability is added to available income for patient pay.

B. Procedures Determine patient pay for the month using the procedures below.

1. Patient Pay Gross Monthly Income Determine the recipient's patient pay gross monthly income according to M1470.100 (including any amounts excluded in determining MN countable income and the spenddown liability).



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2. Subtract Spenddown Liability

From the individual's gross monthly income for the month, subtract the spenddown liability. The result is the remaining income.

3. Subtract Allowable Deductions

Deduct the following from the remaining income:

a. a personal needs allowance (M1470.210),

b. a dependent child allowance, if appropriate (M1470.220),

c. any allowable noncovered medical expenses (M1470.230), not including the facility cost of care,

d. a home maintenance deduction, if appropriate (M1470.240).

The result is the **remaining income**.

4. Add Spenddown Liability

Add the spenddown liability to the remaining income (**because the individual is responsible to pay his spenddown liability to the facility**). The result is the **contributable income** for patient pay.

5. Patient Pay

Compare the contributable income to the Medicaid rate for the month. The patient pay is the lesser of the two amounts.

C. Examples

1. Facility--MN And Patient Pay Income Are The Same (Using April 2000 Figures)

Mr. Cay first applied for Medicaid in April. He was admitted to the facility a year earlier. He has a monthly Civil Service Annuity (CSA) benefit of $1,600. He last lived outside the facility in a Group III locality. His income exceeds the CNNMP 300% SSI income limit. He has no old bills, but he has a health insurance premium of $50 monthly plus a $25 noncovered medical expense he incurred on April 2, and a guardian who charges a guardian fee of 5% of Mr. Cay's income. His MN eligibility is being determined for April. The MN determination results in a spenddown liability of $1,255:

$1,600		monthly MN income
-	20	exclusion
1,580		countable MN income
-	325	MN limit for 1 (Group III)
$1,255		spenddown liability for month

The Medicaid rate is $45 per day, or $1,395 for a projected 31-day month. By projecting the month's cost of facility care, he meets his spenddown because his spenddown liability is less than the Medicaid rate. He is eligible effective the first day of the month and for the whole month of April. Because his spenddown liability is less than the Medicaid rate, Mr. Cay will have ongoing Medicaid eligibility. His patient pay for April is determined:

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$1,600 total patient pay gross income
- 1,255 spenddown liability
345
- 110 personal needs allowance (basic plus guardian fee)
- 50 health insurance premium
- 25 noncovered medical expense incurred April 2
160 remaining income
+1,255 spenddown liability (his responsibility to pay)
$1,415 contributable income for patient pay (April)

Compare the contributable income for patient pay ($1,415) to the facility's Medicaid rate for April, $1,395. The facility can collect no more that the Medicaid rate. Because the Medicaid rate is less than the contributable income for patient pay, Mr. Cay's patient pay for April is the Medicaid rate of $1,395. Any income retained by Mr. Cay is a resource in May.

2. Facility--MN And Patient Pay Income Are Different (Using July 1999 Figures)

Mr. Day is a disabled individual who applied for Medicaid in July 1999. He was admitted to the facility in November 1998. He has a monthly CSA benefit of $1,500 and a monthly Seminole Indian payment of $235. He last lived outside the facility in a Group III locality. His income of $1,735 exceeds the CNNMP 300% of SSI income limit. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His MN eligibility is determined for July 1999. The MN determination results in a spenddown liability of $1,155:

$1,500 monthly MN income (Seminole Indian payment excluded)
- 20 exclusion
1,480 countable MN income
- 325 MN limit for 1 (Group III)
$1,155 spenddown liability for month

He has an old bill of $250 incurred in December 1998, which was not used to meet a spenddown, and a health insurance premium of $50 monthly plus a noncovered medical expense of $25 that he incurred on July 2. The facility's Medicaid rate is $40 per day, or $1,240 for a projected 31-day month. By projecting the month's cost of facility care, he meets his spenddown because his spenddown liability is less than the Medicaid rate. He is eligible for full month's coverage. His patient pay for July is determined:

$1,500 CSA
+ 235 Seminole Indian payment (not excluded for patient pay)
1,735 patient pay gross income
- 1,155 spenddown liability
580
- 30 personal needs allowance
- 50 health insurance
- 250 old bill from December 1998
- 25 non-covered medical expense incurred July 2
$ 225 remaining income
+1,155 spenddown liability (his responsibility to pay)
$1,380 contributable income for patient pay (July)

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Compare the contributable income for patient pay to the facility's Medicaid rate for July. The facility can collect no more than the Medicaid rate. Because the Medicaid rate is less than the contributable income for patient pay for July, Mr. Day's patient pay for July is the Medicaid rate of $1,240. Any income that is retained becomes a resource the following month.

3. Facility-Not Eligible in Admission Month, Eligible in Following Month (Using April 2000 Figures)

Mr. C first applied for Medicaid on April 25. He was admitted to the facility on April 22. He last lived outside the facility in a Group III locality. He is a 40-year-old disabled individual with one dependent child age 10 years; the child lives with his sister in a Group II locality. He has a monthly CSA benefit of $1,700; the child has a CSA benefit of $150 per month. Mr. C has a guardian who charges a 5% guardian fee. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period.

Mr. C's income exceeds the CNNMP 300% of SSI income limit, so he is not eligible as CNNMP. He has a carry-over expense of $200 incurred in the retroactive period. He has a monthly health insurance premium of $50 paid on the 15th of the month plus a $25 noncovered medical expense he incurred on April 2. His MN eligibility is determined for April. The MN determination results in a spenddown liability of $1,355:

$1,700		monthly MN income
-	20	exclusion
1,680		countable MN income
-	325	MN limit for 1 (Group III)
$1,355		spenddown liability for month

The facility's Medicaid rate is $45 per day, or $405 for April 22 - 30 (9 days), the admission month. He does not meet his spenddown by projecting the cost of care at the Medicaid rate for the admission month because his spenddown liability ($1,355) exceeds the Medicaid rate of $405 for the admission month. Therefore, his spenddown cannot be met by projecting the nursing facility costs at the Medicaid rate. His spenddown eligibility must be determined retrospectively using the private pay rate for the number of days of facility care to reduce his spenddown liability. The private pay rate is $50 per day, or $450 for the days April 22 - 30. After subtracting all allowable expenses, he does not meet his spenddown in April and is not eligible for Medicaid in April.

His eligibility for May is determined. His April facility expenses are not deducted because he paid them in April. His $200 January bill is not deducted as a carry-over expense, but any current payments on that bill can be deducted. He incurred a noncovered medical expense on May 2, and paid $65 on his January medical bill.

The facility's Medicaid rate is $45 per day, or $1,395 for a projected 31-day month. By projecting the cost of care at the Medicaid rate, he meets his spenddown on the first of the month (May) because his spenddown liability of $1,355 is less than the Medicaid rate ($1,395). His patient pay for May is determined:

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$1,700 total patient pay gross income
- 1,355 spenddown liability
345
- 105 personal needs allowance (basic plus guardian fee)
- 100 dependent child allowance ($250-150=100)
- 50 health insurance premium
- 25 noncovered medical expense incurred May 2
65
- 65 current payment on January medical bill
0 remaining income
+1,355 spenddown liability (his responsibility)
$1,355 contributable income for patient pay (May)

Compare the contributable income for patient pay to the facility's Medicaid rate for May. The facility can collect no more than the Medicaid rate. Because the contributable income for patient pay is less than the Medicaid rate, Mr. C's patient pay for May is his contributable income of $1,355.

M1470.620 FACILITY PATIENTS--SPENDDOWN LIABILITY GREATER THAN THE MEDICAID RATE

A. Policy

This section is applicable ONLY to an unmarried individual, or a married individual without a community spouse. **DO NOT USE this section** for a married individual with a community spouse; go to subchapter M1480.

1. Retrospective Determination

An MN facility patient whose spenddown liability exceeds the Medicaid rate is not eligible for Medicaid until he actually incurs medical expenses that meet the spenddown liability within the month. ALL of these determinations are made monthly, retrospectively, **after** the month has passed and the expenses have actually been incurred. The individual's resources and income must be verified each month before determining if the spenddown has been met.

2. Full Month's Coverage If Spenddown Met

When incurred expenses equal or exceed the spenddown liability, the individual is eligible for the full month of Medicaid coverage beginning the first day of the month in which the spenddown was met, and ending the last day of the month in which the spenddown was met. See subchapter M1460 for procedures to determine spenddown eligibility for these individuals. Patient pay for the month in which the spenddown was met is calculated after determining that the spenddown was met.

3. Patient Pay

Medicaid must not pay any of the recipient's spenddown liability to the provider. Because the spenddown determination is completed after the month and expenses are not projected, the spenddown liability is NOT added to remaining income for patient pay. Use the following procedures to calculate the patient pay for the month in which the spenddown was met.

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B. Patient Pay Procedures

1. Patient Pay Gross Monthly Income

Determine the recipient's patient pay gross monthly income according to section M1470.100 (including any amounts excluded in determining MN countable income and the spenddown liability).

2. Calculate Remaining Income For Patient Pay

Calculate remaining income for patient pay by deducting the following from gross patient pay income:

a. a personal needs allowance (M1470.210),

b. a dependent child allowance, if appropriate (M1470.220),

c. any allowable noncovered medical expenses (M1470.230) **NOT** including the facility cost of care, and

d. a home maintenance deduction, if appropriate (M1470.240).

The result is individual's **remaining income**.

4. Patient Pay

Compare the remaining income to the facility's Medicaid rate for the month. The patient pay is the lesser of the two amounts.

C. Example—In a Facility, Spenddown Liability Exceeds Medicaid Rate; No Dependent *(Using July 1999 Figures)*

Ms. Day is an institutionalized individual with no dependents who filed an initial application for Medicaid on November 13, 1999. She was admitted to the facility on November 12, 1999. She has a monthly CSA benefit of $1,700 and a monthly payment of $225 from the Seminole Indians Land Trust. She has a $75 old bill incurred in July 1998, and she has a health insurance premium payment of $50 per month paid on the 20th of the month. She does not have Medicare. She last lived outside the facility in a Group II locality. Her income exceeds the 300% SSI income limit. Her MN eligibility is determined for November 1999. The MN determination results in a spenddown liability:

$1,700	monthly MN income (Seminole Indians payment excluded)
- 20	exclusion
1,680	countable MN income
- 250	MN limit for 1 (Group II)
$1,430	spenddown liability for November

The facility's Medicaid rate is $40 per day, or $760 for the 19 days in November, the admission month. Because her spenddown liability of $1,430 exceeds the $760 Medicaid rate for the admission month of November, Ms. Day is not eligible until she actually incurs medical expenses, including the private facility rate, on or before November 30 that equal or exceed the spenddown liability of $1,430. The private rate is $65 per day. The old bill of $75 is deducted on November 1. She incurs $1,235 for 19 days of care and the $50 insurance premium on November 21; she incurs no other expenses. She does not meet the spenddown in the admission month of November. She paid her all of her November medical expenses in November.



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Her eligibility for December (the month following the admission month) is determined. The Medicaid rate of $40 per diem is projected for a 31-day month and equals $1,240. The spenddown liability for the month is compared to the Medicaid rate before deducting any incurred medical expenses. Because the monthly spenddown liability of $1,430 exceeds the Medicaid rate, eligibility must be determined, retrospectively, after the actual facility care costs have been incurred.

In January, to determine if the spenddown was met in December, the worker compares the spenddown liability to the private cost of care for December. The private daily rate of $65 per day is multiplied by 31 days in December to determine the private monthly cost of care. Because the monthly spenddown liability of $1,430 is less than the private monthly cost of care of $2,015, Ms. Day met her spenddown in December and is eligible for the full month of December. She is enrolled *for a* closed period of eligibility, beginning 12-01-99 and ending 12-31-99. On December 3, she made a payment of $75 on her July 1998 medical expense. Her patient pay for December is calculated as follows:

$1,700	CSA
+ 225	Seminole Indians payment (not excluded for patient pay)
1,925	gross income for patient pay
- 30	personal needs allowance
- 75	12/3/99 current payment on medical bill from July 1998
- 50	health insurance premium paid on the 21st
$1,770	remaining income for patient pay (December)

The eligibility worker compares the remaining income to the Medicaid rate ($1,240) for December. The facility can collect no more than the Medicaid rate. Because the Medicaid rate is less than the remaining income for patient pay, Ms. Day's patient pay for December is the Medicaid rate of $1,240. Since she paid the nursing facility the private rate of $2,015 for December, the facility will reimburse her after receiving the Medicaid payment for December. If she retains this money, it becomes a resource to her in the month in which she receives the reimbursement (January at the earliest). Her countable resources must be verified for January before determining if her January spenddown was met.

M1470.630 CBC PATIENTS WITH SPENDDOWN LIABILITY

A. Policy

This section is applicable ONLY to an unmarried individual, or a married individual without a community spouse. **DO NOT USE this section** for a married individual with a community spouse; go to subchapter M1480.

1. Retrospective Determination

Community Based Care (CBC) patients who have income over the 300% of SSI income limit are placed on a monthly spenddown as institutionalized individuals because they have been screened and approved for waiver services. The monthly CBC expenses are determined retrospectively; they cannot be projected for the spenddown budget period.

Retrospective spenddown eligibility determinations are made monthly after the month has passed and the expenses have actually been incurred. The CBC expenses, along with other allowable medical and dental expenses, are deducted

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daily and chronologically as the expenses are incurred. The individual's resources and income must be verified each month before determining if the spenddown has been met.

2. Full Month's Coverage If Spenddown Met

When incurred medical expenses equal or exceed the monthly spenddown liability, the individual is eligible for the full month of Medicaid coverage beginning the first day of the month, and ending the last day of the month.

Patient pay for the month in which the spenddown was met is calculated after determining that the spenddown was met.

3. Patient Pay

Because the spenddown is completed after the month and expenses are not projected, the spenddown liability is NOT added to the available income for patient pay. Use the following procedures to calculate the patient pay for the month in which the spenddown was met.

B. Patient Pay Procedures

1. Patient Pay Gross Monthly Income

Determine the CBC recipient's patient pay gross monthly income according to section M1470.100 (including any amounts excluded in determining MN countable income and the spenddown liability).

2. Calculate Remaining Income for Patient Pay

Calculate remaining income for patient pay by deducting the following from gross patient pay income:

a. a personal needs allowance (M1470.410),

b. a dependent child allowance, if appropriate (M1470.420),

c. any allowable noncovered medical expenses (M1470.430) including any old bills, carry-over expenses and other noncovered expenses that were used to meet the spenddown, but NOT including the cost of CBC care.

The result is the individual's **remaining income** for patient pay.

3. Patient Pay

Compare the remaining income to the Medicaid rate (hours of CBC waiver services multiplied by the Medicaid hourly rate) for the month. The patient pay is the lesser of the two amounts.

4. Example--CBC Spenddown Met (Using January 2000 Figures)

Ms. G. lives in Group III and filed an initial application for Medicaid in January. She is approved by the screener for the EDCD Waiver in January. She has no community spouse or dependent child. Her monthly income of $1800 SSA and a $200 private pension and exceeds the CNNMP 300% SSI limit. Her monthly spenddown liability is determined:

$1,800	SSA
+ 200	private pension
$2,000	total monthly income
- 20	exclusion
$1,980	countable income
- 325	MNIL for Group III
$1,655	monthly spenddown liability

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Her January application is denied and she is placed on a monthly spenddown during the 12-month certification period of January through December.

In February she submits bills to determine if her January spenddown has been met. Her spenddown eligibility is evaluated first by comparing the private cost of care to her spenddown liability. The private cost of care is $15 per hour, 4 hours per day, or $60 per day. She received care on 20 days in January at the private rate of $60 per day. The private cost of care for January was $1,200. Because the private cost of care was less than her spenddown liability, her spenddown eligibility must be determined on a daily basis. She has old bills of $600 incurred prior to the retroactive period, a health insurance premium of $100 paid on the first of the month, and prescription costs of $500 incurred January 2. Her spenddown eligibility is determined:

$1,655		spenddown liability
-	600	old medical bills incurred prior to retroactive period
-	100	medical insurance premium paid January 1
-	60	cost of care incurred January 1
	895	balance beginning January 2
-	500	prescription costs incurred January 2
-	60	cost of care incurred January 2
	335	balance beginning January 3
-	300	cost of care incurred January 3 -7 (5 days)
	35	spenddown liability balance at beginning of January 8
-	60	cost of care incurred on January 8
$	0	spenddown met on January 8

Because she met the spenddown on January 8, she is eligible for *full* Medicaid coverage beginning January 1 and ending January 31. Her patient pay for January is calculated as follows:

$1,800		SSA
+	200	private pension
-	512	personal maintenance allowance
-	600	old bill incurred prior to retroactive period
-	100	medical insurance premium paid January 1
$	788	remaining income for patient pay (January)

The worker compares the remaining income for patient pay to the Medicaid rate for Medicaid CBC waiver services. The Medicaid hourly rate of $10.50 is multiplied by the 80 hours of CBC waiver services received in January. Because her remaining income ($788) is less than the Medicaid rate ($840), Ms. G's patient pay for January is the remaining income of $788.

The following month, Mrs. G submits bills to determine if and when her February spenddown was met. Her February spenddown eligibility is evaluated as follows:

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$1,655	spenddown liability
- 100	medical insurance premium paid February 1
- 60	cost of care incurred on February 1
1,495	spenddown balance beginning February 2
-1,140	cost of care for remainder of February (19 days)
$ 355	spenddown balance on February 29

Mrs. G does not meet her spenddown for the month of February, so she is not eligible for February and no patient pay is calculated. In March and subsequent months, Mrs. G might have additional medical expenses which could enable her to meet her spenddown liability and establish eligibility.

M1470.640 PACE RECIPIENTS WITH SPENDDOWN LIABILITY

A. Policy

This section is applicable ONLY to an unmarried individual, or a married individual without a community spouse. **DO NOT USE this section** for a married individual with a community spouse; go to subchapter M1480.

1. Monthly Spenddown Determination

PACE recipients who have income over the CNNMP 300% of SSI income limit are placed on a monthly spenddown as institutionalized individuals because they have been screened and approved for LTC services.

Unlike CBC, PACE has a capitated monthly rate that is due and payable on the first day of the month. The monthly PACE rate is available from the PACE provider. When an MN individual is in PACE, the amount of allowed PACE expenses is the rate that is due as of the first day of each month.

PACE recipients are not responsible for Medicare Part D premiums, which are included in the monthly PACE rate. **Therefore, the cost of the Medicare Part D premium cannot be used to meet a spenddown and must be subtracted from the monthly PACE rate when determining if the spenddown has been met.**

The individual's spenddown liability and the PACE monthly rate (minus the Medicare Part D premium) establish whether the spenddown eligibility determination can be projected or must be determined retrospectively.

2. Projected Spenddown Determination

If the MN individual's spenddown liability is less than or equal to the monthly PACE rate (minus the Medicare Part D premium), the individual is eligible for Medicaid. As long as the individual's spenddown liability and the PACE monthly rate do not change, the individual is enrolled in ongoing coverage effective the first day of the month in which the spenddown is initially met.

3. Retrospective Spenddown Determination

If the MN individual's spenddown liability exceeds the monthly PACE rate (minus the Medicare Part D premium), he is not eligible for Medicaid until he actually incurs medical expenses that meet the spenddown liability within the month. The monthly medical expenses are determined retrospectively; they cannot be projected for the spenddown budget period.

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Retrospective spenddown eligibility determinations are made monthly after the month has passed and the expenses have actually been incurred. The PACE rate (minus the Medicare Part D premium) along with other allowable medical and dental expenses are deducted daily and chronologically as the expenses are incurred. The individual's income and resources must be verified each month before determining if the spenddown has been met. See M1470.520 for allowable medical deductions.

When incurred medical expenses equal or exceed the monthly spenddown liability, the individual is eligible for the full month of Medicaid coverage beginning the first day of the month and ending the last day of the month.

4. Patient Pay

a. Projected Spenddown Eligibility Determinations

Medicaid must assure that enough of the individual's income is allowed so that he can have a personal maintenance allowance. Therefore, the spenddown liability is NOT subtracted from his gross income nor added to the available income for patient pay.

Subtract the allowances listed in M1470.400 from gross monthly income, as applicable. Compare the remaining income for patient pay to the monthly PACE rate (minus the Medicare Part D premium) for the month. The patient pay is the lesser of the two amounts.

b. Retrospective Spenddown Eligibility Determinations

Because the spenddown eligibility determination is completed after the month in which the PACE services were received and expenses are not projected, the spenddown liability is NOT added to the available income for patient pay. Follow the instructions in M1470.630 for calculating the spenddown and patient pay when the spenddown liability exceeds the monthly PACE rate (minus the Medicare Part D premium).

M1470.800 COMMUNICATION BETWEEN LOCAL DSS AND LTC PROVIDER

A. Introduction

Certain information related to the individual's eligibility for and receipt of Medicaid LTC services must be communicated between the local agency and the LTC provider. The Medicaid LTC Communication Form (form DMAS-225) is used by both the local agency & LTC providers to exchange information.

B. Purpose

Eligibility workers should generate the DMAS-225 through VaCMS. The DMAS-225 form is also *available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*.

The form is used to:

- notify the LTC provider of a patient's Medicaid eligibility status;
- notify a new provider that the patient pay is available through the verification systems;
- reflect changes in the patient's deductions, such as a medical expense allowance;
- document death of an individual;

- document admission or discharge of a patient to an institution or community-based care services;
- provide information on health insurance, LTC insurance or VA contract coverage, and
- provide other information unknown to the provider that might cause a change in eligibility status or patient pay amount.

Do not use the DMAS-225 to relay the patient pay amount. Providers are responsible for obtaining patient pay information from the ARS/MediCall verification systems.

C. When to Complete the DMAS-225

Complete the DMAS-225 at the time of eligibility determination and/or the recipient's entry into LTC. Complete a new DMAS-225 when the recipient's eligibility status changes, such as when the recipient's Medicaid coverage is canceled or changed to limited QMB or SLMB coverage, or when the LTC provider changes.

Additionally, complete a DMAS-225 for an ongoing enrollee whose patient pay has been initially transitioned into MES to notify the provider that the patient pay information is available through ARS/MediCall.

D. Where to Send the DMAS-225

Refer to M1410.300 B.3.b to determine where to send the form. The worker must complete, send, and return the form timely.

M1470.900 ADJUSTMENTS AND CHANGES

A. Policy

The Medicaid recipient or authorized representative is responsible to report any changes in his or her situation within 10 days of the day the change is known. In situations where the patient pay amount is less than the Medicaid rate the patient pay must be adjusted within 30 days of notification or discovery of the change. This section contains the procedures for when and how to adjust patient pay.

There are situations when the EW **cannot increase** the patient pay, such as when the current patient pay amount equals the Medicaid rate for the month. In this situation, an adjustment that results in an increase in patient pay cannot be made and a referral to the DMAS Recipient Audit Unit (RAU) must be completed following the procedures in M1470.900 D.3.c.1) below.

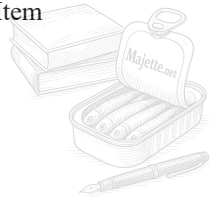
B. Action When A Change Is Reported

Upon receipt of notice that a change in an enrollee's income or deductions has occurred, the EW must evaluate continued income eligibility (see subchapter M1460). If eligibility no longer exists, follow the procedures for LTC medically needy income and spenddown (see M1460.700). If eligibility continues to exist, the EW must:

1. Recalculate the patient pay.

2. If the patient pay remains the same, send written notification to the person handling the patient's income that the patient pay is unchanged.

3. If the patient pay decreases, follow the instructions found in Item C. below. If the patient pay increases, follow the instructions found in Item D. below.



C. Patient Pay Decreases

1. When to Adjust

Reflect a patient pay decrease using the *VaCMS* Patient Pay process effective the month following the month in which the change was reported when:

- the patient's income decreases;
- an allowable deduction is added or increased;
- the patient did not receive, or no longer receives, some or all of his income.

Adjust the patient pay for the month following the month in which the change was reported. DO NOT adjust patient pay retroactively, unless the patient meets a condition specified in section M1470.910 below.

2. Procedures

Using the *VaCMS* Patient Pay process, take the following steps to reflect a decrease in patient pay:

a. Verify the decrease.

b. Once the decrease is verified, *enter the correct information into VaCMS along with the correct effective begin dates. VaCMS will* calculate the new patient pay based on the change(s).

c. Subtract the "new" patient pay from the "old" patient pay amount; the result is the reduced amount.

d. Multiply the reduced amount by the number of months in which the reduced amount should have been effective; the result is the total reduction.

e. Subtract the total reduction from the next month's (the month following the month in which the worker is taking this action) patient pay. If the total reduction exceeds the patient pay, the patient pay amount will be zero until the total reduction has been subtracted from the patient pay.

3. Example-Patient Pay Decrease

Mr. F is an institutionalized individual who had been receiving a SSA payment of $1,000 and a workman's compensation payment of $400 each month. On June 30, he reported he received his final worker's compensation payment on June 15. The EW requested verification of the termination of the worker's compensation and received the verification on August 22. His patient pay had been $1,370 per month. His new patient pay is calculated to be $960 per month. The "new" patient pay of $960 is subtracted from the "old" patient pay of $1,370. The monthly amount is reduced by $410. Since Mr. F reported the change in June, the patient pay must be adjusted for July and subsequent months. The reduction of $410 is multiplied by 2 months (July and August) and totals $820. The EW adjusts Mr. F's September patient pay to reflect the decreased monthly income for July and August. *VaCMS* shows a September patient pay of $140 and also shows a patient pay of $960 for October and subsequent months.



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D. Patient Pay Increases

Using the *VaCMS* Patient Pay process, reflect a patient pay increase effective the month following the month in which the 10-day advance notice period ends when the patient's income increases or an allowable deduction stops or decreases. *No underpayments are to be calculated or referred to the DMAS Recipient Audit Unit.*

1. Prospective Month(s)

Calculate the new patient pay based on the current income and make the change effective the month following the month in which the 10-day advance notice period ends. This will be the new ongoing patient pay.

2. Current and Past Month(s)

Do not revise the patient pay retroactively for the current and past month(s) unless the requirements in section M1470.910 below are met.

3. Procedures

a. Determine the new *patient pay amount*:

1) Calculate the new monthly patient pay based on the change(s), beginning with the month *following the month in which the 10 day advance notice period ends.*

2) Do not calculate or enter any underpayment amounts.

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M1470.910 RETROACTIVE ADJUSTMENTS FOR PRIOR MONTHS

A. Retroactive Adjustment

If a change was reported timely and the patient pay for prior months is incorrect, adjust the patient pay for the prior months only in the following situations:

1. a deceased individual had health insurance premiums or noncovered medical expenses that should have reduced patient pay; or
2. a community spouse is owed money for a spousal allowance and the institutionalized spouse is deceased or no longer in long-term care. However, if the community spouse had decreased income and did not report the change in a timely manner, do not adjust the patient pay.
3. *Patient pay may be reduced in the past when there is no other way to make the member whole (e.g. ongoing patient pay is zero). The reduction must be for the most recent months and must be approved and completed by DMAS. Send the Patient Pay Correction form to patientpay@dmas.virginia.gov.*
4. If an individual has moved from NF to CBC, adjust the patient pay effective the month after the change.

In these situations, adjust the patient pay retroactively using the VaCMS Patient Pay process for the prior months in which the patient pay was incorrect. **In all other situations when a change is reported timely, do not adjust the patient pay retroactively.** If VaCMS is not able to process required transactions, submit a Patient Pay Correction form (DMAS 9PP), available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, to patientpay@dmas.virginia.gov.

B. Notification Requirements

VaCMS automatically generates and sends the Notice of Patient Pay Responsibility. DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into *MES*.

M1470.920 LTC PROVIDER CHANGE WITHIN A MONTH

A. Policy

A change in LTC providers requires a review of the type of provider and living arrangements to determine the correct personal needs allowance and new patient pay, if applicable.

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B. Procedures

DMAS has implemented changes effective for dates of service on or after April 1, 2017, to simplify responsibility for collecting patient pay in the transition month. For any month that an individual is enrolled in a nursing facility on the DMAS eligibility file, patient pay will be deducted only from nursing facility claims and not from agency personal care, respite care, and/or adult day health care claims.

For patients in the CCC Plus Waiver with a patient pay, *MES* will deduct patient pay from the claims submitted by waiver providers for services following the transition month. It may take a short period of time for the local department of social services to revise the patient pay (reflecting a change in status from nursing facility to CCC Plus). This will result in *MES* initially using a higher patient pay that will be adjusted by DMAS after the patient pay is revised. During this time, waiver or nursing facility providers will still be responsible for collection of identified patient pay amounts owed and should work together to collect the appropriate patient pay.

Eligibility staff will continue to calculate monthly patient pay. **There is no need to divide or apportion the patient pay when a patient changes providers or moves from one type of provider/care to another (e.g. CBC to a nursing facility) nor any a need to inform the provider via a DMAS-225.** Changes in patient pay will be made prospectively, based on advance notice requirements. Changes not requiring advance notice can be processed up to the last day of the month. If an individual has moved from NF to CBC, adjust the patient pay effective the month after the change. Patient Pay underpayment corrections should follow the procedures contained in M1470.900.

C. PACE

Enrollment in PACE begins on the first day of a month and ends on the last day of a month. Patient pay for PACE participants is not adjusted due to provider changes within a month.

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A. Policy

The LTC provider may not collect an amount of patient pay that is more than the Medicaid rate for the month. When a patient dies or is discharged from LTC to another living arrangement that does not include LTC services, do not recalculate patient pay for the month in which the patient died or was discharged. The provider is responsible for collecting an amount of patient pay for the month of death or discharge that does not exceed the Medicaid rate for the month.

B. Procedure

Refer to the VaCMS Help feature for procedures regarding death or discharge from LTC. Send a DMAS-225 to the provider regarding the eligibility status of the patient. Send a notice to the patient or the patient's representative that reflects the reduction or termination of services. If VaCMS is not able to process required transactions or additional correction is needed, submit a Patient Pay Correction form (DMAS 9PP), available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, to patientpay@dmas.virginia.gov. DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into *MES*.

M1470.1000 LUMP SUM PAYMENTS

A. Policy

Lump sum payments of income or accumulated benefits are counted as income in the month they are received. Patient pay must be adjusted to reflect this income change for the month following the month in which the 10-day advance notice period expires. Any amount retained becomes a resource in the following month.

B. Lump Sum Defined

Income such as interest, trust payments, royalties, etc., which is received regularly but is received less often than quarterly (i.e., once every four months or three times a year, once every five months, once every six months or twice a year, or once a year) is treated as a lump sum for patient pay purposes.

EXCEPTION: Income that has previously been identified as available for patient pay, but which was not actually received because the payment source was holding the payment(s) for some reason or had terminated the payment(s) by mistake, is **NOT** counted again when the corrective payment is received.

See section M1470.1030 below for instructions for determining patient pay when a lump sum is received.

M1470.1010 LUMP SUM REPORTED IN RECEIPT MONTH

A. Lump Sum Available

Lump sum payments reported in the month the payment was received are counted available for patient pay effective the first of the month following the month in which the 10-day advance notice period expires.

If the individual is no longer in the facility and is not receiving Medicaid CBC, adjust the patient pay for the lump sum receipt month if the money is still available.

B. Lump Sum Not Available

If the money is not available, complete and send a Notice of Recipient Fraud/Non-Fraud to the DMAS Recipient Audit Unit.

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A. Effective Date

Lump sum payments reported AFTER the month in which the payment was received are not reported timely. Evaluate total resources including the lump sum. If the resources are within the limit, determine availability for patient pay. See B. & C. below. If they exceed the resource limit, go to section M1470.1100 below.

B. Lump Sum Not Available

If the money is not available, complete and send a Notice of Recipient Fraud/Non-Fraud to the DMAS Recipient Audit Unit.

C. Lump Sum Available

1. If the money is still available and the individual is no longer in the facility and is not receiving Medicaid CBC, complete and send a Notice of Recipient Fraud/Non-Fraud to the DMAS Recipient Audit Unit.

2. If the money is still available and the individual is still in the facility or is still receiving Medicaid CBC, adjust the patient pay according to procedures in section M1470.1030 below.

M1470.1030 PATIENT PAY DETERMINATION FOR LUMP SUMS

A. Policy

When a lump sum payment is received, the patient pay for the month *following the month* in which the 10-day advance notice period expires must be adjusted using the procedures in this section. ***The patient pay cannot be increased retroactively.***

B. CN Procedures

1. Total Income

Add the lump sum to the patient's regular monthly income; the result is total income for the month.

2. Less Than Or Equal To 300% of SSI

If the total gross income (including the lump sum) is equal to or less than the 300% of SSI income limit, adjust the patient pay. None of the lump sum remains to be evaluated.

3. Greater Than 300% of SSI

If the total gross income (including the lump sum) exceeds the 300% of SSI income limit, adjust the patient pay. Compare the income available for patient pay to the Medicaid rate for the month.

If the income available for patient pay is less than or equal to the Medicaid rate, the available income is the patient pay. If the income available for patient pay exceeds the Medicaid rate, adjust the patient pay to equal the Medicaid rate for the month.

Evaluate the difference between the Medicaid rate and the available income as a resource for the next month. If the patient's total countable resources exceeds the resource limit, take appropriate action to cancel the patient's Medicaid.

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C. MN Procedures

1. Facility Patients-- Spenddown Liability Less Than or Equal To Medicaid Rate

For facility patients who have a spenddown liability that is less than or equal to the facility Medicaid rate and who are enrolled in ongoing Medicaid coverage:

a. add the lump sum to the patient's regular monthly income; the result is total gross income for the month;

b. subtract the correct personal needs/maintenance allowance and any other allowable deductions; the remainder is the income available for patient pay for the month

c. compare the spenddown liability to the Medicaid rate for the month:

- if the available income for patient pay is less than or equal to the Medicaid rate, the available income is the patient pay.

- if the available income for patient pay is **greater than** the Medicaid rate, adjust the patient pay to the Medicaid rate for the month. Evaluate the difference between the Medicaid rate and the available income as a resource for the next month. If the patient's total countable resources, including the remainder of the available income, exceed the resource limit, take appropriate action to cancel the patient's Medicaid.

2. Facility Patients With Spenddown Liability Greater Than Medicaid Rate, & All Medicaid CBC Patients

For facility patients who have a spenddown liability that is greater than the facility Medicaid rate, and for ALL Medicaid CBC patients whose eligibility and patient pay are determined retrospectively:

a. Spenddown Eligibility & Patient Pay Previously Determined

If the individual's spenddown eligibility for the month has been determined without including the lump sum amount and the individual was enrolled for the month:

1) add the lump sum to the patient's regular monthly income in the month the lump sum was received; the result is total gross income for the month;

2) subtract the correct personal needs/maintenance allowance and any other allowable deductions; the remainder is the revised patient pay for the month;

3) compare the revised patient pay to the patient pay that was previously determined and sent to the provider:

- if the revised patient pay is **greater than** the previously determined patient pay, adjust the patient pay to the revised patient pay amount or the Medicaid rate, whichever is less. If the Medicaid rate is less, evaluate the difference between the Medicaid rate and the revised amount as a resource for the next month.



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* if the revised patient pay is **less than or equal to** the previously determined patient pay, DO NOT adjust the patient pay.

Note: If the patient's total countable resources, including the remainder of the available income, exceed the resource limit, take appropriate action to cancel Medicaid eligibility the next month because of excess resources.

b. Spenddown Eligibility & Patient Pay NOT Previously Determined

If the individual's spenddown eligibility for the month has not yet been determined:

1) Recalculate the individual's spenddown liability by adding the lump sum to the patient's regular monthly income in the month the lump sum was received; determine spenddown eligibility by policy and procedures in section M1460.700.

2) If the individual meets the revised spenddown, determine patient pay by using the policy and procedures in section M1470.620 or M1460. 630.

M1470.1100 REDUCTION OF EXCESS RESOURCES

A. Policy

Medicaid policy allows for a full month of eligibility if the resource limit is met at any time during the month. LTC patients whose patient pay is less than the Medicaid rate can choose to reduce excess resources by expending the excess for the cost of LTC services. *This policy does not apply to individuals whose Medicaid application is pending.*

B. Resource Reduction Defined

A decrease in property value, such as an official reassessment or a lien placed against property, is not a reduction of resources. It is a decrease in the value of the resource.

In order to reduce resources, a resource must be transferred out of the patient's possession. Liquid resources such as bank accounts and prepaid burial accounts must actually be expended or encumbered. Non-liquid resources must be liquidated and the money expended.

A reduction of resources is an asset transfer and must be evaluated under asset transfer policy in subchapter M1450.

C. Procedures

1. Required Contact

When a Medicaid-enrolled LTC recipient is found to have excess resources, evaluate whether an adjustment to patient pay by using the excess toward the cost of care will allow continued eligibility in the month in which the 10-day advance notice period expires. Do not assume that the recipient or the recipient's representative will agree to use the excess resources to pay an increased patient pay.

Prior to initiating the following procedures, contact the individual or his authorized representative and tell him of the alternatives available. In the case record, document the conversation and the decision made. If unable to make contact by phone, send the Advance Notice of Proposed Action for cancellation due to excess resources.

2. Reduce Excess Resources

When the patient agrees to use the excess resources toward the cost of care, take the following steps for the month in which the 10-day advance notice period expires:

Step 1 Determine amount of excess resources (total resources minus the resource limit).

Step 2 Determine the monthly Medicaid rate:

* for a facility patient, the monthly rate is the patient's daily *PDPM* rate multiplied by 31 days.

- for a CBC patient, the monthly rate is each CBC service provider's hourly rate multiplied by the number of hours of services provided to the patient in the month.

Step 3 Add the amount of excess resources to the current patient pay.

Step 4 If the result of Step 3 is less than the monthly Medicaid rate obtained in Step 2, adjust the patient pay for one month to allow the excess resources to be reduced.

Step 5 If the result of Step 3 is more than the monthly Medicaid rate obtained in Step 2, the patient is ineligible due to excess resources. Send an "Advance Notice of Proposed Action" to cancel Medicaid coverage due to excess resources.

D. Example-- Recipient Reduces Resources

An institutionalized Medicaid recipient's resources accumulate to $2,200 in February. Monthly income is $500 from Social Security (SS) and $100 VA Compensation. Patient pay of $560 is less than the Medicaid rate. The individual pays the amount of his excess resources ($200) to the nursing facility as part of March's patient pay, remains eligible.

$ 500 SS
+ 100 VA Compensation
$ 600 total gross income
- 40 personal needs allowance
$ 560 current patient pay (prior to adding excess resources)

$ 560 current patient pay
+ 200 excess resources
$760 patient pay for March only

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Patient pay for April and subsequent months is calculated:

$ 500 SS
+ 100 VA Compensation
$ 600 total gross income
- 40 personal needs allowance
$ 560 patient pay for April and subsequent months

M1470.1200 INCORRECT PAYMENTS TO PROVIDER

A. Introduction

There may be instances when the amount of patient pay collected by an LTC provider is less than the amount determined available for payment. This situation is most likely to occur when some other person is the payee for the patient's benefits.

B. Procedures

This section provides policy and procedures used to determine patient pay when the provider collects less than the patient pay amount. Patient pay can be adjusted according to whether certain criteria, specified in sections M1470.1210 and M1470.1220 below, are met.

M1470.1210 ADJUSTMENTS NOT ALLOWED

A. Policy

The facility or CBC provider is responsible to collect the patient pay from the patient or the person handling the patient's funds. When the provider is not successful in collecting the patient pay, the EW **cannot** adjust the patient pay.

B. Do Not Adjust Patient Pay

The patient pay reported in ARS/MediCall is considered available by Medicaid. Do not adjust the patient pay when:

1. the patient directly receives benefits and is considered to be competent but does not meet his patient pay responsibility; or

2. the amount of patient pay in question is from the patient's own funds which have been withheld by a payee or other individual receiving the patient's funds and have not been paid toward the cost of the patient's care, as specified by policy in this chapter and by the "Notice of Obligation for LTC Costs" sent to the individual.

Should the situation indicate that a change in payee is necessary, contact the program which is the source of the benefit payment and recommend a change. Additionally, be alert to situations that may require a referral to Adult Protective Services for an evaluation of exploitation.

C. Entitlement Benefits Adjustment

For an ongoing case, if benefits from entitlement programs (such as Social Security) are not received because the program is holding the check(s) for some reason, but the benefits will be paid some time in the future in a lump sum, do not adjust the patient pay for the months the benefits are not received.

When the lump sum payment is received, do **not** count the lump sum payment and do **not** follow instructions for lump sum payments as found in this subchapter because the patient must use the lump sum to pay the previous months' remaining patient pay amounts the patient still owes to the provider.



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M1470.1220 ADJUSTMENTS ALLOWED

A. Adjust Patient Pay

Adjust the patient pay when:

* the income counted in the patient pay calculation was not actually received because the source did not pay; *and*
* the income will not be paid some time in the future; and
* documentation of the change in income is received by the worker.

See section M1470.900 for instructions on adjusting patient pay.

B. Adjustment Allowed Due To Income Changes

Some examples of when income is not received and will not be paid in the future are:

1. Rental Income

Rental income is no longer received because the property was not rented for a period of time, or the renter did not pay. Be aware that if property no longer produces income, the resource exclusion may be affected. Evaluate *the individual's* continued eligibility.

2. Contribution Not Received

A contribution from a responsible relative or other source is not received. Advise the responsible relative of his legal responsibility. If there is a legal responsibility to support the individual, advise the responsible relative that continued failure to meet that responsibility may result in a non-support petition being filed with the appropriate court.

3. Income Source Exhausted

Interest income is not received because the source of income was exhausted or is no longer available.

4. Trust Income

Income from a trust fund is not received because the trustee did not make it available and/or will no longer make it available.

5. Policy/Benefits Ran Out

Payment from an insurance company or organization is not paid because the policy is no longer in force, benefits ran out, the organization refuses to or cannot pay, etc.

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Sample Notice of *Patient Pay Responsibility* from VaCMS

COMMONWEAL TH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

NOTICE OF PATIENT PAY RESPONSIBILITY

TO:

Recipient Name:

Recipient ID:

This form serves as your notice of patient pay, which is the amount of your income that must be paid to the provider every month for the cost of long-term care services you receive. The long-term care provider who is responsible for collection of any portion of your patient pay will directly bill you or your representative. A portion of patient pay may be paid to more than one provider when services are received from multiple providers. If you currently receive Medicaid long-term care services, this will serve as the 10-day advance notice when your patient pay amount is increased. Please contact your local worker if you have questions.

PATIENT PAYCALCULATIONS

Effective Date of Patient
Pay (Month and Year):

Reason

Income
Social Security
Other Unearned Income
Total Earned Income
Total Gross Income
Minus Spenddown Liability (SDL)
Remaining Income

Allowances Deducted from Income Personal/Maintenance Needs Spousal
Child/Family Member
Non-covered Medical Expenses Home Maintenance
Income Remaining after Allowances

Spenddown Liability Contribution Income Medicaid Rate for Month
Patient Pay

DATE OF ACTION/NOTICE AGENCY REPRESENTATIVE TELEPHONE NUMBER

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COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Patient pay may be the lesser of the SDL amount, contributable income amount (income remaining after deductions plus the SDL), remaining income or the Medicaid Rate, whichever is applicable to the individual's circumstances.

Patient pay will not exceed the Medicaid Rate.

You must report any changes in income or resources to the local agency. Failing to report changes or providing false or misleading information may result in your prosecution for fraud.

Ifyou have Medicare Part A coverage, and were admitted to a nursing facility under "Skilled Care", the patient pay amount you owe for the first 100 days may be less than the amount shown on this notice. The nursing facility will determine how many days are covered by Medicare and will send you a bill. Once Medicare stops paying, you will be responsible for the full patient pay amount shown on this notice.

Appeal Information
If you disagree with this action, you have the right to file an appeal. You or your authorized representative must send a written appeal request within 30 days of receipt of this notification. If you file an appeal before the effective date of this action, the patient pay will remain unchanged during the appeal process. However, if the Appeals Division upholds this action, you may be required to reimburse the Medicaid Program for the excess cost of services paid on your behalf during the appeal period.

You may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, at your local department of social services, or by calling (804) 371-8488.

Please include a copy of this notification. Sign the appeal request and mail it to:

Department of Medical Assistance Services, Appeals Division
600 E Broad Street, Richmond,
Virginia 23219

Appeal requests may also be faxed to *(804) 452-5454*

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CHAPTER M14
LONG-TERM CARE
SUBCHAPTER 80

MARRIED INSTITUTIONALIZED INDIVIDUALS' ELIGIBILITY & PATIENT PAY

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TN #DMAS-36	10/1/25	Page 66
TN #DMAS-35	7/1/25	Pages 1 and 66
TN #DMAS-34	1/1/25	Pages 7, 18c, 66, 69, 70
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UP #11	7/1/15	Page 18c
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M1480 MARRIED INSTITUTIONALIZED INDIVIDUALS' ELIGIBILITY & PATIENT PAY

M1480.000 GENERAL

A. Introduction

Section 1924 of the Social Security Act contains special eligibility rules that apply ONLY to married institutionalized individuals whose first continuous period of institutionalization began on or after September 30, 1989. These rules are intended to prevent the impoverishment of a spouse living in the community when the other spouse enters long-term care. **For resource assessment and eligibility determination, the resource value is its value as of the first moment of the first day of a calendar month.**

Section 1924 supersedes all other sections of Medicaid law when determining countable resources and income of a married institutionalized individual who has a community spouse. Therefore, the usual Medicaid eligibility rules do not apply to an institutionalized individual with a community spouse whenever the usual Medicaid rules conflict with the law in section 1924.

An institutionalized spouse is an individual who is in a medical institution, who is receiving Medicaid waiver services or who has elected hospice services, and who is married to a spouse who is not in a medical institution or nursing facility. The term "community spouse" means the spouse of an institutionalized spouse. The community spouse can be living outside an institution or in a residential institution such as an adult care residence.

B. Applicability

1. MAGI Adult

DO NOT use this subchapter to determine the individual's financial eligibility for Medicaid if the individual is eligible in the MAGI Adult covered group. If a *married* individual who has been determined eligible for LTSS in the MAGI Adult covered group *is no longer eligible in a MAGI group (turns 65 or begins receiving Medicare), eligibility must be redetermined and a Resource Assessment completed as of the first day of the first month the individual began their first continuous period of institutionalization (receiving LTSS services for more than 30 days). If an individual* subsequently marries and is no longer financially eligible in the MAGI Adults covered group, use the policy in M1480 to determine continuing financial eligibility for LTSS. The resource assessment is completed based on resources owned by the couple as of the first moment of the first day of the month in which the marriage took place (see M1480.220).

2. Admitted Before 9-30-89

DO NOT use this subchapter to determine the individual's financial eligibility for Medicaid when the married institutionalized individual was admitted to long-term care **prior to** September 30, 1989 and has been continuously institutionalized since admission. Use subchapters M1410 - M1460 to determine the individual's financial eligibility for Medicaid.

3. Admitted On/ After 9-30-89

Use this subchapter in determining Medicaid eligibility for an institutionalized spouse who

- was admitted to long-term care **on or after** September 30, 1989 and has been continuously institutionalized since admission, and
- has a community spouse.

Do NOT use this subchapter to determine the eligibility of a married institutionalized individual whose spouse is NOT a "community spouse" as defined in this subchapter. Use subchapters M1410 - M1470 to determine the individual's eligibility and patient pay.

The rules in this subchapter apply only to the institutionalized spouse's financial eligibility. If the community spouse applies for Medicaid, use the financial eligibility rules for non-institutionalized persons in the community spouse's covered group to determine the community spouse's Medicaid eligibility.

M1480.010 DEFINITIONS

A. Introduction

This section provides definitions for those words and terms used in this subchapter.

B. Definitions

1. Beginning of a Continuous Period of Institutionaliz-ation

means the first calendar month of a continuous period of institutionalization (in a medical institution or receipt of a Medicaid Community-based Care (CBC) waiver service). See section M1410.010 for definition of a medical institution.

2. Community Spouse

means a person who:

- is married to an institutionalized spouse and
- is not an inpatient in a medical institution or nursing facility.

The community spouse can be living in the home with the institutionalized spouse who is a Medicaid CBC patient, can be living in a residential institution such as an assisted living facility (ALF), or can be living in the institutionalized spouse's former home.

If the community spouse is incarcerated, verification of resources and income are still required to be obtained from the couple.

NOTE: A spouse living in the couple's home who is also receiving Medicaid CBC waiver services is a community spouse. The community spouse monthly income allowance policy applies.

3. Community Spouse Monthly Income Allowance

means an amount by which the minimum monthly maintenance needs allowance (MMMNA) exceeds the amount of monthly income otherwise available to the community spouse. [Section 1924(d)(2) of the Social Security Act].

The community spouse monthly income allowance is the maximum amount of the institutionalized spouse's income which is allowed to supplement the community spouse's income, up to the minimum monthly maintenance needs allowance (MMMNA).

4. Community Spouse Resource Allowance (CSRA)

means the amount (if any) by which the greatest of

- the spousal share;
- the spousal resource standard;

- an amount designated by a DMAS Hearing Officer, or

- an amount actually transferred to the community spouse by the institutionalized spouse following a court spousal support order issued as the result of an appeal of a DMAS Hearing Officer's decision

exceeds the amount of resources otherwise available to the community spouse.

5. Continuous Period of Institutionalization means 30 consecutive days of institutional care in a medical institution, or 30 consecutive days of receipt of Medicaid waiver services (CBC), or 30 consecutive days of a combination of institutional and waiver services. Continuity is broken only by *180* or more days absence from a medical institution or *180* or more days of non-receipt of waiver services.

6. Couple's Countable Resources means all of the couple's non-excluded resources, regardless of state laws relating to community property or division of marital property. For purposes of determining the combined and separate resources of the institutionalized and community spouses when determining the institutionalized spouse's eligibility, the couple's home, contiguous property, household goods, and one automobile are excluded.

7. Dependent Child **means a child 21 years old or older**, of either spouse, who lives with the community spouse and who may be claimed as a dependent by either member of the couple for tax purposes pursuant to the Internal Revenue Code. Tax dependency is verified by a verbal or a written statement of either spouse.

8. Dependent Family Member means a dependent parent, minor child, dependent child, or dependent sibling (including half brothers/sisters and adopted siblings) of either member of a couple who resides with the community spouse and who may be claimed as a dependent by either member of the couple for tax purposes under the Internal Revenue Code. Tax dependency is verified by a verbal or a written statement of either spouse.

9. Excess Shelter Allowance means the actual monthly expense of maintaining the community spouse's residence that exceeds the excess shelter standard (30% of the monthly maintenance needs standard). Actual monthly expenses are the total of:

- rent or mortgage including interest and principal;
- taxes and insurance;
- any maintenance charge for a condominium or cooperative; and
- the utility standard deduction under the Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps) that would be appropriate to the number of persons living in the community spouse's household, if utilities are not included in the rent or maintenance charge [Section 1924(d)(4) of the Social Security Act].

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10. Excess Shelter Standard means 30% of the monthly maintenance needs standard. See section M1480.410 below for the current excess shelter standard.

11. Family Member's Income Allowance means an allowance for each dependent family member residing with the community spouse. The family member's income allowance is equal to 1/3 of the amount by which the monthly maintenance needs standard exceeds the family member's income. The family member's income allowance is deducted from the institutionalized spouse's income for the family member's needs.

Family member allowance = (monthly maintenance needs standard - family member income) ÷ 3

EXAMPLE #1:

$1,383 monthly maintenance needs standard
- 300 family member's income
1,083 amount by which monthly maintenance needs standard exceeds the family member's income
÷ 3
$ 361 family member's monthly income allowance.

12. First Continuous Period of Institutionalization means the first day of the month of the first continuous period of institutionalization which began on or after September 30, 1989. For example, a person was institutionalized from September 8, 1989 through March 12, 1991, then readmitted on May 28, 1991. His first continuous period of institutionalization that began on/after September 30, 1989 began on May 1, 1991.

13. Initial Eligibility Determination means:

a. An eligibility determination made in conjunction with a Medicaid application filed during an individual's most recent continuous period of institutionalization; or

b. The initial redetermination of eligibility for a Medicaid-eligible institutionalized spouse after being admitted to a medical institution or Medicaid CBC waiver services.

The initial eligibility determination period includes the application month and any subsequent month(s) up to the date on which the agency takes action to approve the application.

14. Initial Redetermination means the first redetermination of eligibility for a Medicaid-eligible institutionalized spouse which is regularly scheduled or which is made necessary by a change in the individual's circumstances.

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15. Institutionalized Spouse means an individual who:

- is in a medical institution, or who is receiving Medicaid waiver services, or who has elected hospice services;
- is likely to remain in the facility, or to receive waiver or hospice services for at least 30 consecutive days; and
- who is married to a spouse who is NOT in a medical institution or nursing facility.

NOTE: An institutionalized spouse receiving Medicaid CBC Waiver services can also be a community spouse if his spouse is in a medical facility or is receiving Medicaid CBC Waiver services.

16. Likely to Remain in an Institution means a reasonable expectation based on acceptable medical evidence that an individual will receive *LTC services* for 30 consecutive days, *unless it is known prior to processing the application that the 30-day requirement has not been met or will not be met. If it is known at the time the application is processed that the individual did not or will not meet the 30 consecutive day requirement, the individual is not to be treated as an institutionalized individual.*

17. Maximum Spousal Resource Standard means the maximum amount of the couple's combined countable resources established for a community spouse to maintain himself in the community ($60,000 in 1989). This amount increases annually by the same percentage as the percentage increase in the Consumer Price Index (CPI) for all urban consumers between September 1988 and the September before the calendar year involved. [1924(f)(2)(A)(ii)].

See section M1480.231 for the current maximum spousal resource standard.

18. Minimum Monthly Maintenance Needs Allowance (MMMNA) The minimum monthly maintenance needs allowance [1924(d)(3)(A)] is the monthly maintenance needs standard, plus an excess shelter allowance if applicable, up to a maximum [1924(d)(3)(C)]. The minimum monthly maintenance needs allowance is the amount to which a community spouse's income is compared in order to determine the community spouse's monthly income allowance.

The monthly maintenance needs standard and monthly maintenance needs allowance maximum change each year. See section M1480.410 below for the current standard and maximum.

19. Minor Child means a child under age 21 years, of either spouse, who lives with the community spouse and who may be claimed as a dependent by either member of the couple for tax purposes pursuant to the Internal Revenue Service Tax Code. Tax dependency is verified by a verbal or written statement from either spouse.

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20. Monthly Maintenance Needs Standard

The monthly maintenance needs standard is 150% of 1/12 of the federal poverty level for a family of two in effect on July 1 of each year [Section 1924(d)(3)(A)(i)].

See section M1480.410 below for the current monthly maintenance needs standard.

21. Otherwise Available Income or Resources

means income and resources which are legally available to the community spouse and to which the community spouse has access and control.

22. Promptly Assess Resources

means within 45 *calendar* days of the request for resource assessment, unless the delay due to non-receipt of documentation or verification, if required, from the applicant or from a third party.

23. Protected Period

means a period of time, not to exceed 90 *calendar* days after an initial determination of Medicaid eligibility. During the protected period, the amount of the community spouse resource allowance (CSRA) will be excluded from the institutionalized spouse's countable resources IF the institutionalized spouse expressly indicates his intention to transfer resources to the community spouse.

24. Resource Assessment

means a calculation, completed by request or upon Medicaid application, of a couple's combined countable resources at the beginning of the **first** continuous period of institutionalization of the institutionalized spouse beginning on or after September 30, 1989.

25. Spousal Protected Resource Amount (PRA)

means at the time of Medicaid application as an institutionalized spouse, the greater of:

- the spousal resource standard in effect at the time of application;
- the spousal share, not to exceed the maximum spousal resource standard in effect at the time of application;
- the amount of resources designated by a DMAS Hearing Officer, or
    - an amount actually transferred to the community spouse by the institutionalized spouse pursuant to a court spousal support order issued as the result of an appeal of the DMAS Hearing Officer's decision.

26. Spousal Resource Standard

means the minimum amount of the couple's combined countable resources ($12,000 in 1989) necessary for a community spouse to maintain himself in the community. This amount increases each calendar year after 1989 by the same percentage increase as in the Consumer Price Index (CPI). [1924(f)(2)(A)(i)].

See section M1480.231 for the current spousal resource standard.



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27. Spousal Share means ½ of the couple's combined countable resources at the beginning of the **first** continuous period of institutionalization, as determined by a resource assessment.

28. Spouse means a person who is legally married to another person under Virginia law.

29. Waiver Services means Medicaid-reimbursed home or community-based services covered under a 1915© waiver approved by the Secretary of the United States Department of Health and Human Services.

M1480.015 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LONG-TERM CARE

A. Applicability

The policy in this section applies to nursing facility and CBC/PACE patients, who meet the requirements for LTC services, now called long term services and supports (LTSS), on or after January 1, 2006. This includes individuals who filed reapplications after a break in Medicaid eligibility. It does **not apply** to Medicaid recipients who were approved for LTSS prior to January 1, 2006, and who maintain continuous Medicaid eligibility.

For Medicaid applicants or enrollees approved for LTSS on or after July 1, 2006, the amount of equity in the home at the time of the initial LTC determination and at each renewal must be evaluated. For the purposes of the home equity evaluation, the definition of the home in M1130.100 A.2 is used; the home means the house and lot used as the principal residence and all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000.

B. Policy

Individuals with equity value (tax assessed value minus encumbrances) in home property that exceeds the limit are NOT eligible for Medicaid payment of long-term care services unless the home is occupied by:

- a spouse,
- a dependent child under age 21 years, or
- a blind or disabled child of any age.

If substantial home equity exists, the individual is not evaluated for or eligible for the Medicaid payment of LTSS. Do not evaluate asset transfers.

An individual with excess home equity is not eligible in the 300% of SSI covered group, but may be eligible for Medicaid payment of covered services other than LTSS if he is eligible in another covered group. Evaluate eligibility for an individual with substantial home equity in other covered groups.

***1.* Home Equity Limit**

The applicable home equity limit is based on the date of the application or request for LTSS coverage. Effective January 1, 2011, the home equity limit is subject to change annually. The home equity limit is:

- Effective January 1, 2023: $688,000
- Effective January 1, 2024: $713,000
- Effective January 1, 2025: $730,000
- *Effective January 1, 2026: $752,000*

***2.* Reverse Mortgages**

Reverse mortgages **do not** reduce equity value until the individual begins receiving the reverse mortgage payments from the lender.



3. Home Equity Lines of Credit

A home equity line of credit **does not** reduce the equity value until credit line has been used or payments from the credit line have been received

B. Verification Required

Do not assume that the community spouse is living in the home. Obtain a statement from the applicant indicating who lives in the home. If there is no spouse, dependent child under age 21, or blind or disabled child living in the home, verification of the equity value of the home is required.

C. Notice Requirement

If an individual is ineligible for Medicaid payment of *LTSS* because of substantial home equity exceeding the limit, the Notice of Action must state why he is ineligible for Medicaid payment of *LTSS*. The notice must also indicate whether the applicant is eligible for other Medicaid covered services.

If the individual is in a nursing facility, send the facility a DMAS-225 indicating that the individual is not eligible for the Medicaid payment of LTSS.

D. References

See section M1120.225 for more information about reverse mortgages.

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M1480.200 RESOURCE ASSESSMENT RULES

A. Introduction

A resource assessment must be completed when an institutionalized spouse with a community spouse applies for Medicaid coverage of long term care services and may be requested without a Medicaid application.

A resource assessment is strictly a:

- compilation of a couple's reported resources that exist(ed) at the first moment of the first day of the month in which the first continuous period of institutionalization began on or after September 30, 1989.
- calculation of the couple's total countable resources at that point, and
- calculation of the spousal share of those total countable resources.

A resource assessment does not determine resource eligibility but is the first step in a multi-step process. A resource assessment determines the spousal share of the couple's combined countable resources.

B. Policy Principles

1. Applicability

The resource assessment and resource eligibility rules apply to individuals who began a continuous period of institutionalization on or after September 30, 1989 and who are likely to remain in the medical institution for a continuous period of at least 30 consecutive days, or have been authorized for Medicaid CBC waiver services, or have elected hospice services.

The resource assessment and resource eligibility rules do **NOT** apply to individuals who were institutionalized before September 30, 1989, **unless** they leave the institution (or Medicaid CBC waiver services) for at least 30 consecutive days and are then re-institutionalized for a new continuous period that began on or after September 30, 1989.

Resource Assessment policy does not apply to individuals eligible in the MAGI Adult covered group. However, a resource assessment may be needed when a married individual FORMERLY received LTSS as a MAGI Adult and needs to be re-evaluated for LTSS in a non-MAGI group. If the individual is currently married but was not married on the first day of the first continuous period of institutionalization, no resource assessment is needed.

2. Who Can Request

A resource assessment without a Medicaid application can be requested by the institutionalized individual in a medical institution, *the* community spouse, or an authorized representative. See section M1410.100.

3. When to Do A Resource Assessment

a. Without A Medicaid Application

A resource assessment without a Medicaid application may be requested when a spouse is admitted to a **medical institution**. Do not do a resource assessment **without** a Medicaid application unless the individual is in a medical institution.

b. With A Medicaid Application

The spousal share is used in determining the institutionalized individual's resource eligibility. A resource assessment must be completed when a married institutionalized individual has a community spouse and



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- is in a nursing facility, or
  is authorized to receive nursing facility or Medicaid CBC waiver services, or
- has elected hospice services

applies for Medicaid. The resource assessment is completed when the applicant is authorized to receive nursing facility or Medicaid CBC services or within the month of application for Medicaid, whichever is later.

NOTE: Once an institutionalized spouse has established Medicaid eligibility as a Non-MAGI institutionalized spouse, count only the institutionalized spouse's resources when redetermining the institutionalized spouse's Medicaid eligibility. Do not count or deem the community spouse's resources available to the institutionalized spouse.

If an institutionalized spouse's Medicaid coverage was cancelled and he reapplies as an institutionalized individual, use only the resources in his name (including his share of jointly owned resources) for the eligibility determination.

The following table contains examples that indicate when an individual is treated as an institutionalized individual for the purposes of the resource assessment:

LTSS Authorized in:	In a Facility?	Application Month	Resource Assessment Month	Processing Month	Month of Application/ ongoing as Institutionalized	Retroactive Determination as Institutionalized (in a medical facility)
January	no	January	January	January	yes	no
January	no	February	February	February	yes	no
N/A	yes	January	first continuous period of institution-alization	February	yes	yes
January	no	March	March	April	yes	no
April	no	March	April	Whenever	no, but yes for April	no

c. Both Spouses Request Medicaid CBC

When both spouses request Medicaid CBC, one resource assessment is completed. The $2,000 Medicaid resource limit applies to each spouse.

C. Responsible Local Agency

The local department of social services (DSS) in the Virginia locality where the individual last resided outside of an institution (including an ACR) is responsible for processing a request for a resource assessment without a Medicaid application, and for processing the individual's Medicaid application. If the individual never resided in Virginia outside of an institution, the local DSS responsible for processing the request or application is the local DSS serving the Virginia locality in which the institution is located.

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M1480.210 RESOURCE ASSESSMENT WITHOUT A MEDICAID APPLICATION

A. Introduction

This section applies only to married individuals with community spouses who are inpatients in medical institutions or nursing facilities and who have NOT applied for Medicaid.

B. Policy

1. Resource Evaluation

For the purposes of the resource assessment and spousal share calculation, countable and excluded resources are determined for all covered groups using the ABD resource policy found in Chapter S11 **regardless of the individual's covered group and regardless of community property laws or division of marital property laws**, except for the following resources which are excluded as indicated below when completing the resource assessment and spousal share [1924(c)(5)]:

- the home and all contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SS & SSI payments received on or after 11/01/05 for nine (9) calendar months following the month in which the individual receives the benefits; and
- up to **$1,500** of burial funds for each spouse (NOT $3,500), if there are designated burial funds.

Resources owned in the name of one or both spouses are considered available regardless of whether either spouse agrees to sell or liquidate the resource and regardless of whether either spouse refuses to make the resource available.

If either or both spouses own more than one home, the home in which the institutionalized spouse last resided prior to institutionalization is excluded. Any other home(s) owned by either or both spouse is counted.

The resource assessment is not affected by the amount disregarded in the eligibility determination as a result of an LTC Partnership Policy (Partnership Policy).

2. No Appeal Rights

When a resource assessment is requested and completed **without** a concurrent Medicaid application, it cannot be appealed pursuant to the existing Virginia Client Appeals regulations (VR 460-04-8.7). The spousal share determination may be appealed when a Medicaid application is filed.

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C. Procedures

The Medicaid Resource Assessment Request form (#032-03-815) is completed by the person requesting the resource assessment when the assessment is not part of a Medicaid application.

Nursing facilities are required to advise new admissions and their families that Medicaid resource assessments are available for married individuals from their local department of social services.

1. Case Record Number

If the institutionalized individual does not already have a case record, assign a case number and establish a case record in the institutionalized individual's name. If there is an existing case record for the institutionalized individual, use the established case number and record for the resource assessment.

2. Determining the First Continuous Period of Institutionaliz-ation

The resource assessment is based on the couple's resources owned **on the first moment of the first day of the first month** of the first continuous period of institutionalization that began on or after September 30, 1989. This may be different from the current period of institutionalization. Use the information below to determine exactly when the individual's first continuous period of institutionalization began.

Inquire if the individual was ever institutionalized prior to the current institutionalization but not earlier than September 30, 1989. If yes, ascertain the first date on or after September 30, 1989, on which the individual was admitted to a medical institution.

Ask the following:

- From where was he admitted?

  If admitted from a home in the community that is not an institution as defined in section M1410.010, determine if Medicaid CBC waiver services were received and covered by Medicaid while the individual was in the home. If so, the days of Medicaid CBC receipt are "institutionalization" days.

  If admitted from another institution, ascertain the admission and discharge dates, institution's name and type of institution. The days he was in a medical institution are institutionalization days if there was less than a 30-day break between institutionalizations.

- What was the last date the individual resided outside a medical institution (in the community, at home, or in a non-medical institution)?

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3. Verification

The EW must advise the requesting party of the verification necessary to complete the assessment. Ownership interest and value of resources held **on the first moment of the first day of** the first month of the first continuous period of institutionalization must be verified.

Verify all non-excluded resources. Acceptable verification, for example, is a copy of the couple's bank statement(s) for the period. Do not send bank clearances; the requesting party is responsible to obtain verification of resources.

The EW is not required to assist the requesting party in obtaining any required verification for the resource assessment.

4. Failure To Provide Verification

If the applicant refuses to or fails to provide requested verification of resources held at the beginning of the first continuous period of institutionalization and does not notify the EW of difficulty in securing the requested data, the worker is unable to complete the resource assessment and is unable to determine the spousal share of resources. Go to item 8 below, "Notification Requirements."

5. Processing Time Standard

A resource assessment must be processed within 45 days of the date on which the agency receives the written and signed Medicaid Resource Assessment Request form.

If the requestor fails to provide requested verification within 45 days of receipt of notification, notify the applicant that the assessment cannot be completed, and of the reason(s) why. Use the Notice of Medicaid Resource Assessment (#032-03-817).

6. Completing the Medicaid Resource Assessment

When verification is provided, completion of the resource assessment establishes the spousal share which is equal to ½ of a couple's total countable resources as of **the first moment of the first day of** the first month of the first continuous period of institutionalization that began on or after September 30, 1989.

a. Compile the Couple's Resources

The value of non-excluded resources must be verified *and entered into VaCMS. Enter* all resources in which the couple has an ownership interest, including resources in their joint names, those in the institutionalized spouse's name and those in the community spouse's name, including those resources owned jointly with others. List each resource separately.

VaCMS will calculate the spousal share. The process used to calculate the spousal share is found in M1480.210 6.b below.

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b. Calculate the Spousal Share

Calculate the total value of the couple's countable resources. Divide this total by 2 to obtain the spousal share. The spousal share is ½ of the couple's combined countable resources as of **the first moment of the first day of the first month** of the first continuous period of institutionalization that began on or after September 30, 1989.

Calculate the spousal share only once; it remains a constant amount for any Medicaid application filed after the resource assessment.

EXAMPLE #2: A Medicaid Resource Assessment Request is received on October 20, 1996 for Mrs. H who was admitted to the nursing facility on October 18, 1996. Her first continuous period of institutionalization began on December 21, 1995, and ended with her discharge on May 30, 1996. Mr. H provides verification which proves that the couple's total countable resources as of December 1, 1995 (the first day of the first month of the first continuous period of institutionalization) were $131,000. The spousal share is ½ of $131,000, or $65,500.

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

Resource	Owner	Countable	Countable Value
Home	Mr & Mrs	No	0
Savings	Mr & Mrs	Yes	$100,000
CD	Mr	Yes	$ 31,000

$131,000	Total Value of Couple's Countable Resources
$ 65,500	Spousal Share

If in the future, Mrs. H applies for Medicaid and she is still married to Mr. H, the worker must use the spousal share of $65,500 determined by the October 1996 resource assessment.

7. Send Loans and/or Judgments to DMAS

When the resource assessment identifies a loan or a judgment against resources, send the documents pertaining to the loan and/or judgment to DMAS for review before taking action on the resource assessment. Send the documents, along with case identifying information (institutionalized spouse's and community spouse's names, address, SSN, case number) to:

DMAS, *Eligibility & Enrollment Services Division*
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

8. Notification Requirements

a. When the Assessment Is Not Completed

Both spouses and the guardian, conservator or authorized representative must be notified in writing that the assessment was not completed; note the specific reason on the form. Use the form Notice of Medicaid Resource Assessment (#032-03-817).



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b. When the Assessment Is Completed

Both spouses and the guardian, conservator, or authorized representative must be notified in writing of the assessment results and the spousal share calculated. Use the form Notice of Medicaid Resource Assessment (#032-03-817). Attach a copy of the Medicaid Resource Assessment form (#032-03-816) to each Notice. A copy of all forms and documents used must be kept in the agency's case record.

M1480.220 RESOURCE ASSESSMENT WITH MEDICAID APPLICATION

A. Introduction

This section applies to married individuals with community spouses who are inpatients in medical institutions or nursing facilities, who have been *authorized* to receive Medicaid CBC waiver services, or who have elected hospice services. If a married individual with a community spouse is receiving private-pay home-based services, he **cannot** have a resource assessment done without also filing a concurrent Medicaid application.

B. Policy

1. Resource Assessment

If a resource assessment was **not completed** before the Medicaid application was filed, the spousal share of the couple's total countable resources that existed **on the first moment of the first day of** the first month of the first continuous period of institutionalization that began on or after September 30, 1989, is calculated when processing a Medicaid application for a married institutionalized individual with a community spouse.

If a resource assessment was completed before the Medicaid application was filed, use the spousal share calculated at that time in determining the institutionalized spouse's eligibility.

2. Use ABD Resource Policy

For the purposes of the resource assessment and spousal share calculation, countable and excluded resources are determined for all covered groups using the ABD resource policy in Chapter S11, **regardless of the individual's covered group and regardless of community property laws or division of marital property laws,** except for the following resources which are excluded as indicated below when completing the resource assessment and spousal share:

- the home and **all** contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SS & SSI payments for nine (9) calendar months following the month in which the individual receives the benefits; and
- up to **$1,500** of burial funds for each spouse (NOT $3,500), if there are designated burial funds.

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Resources owned in the name of one or both spouses are considered available regardless of whether either spouse agrees to sell or liquidate the resource, and regardless of whether either spouse refuses to make the resource available.

If either or both spouses own more than one home, the home in which the institutionalized spouse resides or last resided prior to institutionalization is excluded. Any other home(s) owned by either or both spouse are counted.

The resource assessment is not affected by the amount disregarded in the eligibility determination as a result of a Partnership Policy.

C. Appeal Rights

When the resource assessment is completed as part of a Medicaid application and eligibility determination, the spousal share calculation can be appealed pursuant to the existing Client Appeals regulations (VR 460-04-8.7).

D. Eligibility Worker Responsibility

Each application for Medicaid for a person receiving *LTSS* services who has a community spouse requires the completion of a resource assessment to determine the spousal share used in determining eligibility.

The EW must provide the applicant with a written request for verification of:

- all reported countable resources owned by the couple **on the first moment of the first day of the first month (FOM)** of the first continuous period of institutionalization. Request this information using the Medicaid Resource Assessment form (#032-03-816) when the FOM is prior to the application's retroactive period.
- all reported countable resources owned by the couple on the first moment of the first day of the month of application, and
- all reported countable resources owned by the couple as of the first moment of the first day of each retroactive month for which eligibility is being determined.

To expedite the application processing, the EW may include a copy of the "Intent to Transfer Assets to A Community Spouse" form, available on *the VDSS intranet* with the request for verifications.

The same verification requirements as for all Medicaid applications apply to the resource assessment.

If the applicant reports to the EW that he cannot obtain certain verifications, the EW must determine why he cannot obtain them and what the EW can do to assist the applicant.

E. Procedures

The resource assessment is only a part of the eligibility determination process. The spousal share is calculated as a result of the resource assessment. The spousal share is used in the calculation of the spousal protected resource amount (PRA) and the institutionalized spouse's countable resources.

1. Forms

The applicant or his representative does not complete a Medicaid Resource Assessment Request form. The Medicaid application is the resource assessment request. The resource assessment will be calculated in VaCMS as part of the eligibility determination process.

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2. Send Judgments to DMAS

When the resource assessment or eligibility determination identifies a judgment against resources, send the documents pertaining to the judgment to DMAS for review and how it relates to the resource before taking action on the application. Send the documents, along with case identifying information (institutionalized spouse's and community spouse's names, address, SSN, case number) to:

DMASEvaluation@dmas.virginia.gov

Or mail to:
Eligibility *Policy and Outreach* Division – Policy Unit
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

3. Determining the First Continuous Period of Institutionalization

The spousal share is based on the couple's resources owned **on the first moment of the first day of** the first month of the first continuous period of institutionalization which occurred on or after September 30, 1989. This may be different from the current period of institutionalization. Use the information below to determine exactly when the individual's first continuous period of institutionalization began.

Inquire if the individual was ever institutionalized prior to current institutionalization but not earlier than September 30, 1989. If yes, ascertain the first date on or after September 30, 1989, on which the individual was admitted to a medical institution or the first date Medicaid CBC waiver services began.

Ask the following:

- From where was *the individual* admitted?

  If admitted from a home in the community which is not an institution as defined in section M1410.010, determine if Medicaid CBC waiver services were received and covered by Medicaid while the individual was in the home. If so, the days of Medicaid CBC receipt are "institutionalization" days.

  If admitted from another institution, ascertain the admission and discharge dates, institution's name and type of institution. The days he was in a medical institution are institutionalization days if there was less than a 30-day break between institutionalizations.

- What was the last date the individual resided outside a medical institution (in the community, at home, or in a non-medical institution)?

4. Failure to Provide Verification

a. Applicant Does Not Notify Agency of Difficulty Securing Verifications

If the applicant fails to provide requested verification of the value of the couple's resources held at the beginning of the first continuous period of institutionalization and does not notify the EW of difficulty in securing the



requested data, the worker is unable to complete the resource assessment and eligibility as a married institutionalized individual cannot be determined. The application must be processed using rules for non-institutionalized individuals and payment for LTC services must be denied for failure to verify resources held at the beginning of institutionalization.

b. Applicant Notifies Agency of Difficulty Securing Verifications

If the applicant is unable to provide verification of the value of the couple's resources held at the beginning of the first continuous period of institutionalization and notifies the EW of difficulty in securing the requested data, the applicant may claim undue hardship.

Undue hardship can be claimed when both spouses have exhausted all avenues to verify the value of the resources owned on the first day of the first month of the first continuous period of institutionalization. When undue hardship is claimed, the applicant must provide documentation of the attempts made to obtain the verification. **Claims of undue hardship must be evaluated and can only be granted by DMAS.** The EW must send a summary of the needed verifications and documentation of the attempts to secure the verifications, along with the applicant's name and case number to:

DMAS, Eligibility *Policy and Outreach* Division
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

Or email DMASEvaluation@dmas.virginia.gov.

If DMAS determines undue hardship does not exist, the resource assessment cannot be completed and the application must be denied due to failure to verify resources held at the beginning of institutionalization. If DMAS determines undue hardship exists, the completion of a resource assessment is waived, and the spousal resource standard is to be substituted for the spousal share in determining the individual's resource eligibility. Go to section M1480.230 below.

5. Completing the Medicaid Resource Assessment

When verification is provided, completion of the resource assessment establishes the spousal share which is equal to ½ of a couple's total countable resources as of **the first moment of the first day of** the first month of the first continuous period of institutionalization that began on or after September 30, 1989. The spousal share is one factor in determining the spousal protected resource amount (PRA) in section M1480.230 below.

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a. Compile the Couple's Resources

The value of countable resources must be verified and recorded on the Medicaid Resource Assessment form (#032-03-816). Excluded resources must be listed separately on the form, but their value does not need to be noted or verified.

On the assessment form, list all resources in which the couple has an ownership interest - resources in their joint names, those in the institutionalized spouse's name and those in the community spouse's name, including those resources owned jointly with others. List each resource separately.

b. Calculate the Spousal Share

Calculate the total value of the couple's countable resources. Divide this total by 2 to obtain the spousal share. The spousal share is ½ of the couple's total countable resources as of the first moment of the first day of the first month of the first continuous period of institutionalization that began on or after September 30, 1989.

Calculate the spousal share only once; it remains a constant amount for the current Medicaid application and all subsequent Medicaid applications filed.

EXAMPLE #3: A Medicaid application is received on October 20, 1996 for Mrs. H who was admitted to the nursing facility on October 18, 1996. Her first continuous period of institutionalization began on December 21, 1995, and ended with her discharge on May 30, 1996. Neither she nor her spouse requested a resource assessment before applying for Medicaid.

To determine Mrs. H's eligibility and the amount of the couple's current resources that can be "protected" for Mr. H, Mr. H provides verification which proves that the couple's total countable resources as of December 1, 1995 (the first day of the beginning of the first continuous period of institutionalization) were $131,000. The spousal share is ½ of $131,000, or $65,500.

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

Resource	Owner	Countable	Countable Value
Home	Mr & Mrs	No	0
Savings	Mr & Mrs	Yes	$100,000
CD	Mr	Yes	$31,000

$131,000 Total Value of Couple's Countable Resources
$ 65,500 Spousal Share

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

F. Notice Requirements

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

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

M1480.225 INABILITY TO COMPLETE THE RESOURCE ASSESSMENT-UNDUE HARDSHIP

A. Policy

Federal law states that a resource assessment must be completed on all Medicaid applications for institutionalized individuals who have a community spouse. On occasion, however, it is difficult to comply with this requirement because the applicant is unable to establish marital status or locate a separated spouse, or the community spouse refuses or fails to provide information necessary to complete the resource assessment. *A claim of undue hardship cannot be made on a denied or closed Medicaid case or when the individual is deceased.* In situations where the applicant is unable to provide information necessary to complete the resource assessment, undue hardship can be claimed if each of the following criteria is met:

1. The applicant establishes by affidavit specific facts sufficient to demonstrate (a) that all *reasonable* steps *have been taken* under the circumstances to locate the spouse, to obtain relevant information about the resources of the spouse, and to obtain financial support from the spouse (including information about any legal proceedings initiated, protective orders in effect, etc.); and (b) that *these efforts have* been unsuccessful;

   Absent extraordinary circumstances, determined by DMAS, the requirements of A.1 (a) cannot be met unless the applicant and spouse have lived separate and apart without cohabitation and without interruption for at least 36 months.

2. Upon such investigation as DMAS may undertake, no relevant facts are revealed that refute the statement contained in the applicant's affidavit, as required by paragraph A.1.

3. The applicant has assigned to DMAS, to the full extent allowed by law, all claims to financial support from the spouse; and

4. The applicant cooperates with DMAS in any effort undertaken or requested by DMAS to locate the spouse, to obtain information about the spouse's resources and/or to obtain financial support from the spouse. *If the applicant cannot complete the Resource Assessment due to a medical condition, a physician's statement must be provided documenting the medical condition.*

B. Procedures

1. Assisting the Applicant

The *Benefits Worker* must advise the applicant of the information needed to complete the resource assessment and assist the applicant in contacting the separated spouse to obtain resource and income information.

If the applicant cannot locate the separated spouse, document the VaCMS case record. Refer to M1480.225 B.2.b below.

If the applicant locates the separated spouse, the *Benefits Worker* must contact the separated spouse to explain the resource assessment requirements for the determination of spousal eligibility for long-term care services.

If the separated spouse refuses to cooperate in providing information necessary to complete the resource assessment, document the VaCMS case record. Refer to M1480.225 B.2.b below.

EXCEPTION: If the separated spouse is institutionalized and is a Medicaid applicant/recipient, the definition of "community spouse" is not met, and a resource assessment is not needed.

2. Undue Hardship

If the applicant is unable to provide the necessary information to complete the resource assessment, he/she must be advised of the hardship policy and the right to claim undue hardship.

a. **Undue hardship not claimed**

If the applicant does not wish to claim undue hardship, the *Benefits Worker* must document the VaCMS case record, and the application must be processed using rules for non-institutionalized individuals. Payment for *LTSS* services must be denied for failure to verify resources held at the beginning of institutionalization.

b. **Undue hardship claimed**

If the applicant claims an undue hardship, a written statement requesting an undue hardship evaluation *must be provided*. A Resource Assessment Undue Hardship Request Form, including affidavit and assignment forms, may be given to the applicant to be used instead of an original statement but is **not required**. The forms are available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms.

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1) Applicant or Authorized Representative

The applicant or his authorized representative must provide a letter or the Resource Assessment Undue Hardship Request Form – DMAS-E10 indicating the following:

- The applicant is requesting an undue hardship evaluation;
- The name of the applicant's attorney-in-fact (i.e. who has the power of attorney) or authorized representative (if applicable);
- The length of time the couple has been separated;
- The name of the estranged spouse and his
  - Last known address,
  - Last known employer,
  - The types (i.e. telephone, in-person visit) and number of attempts made to contact the spouse:
    - Who made the attempt
    - Date(s) the attempt(s) were made,
    - The name of the individual contacted and relationship to estranged spouse; and
- Any legal proceeding initiated, protective orders in effect, etc.

If not included with the request, the applicant or authorized representative may also be asked to provide:

- A completed, signed, and notarized Affidavit Form (DMAS-E11);
- A signed and dated Assignment Form (DMAS-E12)

A completed Resource Assessment Undue Hardship Request Form (including the affidavit and assignment forms) may be used instead of a letter from the worker but is **not required**.

2) *Benefits* Worker

A cover sheet is to be prepared that includes the following information:

- The applicant's name and case number;
- Documentation of any actions the *Benefits Worker* took to locate or contact the estranged spouse; and
- Include any documentation provided by the applicant or authorized representative.

The cover sheet and all information supporting the claim must be sent to:
DMASEvaluation@dmas.virginia.gov

Or mailed to:
Eligibility *Policy and Outreach* Division – Policy Unit
DMAS
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If DMAS determines that undue hardship does not exist, and the resource assessment cannot be completed, the *Benefits Worker* must deny the application due to failure to verify resources held at the beginning of institutionalization.

If DMAS determines an undue hardship does exist, the *Benefits Worker* will be sent instructions for continued processing of the case.

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M1480.230 RESOURCE ELIGIBILITY OF INSTITUTIONALIZED SPOUSE

A. Introduction

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

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

B. Policy

An institutionalized spouse meets the resource eligibility requirements for Medicaid if the difference between the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined and the spousal protected resource amount (PRA) is equal to or less than $2,000.

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

For the purposes of determining eligibility of an institutionalized spouse with excess resources, an institutionalized spouse **cannot** establish resource eligibility by reducing resources within the month. The institutionalized spouse may become eligible for Medicaid payment of LTC services when the institutionalized spouse's resources are equal to or below the $2,000 resource limit as of the first moment of the first day of a calendar month.

1. Use ABD Resource Policy

For the purposes of eligibility determination, countable and excluded resources are determined for all covered groups using the ABD resource policy in Chapter S11, **regardless of the individual's covered group and regardless of community property laws or division of marital property laws,** except for the following resources which are excluded as indicated below when determining eligibility of the institutionalized spouse:

- the home and all contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SS & SSI payments received on or after 11/01/05 for nine (9) calendar months following the month in which the individual receives the benefits; and
- up to $3,500 of burial funds for each spouse.

Resources owned in the name of one or both spouses are considered available in the initial month for which eligibility is being determined regardless of whether either spouse agrees to sell or liquidate the resource, and regardless of whether either spouse refuses to make the resource available.

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2. After Eligibility is Established

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

If an institutionalized spouse's Medicaid coverage was cancelled and reapplies as an institutionalized individual, use only the resources of the institutionalized spouse for *the applicant's* eligibility determination.

M1480.231 SPOUSAL RESOURCE STANDARDS

A. Introduction

This section provides the amounts and the effective dates of the standards used to determine an institutionalized spouse's initial and ongoing resource eligibility. Use the standard in effect on the date of the institutionalized spouse's Medicaid application. Definitions of the terms are found in section M1480.010.

B. Spousal Resource Standard

$32,532	*1-1-26*
$31,584	1-1-25
$30,828	1-1-24
$29,724	1-1-23

C. Maximum Spousal Resource Standard

$162,660	*1-1-26*
$157,920	1-1-25
$154,140	1-1-24
$148,620	1-1-23

M1480.232 INITIAL ELIGIBILITY DETERMINATION PERIOD

A. Policy

The initial eligibility determination period begins with the month of application. If the institutionalized spouse is eligible for the month of application, the initial eligibility determination period will both begin and end with that month.

After eligibility is established, the usual reporting and notification processes apply. Send written notice for the month(s) during which the individual establishes Medicaid eligibility. VaCMS will generate the "Notice of Patient Pay Responsibility" and it will be sent to the individual or his authorized representative.

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If the applicant is not eligible in the month of application, the initial eligibility determination period continues until the first month in which the institutionalized spouse is eligible. NOTE: Established application processing procedures and timeframes apply.

An institutionalized spouse meets the resource eligibility requirements for Medicaid if the difference between the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined, the community spouse's protected resource amount (PRA) and the institutionalized spouse's partnership policy disregard amount (see M1460.160) is equal to or less than $2,000.

1. First Application

Use the procedures in item B below for the initial resource eligibility determination for an institutionalized spouse's first application for Medicaid in a continuous period of institutionalization that began on or after 9-30-89.

2. Subsequent Applications

a. Medicaid Eligibility For LTC Services Achieved Previously

If an individual achieved Medicaid eligibility as an institutionalized spouse during a period of institutionalization that began on/after 9-30-89, regardless of whether the period of institutionalization is the same continuous period covered by the previous application(s), **do not consider the couple's resources. Use only the institutionalized spouse's resources**. Use the policy and procedures in section M1480.*230 B.2* to determine the institutionalized individual's financial eligibility.

b. Medicaid Eligibility For LTC Services Not Previously Achieved

If an individual has never achieved Medicaid eligibility as an institutionalized spouse, **treat the application** as an "initial eligibility" determination.

- Determine countable resources for the application month (see item B below);
- Deduct the spousal PRA from the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined.
- Deduct a dollar amount equal to the Partnership Policy disregard, if any.

B. Procedures

Use the following criteria to determine Medicaid eligibility for any month in the initial eligibility determination period.

NOTE: The initial eligibility determination period begins with the month of application. If the institutionalized spouse is not eligible in that month, the initial eligibility determination period continues until the first month in which the institutionalized spouse is eligible.

1. Couple's Total Resources

Verify the amount of the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined.

NOTE: When a loan or a judgment against resources is identified, send the documents pertaining to the loan and/or judgment to DMAS for review before taking action on the application. Send the documents, along with case identifying information (institutionalized spouse's and community spouse's names, address, SSN, case number) to:

DMAS, *Eligibility & Enrollment Services Division*
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

2. Deduct Spousal Protected Resource Amount (PRA)

Deduct the spousal protected resource amount (PRA) from the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined.

If no spousal share was determined because the couple failed to verify resources held at the beginning of the first continuous period of institutionalization, the application must be processed using rules for non-institutionalized individuals and payment for LTC services must be denied for failure to verify resources held at the beginning of institutionalization.

The PRA is the greatest of the following:

- the **spousal share** of resources as determined by the resource assessment, provided it does not exceed the maximum spousal resource standard in effect at the time of application. **If the spousal share exceeds the maximum spousal resource standard, use the maximum spousal resource standard.** The spousal share does not change; if a spousal share was previously established and verified as correct, use it;
- the **spousal resource standard** in effect at the time of application;
- an amount designated by a DMAS Hearing Officer;
- an amount **actually transferred** to the community spouse from the institutionalized spouse under a **court spousal support order** issued as the result of an appeal of the DMAS Hearing Officer's decision**.**

The EW cannot accept a court order for a greater PRA unless the individual has exhausted the Medicaid administrative appeals process, the individual appealed the DMAS Hearing Officer's decision to the circuit court and the circuit court ordered a higher amount.

If the individual does not agree with the PRA, see subsection F. below.

Once the PRA is determined, it remains a constant amount for the current Medicaid application (including retroactive months). If the application is denied and the individual reapplies, the spousal share remains the same but a new PRA must be determined.

3. Deduct Partnership Policy Disregard Amount

When the institutionalized spouse is entitled to a Partnership Policy disregard, deduct a dollar amount equal to the benefits paid as of the month of application.

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4. Compare Remainder

Compare the remaining amount of the couple's resources to the appropriate Medicaid resource limit for one person.

a. Remainder Exceeds Limit

When the remaining resources exceed the limit and the institutionalized spouse does not have Medicare Part A, the institutionalized spouse is not eligible for Medicaid coverage because of excess resources.

If the institutionalized spouse has Medicare Part A, may be eligible for limited coverage QMB, SLMB or QI Medicaid (which will not cover the cost of the LTC services) because the resource requirements and limits are different. **The resource policies in subchapter M1480 do not apply to limited-coverage Medicaid eligibility determinations**. Follow the procedures for determining resource eligibility for an individual in Chapter S11. More information about the QMB, SLMB, and QI covered groups is contained in subchapter M0320.

Note: The institutionalized spouse cannot be eligible for QDWI Medicaid.

b. Remainder Less Than or Equal to Limit

When the remaining resources are equal to or less than the Medicaid limit, the institutionalized spouse is resource eligible in the month for which eligibility is being determined:

- determine the community spouse resource allowance (CSRA). To calculate the CSRA, see sections M1480.240 and 241 below;
- determine a protected period of eligibility for the institutionalized spouse, if the institutionalized spouse expressly states his intent to transfer resources that are in his name to the community spouse; see section M1480.240 below.

C. Example-- Calculating the PRA

EXAMPLE #4:

Mr. A is married to a community spouse. He applied for Medicaid on December 2, 1997. The beginning of his first continuous period of institutionalization which began on or after 9-30-89 was October 12, 1993, when he was admitted to a nursing facility. He was discharged from the facility on February 5, 1995, then readmitted to the nursing facility on December 5, 1997 and remains there to date. Eligibility is being determined for December 1997.

Step 1:

The couple's total countable resources on October 1, 1993 (the first moment of the first day of the first continuous period of institutionalization) were $130,000.

4. Compare Remainder

Compare the remaining amount of the couple's resources to the appropriate Medicaid resource limit for one person.

c. Remainder Exceeds Limit

When the remaining resources exceed the limit and the institutionalized spouse does not have Medicare Part A, the institutionalized spouse is not eligible for Medicaid coverage because of excess resources.

If the institutionalized spouse has Medicare Part A, he may be eligible for limited coverage QMB, SLMB or QI Medicaid (which will not cover the cost of the LTC services) because the resource requirements and limits are different. **The resource policies in subchapter M1480 do not apply to limited-coverage Medicaid eligibility determinations**. Follow the procedures for determining resource eligibility for an individual in Chapter S11. More information about the QMB, SLMB, and QI covered groups is contained in subchapter M0320.

Note: The institutionalized spouse cannot be eligible for QDWI Medicaid.

d. Remainder Less Than or Equal to Limit

When the remaining resources are equal to or less than the Medicaid limit, the institutionalized spouse is resource eligible in the month for which eligibility is being determined:

- determine the community spouse resource allowance (CSRA). To calculate the CSRA, see sections M1480.240 and 241 below;
- determine a protected period of eligibility for the institutionalized spouse, if the institutionalized spouse expressly states his intent to transfer resources that are in his name to the community spouse; see section M1480.240 below.

C. Example-- Calculating the PRA

EXAMPLE #4:

Mr. A is married to a community spouse. He applied for Medicaid on December 2, 1997. The beginning of his first continuous period of institutionalization which began on or after 9-30-89 was October 12, 1993, when he was admitted to a nursing facility. He was discharged from the facility on February 5, 1995, then readmitted to the nursing facility on December 5, 1997 and remains there to date. Eligibility is being determined for December 1997.

Step 1:

The couple's total countable resources on October 1, 1993 (the first moment of the first day of the first continuous period of institutionalization) were $130,000.

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Step 2: $130,000 ÷ 2 = 65,000. The spousal share is $65,000.

Step 3: The couple's total countable resources as of December 1, 1997 (the first moment of the first day of the month for which eligibility is being determined), are $67,000.

Step 4: Determine the spousal protected resource amount (PRA). The spousal PRA is the greatest of:

- $65,000 (the spousal share, which is less than the maximum spousal resource standard of $79,020 in December 1997, the time of application).
- $15,804 (the spousal resource standard in December 1997, the time of the application).
- *$0* (DMAS hearing decision amount or court-ordered spousal support resource amount;(there is neither in this case).

Since $65,000 is the greatest, $65,000 is the PRA.

Step 5: Deduct the PRA from the couple's combined countable resources as of December 1, 1997 (the first moment of the first day of the month for which eligibility is being determined.

$67,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined (December 1, 1997)
- 65,000	Step 4 PRA
$2,000	countable resources in month for which eligibility is being determined (December 1, 1997).

The remaining $2,000 is the countable resource *amount* available to the institutionalized spouse on December 1, 1997 (the first moment of the first month for which eligibility is being determined).

Step 6: Compare the $2,000 countable resources to the resource limit of $2,000. The countable resources of the institutionalized spouse are equal to the limit and he is resource eligible in December (the month for which eligibility is being determined). A CSRA and protected period of eligibility are determined in section M1480.240 and 241 below.

D. Example--DMAS Hearing Officer Revised PRA

EXAMPLE #5: Mr. C applied for Medicaid on November 21, 1996. He was admitted to a nursing facility on December 20, 1994. This is his first application for Medicaid as an institutionalized spouse. He is married to Mrs. C who lives in their community home. The first moment of the first day of the first month of the first continuous period of institutionalization is December 1, 1994. Mr. C is not resource eligible in the retroactive period. Eligibility is being determined for November 1996. The couple's total countable resources as of December 1, 1994 (the first moment of the first day of the first continuous period of institutionalization) were $150,000.



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Step 2: $150,000 ÷ 2 = $75,000. The spousal share is $75,000.

Step 3: The couple's total countable resources on November 1, 1996 (first moment of the first day of the month for which eligibility is being determined) are $80,000.

Step 4: Determine the spousal protected resource amount (PRA). The spousal PRA is the greatest of:

$75,000 (the spousal share, which is less than the maximum spousal resource standard of $76,740 in November 1996);

$16,152 (the spousal resource standard at the time of the application);

$0 DMAS hearing decision amount (there is none in this case).

$0 amount actually transferred to community spouse pursuant to court-ordered spousal support (there is none in case).

Since $75,000 is the greatest, $75,000 is the PRA.

Step 5: Deduct the PRA from the couple's combined countable resources as of November 1, 1996 (the first moment of the first day of the month for which eligibility is being determined.

$80,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
- 75,000	Step 4 PRA
$ 5,000	countable resources in month for which eligibility is being determined.

$5,000 is the countable resources available to the institutionalized spouse in the month for which eligibility is being determined.

Steps 6 & 7: Compare the $5,000 countable resources to the resource limit of $2,000. The countable resources of the institutionalized spouse exceed the limit, so he is not eligible for *full-benefit* Medicaid in November 1996 (the month for which eligibility is being determined).

Mrs. C appealed the denial because she believes that she needs more resources protected so that her income will be sufficient to meet her needs. After a hearing in March 1997, and evidence gathered of Mrs. C's extraordinary shelter and medical expenses, the DMAS Hearing Officer decided that more of the couple's resources should be protected in order to raise Mrs. C's income to the minimum monthly maintenance needs allowance (MMMNA). The Hearing Officer decided that the spousal resource maximum of $76,740 should be the PRA. Mr. C's eligibility was recalculated using the $76,740 PRA.

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Step 5 again: The revised PRA was deducted from the couple's total combined countable resources in November 1996 (the initial month for which eligibility is being determined):

$80,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
- 76,740	Step 4 PRA
$3,260	countable resources in month for which eligibility is being determined.

$3,260 is the countable resources available to Mr. C in November 1996 (the month for which eligibility is being determined). He is not eligible for full-benefit Medicaid and the denial was sustained.

***E.* Example--PRA Is Amount Transferred Per Court-Ordered Spousal Support**

EXAMPLE #6: Mrs. C in Example #5 above is not satisfied with the Hearing Officer's decision to increase the PRA to $76,740 and files an appeal in circuit court. The hearing is held and the court orders Mr. C to transfer $79,000 of his resources to Mrs. C. He immediately completes the transfers, provides the documentation to his eligibility worker, and requests his eligibility be re-evaluated.

Step 1: The couple's total countable resources as of December 1, 1994 (the first moment of the first day of the first continuous period of institutionalization) were $150,000..

Step 2: $150,000 ÷ 2 = $75,000. The spousal share is $75,000.

Step 3: The couple's total countable resources as of November 1, 1996 (the first moment of the first day of the month for which eligibility is being determined) are $80,000.

Step 4: *Determine the spousal protected resource amount (PRA)*. The spousal PRA is the greatest of:

- $75,000 (the spousal share, which is less than the maximum spousal resource standard of $80,760 in the application month);
- $16,152 (the spousal resource standard at the time of the application);
- $76,740 DMAS hearing decision amount
- $79,000 amount actually transferred to community spouse pursuant to court-ordered spousal support.

Since $79,000 is the greatest, $79,000 is the PRA.

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F. PRA Revisions Policy

Revisions to the community spouse's calculated protected resource amount (PRA) can be made when:

1. A DMAS Hearing Officer determines that the income generated from the resources is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance (MMMNA). Substitute the amount the DMAS Hearing Officer determines for the PRA calculated in section M1480.232 above.

2. A DMAS Hearing Officer confirms that the initial PRA determination was incorrect.

3. A court orders spousal support in an amount that is greater than the PRA established in subsection B above ***after*** *the applicant completes the administrative appeals process.*

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M1480.233 INITIAL ELIGIBILITY - RETROACTIVE MONTHS

A. First Application

Use the procedures for the initial resource eligibility determination (section M1480.232 above) for each of the three (3) months preceding an institutionalized spouse's first application for Medicaid in a continuous period of institutionalization that began on or after 9-30-89.

To determine the institutionalized spouse's countable resources in each retroactive month, subtract the spousal PRA from the couple's total countable resources held **on the first moment of the first day of each retroactive month.** Use the procedures in C below.

B. Subsequent Applications

1. Medicaid Eligibility Established Previously

If an individual established Medicaid eligibility as an institutionalized spouse during a period of institutionalization that began on/after 9-30-89, regardless of whether the period of institutionalization is the same continuous period covered by the previous application(s), **do not consider the couple's resources. Use only the institutionalized spouse's resources**. Use the policy and procedures in section M1480.*230 B.2* to determine the institutionalized individual's financial eligibility.

For the application's retroactive month(s), determine resources using only the institutionalized spouse's resources in each retroactive month. If the institutionalized spouse's countable resources exceed the Medicaid resource limit in a retroactive month, the institutionalized spouse is NOT eligible for that month.

2. Medicaid Eligibility Not Previously Established

If an individual has never established Medicaid eligibility as an institutionalized spouse, **treat the application** as an "initial eligibility" determination (section M1480.232 above).

- Determine countable resources for the application month (see section M1480.232 above).
  - Deduct the spousal PRA from the couple's total countable resources held **on the first moment of the first day of each retroactive month.**
  - Deduct a dollar amount equal to the Partnership Policy disregard as of **the month of application** (Note: this amount is also used when determining eligibility for a retroactive month).

For the application's retroactive month(s), determine resources using the procedures in subsection C below.

C. Procedures

The procedures in this subsection are used for the retroactive determination based on a

- first application; or
- subsequent application when Medicaid eligibility as an institutionalized spouse was NOT previously established.

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1. Couple's Resources — Determine the couple's total countable resources as of the **first moment of the first day of each retroactive month.**

2. Subtract PRA — Subtract the spousal PRA (M1480.232 above) from the couple's total resources in each retroactive month. Each result is the countable resources available to the institutionalized spouse in each retroactive month.

3. *Subtract Partnership Policy Disregard* — *When the institutionalized spouse is entitled to a Partnership Policy disregard, deduct the dollar amount equal to the benefits paid as of the month of application.*

***4.* Countable Resources Within Limit** — If the countable resources in a *retroactive* month are less than or equal to the resource limit, the institutionalized spouse is eligible in that month.

***5.* Countable Resources Exceed Limit** — If the countable resources exceed the Medicaid resource limit in a retroactive month, the institutionalized spouse is NOT eligible for that month.

D. Retroactive Example — **EXAMPLE #8:** Mr B's first continuous period of institutionalization began on 9-20-92. He **first applied for Medicaid on February 3, 1998** and requested retroactive coverage for December 1997 and January 1998. Mrs. B is his community spouse.

Retroactive Month — December 1997

Step 1: — The couple's total resources as of September 1, 1992 (the first moment of the first day of the first continuous period of institutionalization) were $200,000.

Step 2: — $200,000 ÷ 2 = $100,000. The spousal share is $100,000.

Step 3: — The couple's total countable resources as of December 1, 1997 (the retroactive month for which eligibility is being determined) are $96,000.

Step 4: — Determine the spousal protected resource amount (PRA). The spousal PRA is the greatest of:

- $80,760(the maximum spousal resource standard in effect at the time of application (February 20, 1998) is less than the spousal share of $100,000);
- $16,152(the spousal resource standard in effect at the time of application (February 20, 1998),
- $0(no amount designated by DMAS Hearing Officer),
- $0(no amount transferred pursuant to court support order).

The PRA is $80,760 (the lesser of the maximum resource standard and the spousal resource standard, because there was no amount designated by DMAS Hearing Officer or transferred per court order).

NOTE: Once the PRA is determined, it remains the same for all retroactive months and for months in the initial eligibility determination period.



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Step 5: *Deduct the PRA from the couple's combined countable resources on as of December 1, 1997 (the first moment of the first day of the month for which eligibility is being determined)*

$96,000	Step 3 couple's total *resources owned as of first moment of the first day of the month for which eligibility is being determined*
- 80,760	Step 4 PRA
$15,240	countable resources *in month for which eligibility is being determined.*

$15,240 countable to Mr. B.

Step 6: Since $15,240 exceeds the $2,000 limit, Mr. B is not eligible for Medicaid for December 1997 (the retroactive month for which eligibility is being determined.

Complete a retroactive determination for January 1998.

Retroactive Month *January 1998*

Step 1: *The couple's total resources as of September 1, 1992 (the first moment of the first day of the first continuous period of institutionalization) were $200,000.*

Step 2: *$200,000 ÷ 2 = $100,000. The spousal share is $100,000.*

Step 3: *The couple's total countable resources as of January 1, 1998 (the retroactive month for which eligibility is being determined) are $93,000.*

Step 4: *Determine the PRA: Once the PRA is determined, it remains the same for all retroactive months and for months in the initial eligibility determination period.*

The PRA is $80,760 (See Step 4 in the retroactive determination for December 1997 above).

Step 5: *Deduct the PRA from the couple's combined countable resources as of January 1, 1998 (the first moment of the first day of the month for which eligibility is being determined):*

$93,000	*Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined*
- 80,760	*Step 4 PRA*
$ 12,240	*countable resources in month for which eligibility is being determined.*

$12,240 countable resources for Mr. B.

Step 6: *Since $12,240 exceeds the $2,000 limit, Mr. B is not eligible for Medicaid in for January 1998 (the retroactive month for which eligibility is being determined. Proceed to determine eligibility for the initial eligibility determination period that begins with February 1998 (month of application).*



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Initial Eligibility Determination *Month* February 1998

Step 1: The couple's total resources as of September 1, 1992 (the first moment of the first day of the first continuous period of institutionalization) were $200,000.

Step 2: $200,000 x 2 = $100,000. The spousal share is $100,000.

Step 3: The couple's total countable resources as of February 1, 1998 (the month for which eligibility is being determined) are $90,000.

Step 4: Determine the PRA: Once the PRA is determined, it remains the same for all retroactive months and for months in the initial eligibility determination period.

The PRA is $80,760 (See Step 4 in the retroactive determine for December 1997 above).

Step 5: Deduct the PRA from the couple's combined countable resources on February 1, 1998 (the first moment of the first day of the month for which eligibility is being determined):

$90,000 Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
- 80,760 Step 4 PRA
$9,240 countable resources in month for which eligibility is being determined.

$ 9,240 countable resources for Mr. B.

Step 6: Since $9,240 exceeds the $2,000 limit, Mr. B is not eligible for Medicaid in February 1998 (the month for which eligibility is being determined).

Note: The initial eligibility determination period continues until the individual is found eligible. If Mr. B reapplies, he will still be in the initial eligibility determination period.

M1480.240 *INTENT TO TRANSFER - PROTECTED PERIOD*

A. Policy

After the initial eligibility determination, an institutionalized spouse who has resources in his name which exceed the Medicaid resource limit may have his Medicaid resource eligibility "protected" for a period of time if all of the following criteria are met:

- *resources in the community spouse's name are less than the PRA at the time of application,*

- the amount of resources that may be transferred to bring the community spouse up to the PRA will reduce the resources in the institutionalized spouse's name to no more than $2,000, and

- the institutionalized spouse has expressly indicated in writing *the* intent to transfer resources to the community spouse.

The protected period is designed to allow the institutionalized spouse time to legally transfer some or all of his resources to the community spouse. Resources in the institutionalized spouse's name are excluded only for one 90-day period.

If the institutionalized spouse does not transfer resources to the community spouse within the 90-day period, all of the institutionalized spouse's resources will be counted available to the institutionalized spouse when the protected period ends. If the institutionalized spouse loses eligibility after the 90-day protected period is over, and then reapplies for Medicaid, *the applicant* CANNOT have resource eligibility protected again and a PRA is NOT subtracted from resources *in the applicant's name*.

B. Protected Period Is Not Applicable

A protected period of eligibility is not applicable to an institutionalized spouse when:

- the institutionalized spouse is not eligible for Medicaid;

- the institutionalized spouse previously established Medicaid eligibility as an institutionalized spouse, had a protected period of eligibility, became ineligible, and reapplies for Medicaid; or

- at the time of application, a community spouse has title to resources equal to or exceeding the PRA.

C. Intent to Transfer Resources To Community Spouse

The institutionalized spouse or authorized representative must expressly indicate in writing *the* intention to transfer resources to the community spouse. If not previously obtained, send an "Intent to Transfer Assets to A Community Spouse" form, available at *https://fusion.dss.virginia.gov/bp/BP- Home/Medical-Assistance/Forms*, to the institutionalized spouse or authorized representative, allowing 10 days from the date of mailing for return of the form.

If the completed Intent to Transfer Assets form is not returned by the time the application is processed, no protected period of eligibility may be established. All resources in the institutionalized spouse's name must be counted in *the* eligibility determination beginning with the month following the initial eligibility determination period. If eligible, enroll the institutionalized spouse for a closed period of coverage beginning with the retroactive period and ending with the last day of the month of the initial eligibility period.

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If the institutionalized spouse submits a new application for Medicaid payment of long-term care services, the process starts again and a new Intent to Transfer form must be mailed.

When the community spouse is a Medicaid recipient, the eligibility worker must inform the couple that the transfer of resources to the community spouse could impact the community spouse's Medicaid eligibility.

D. How to Determine the Protected Period

The 90-day protected period begins with the date the local agency takes action to approve the institutionalized spouse's initial eligibility for Medicaid LTC services, if the institutionalized spouse or authorized representative has signed the Intent to Transfer Assets form.

E. Protected Period Ends

Set a special review for the month in which the 90-day period ends. When the protected period of eligibility is over, all resources owned in the institutionalized spouse's name are counted available to the institutionalized spouse. Extension of the protected period is NOT allowed.

F. Institutionalized Spouse Acquires Resources During the Protected Period of Eligibility

If the institutionalized spouse obtains additional resources during the protected period of eligibility, the additional resources shall be excluded during the protected period if:

- the new resources combined with other resources that the institutionalized spouse intends to retain do not exceed the appropriate Medicaid resource limit for one person, OR
- the institutionalized spouse intends to transfer the new resources to the community spouse during the protected period of eligibility and the total resources to be transferred do not exceed the balance remaining (if any) of the PRA.

NOTE: Some assets, such as inheritances, are income in the month of receipt. Be careful to count only those assets that are resources in the month of receipt, and to count assets that are income as a resource if retained in the month following receipt.

M1480.241 COMMUNITY SPOUSE RESOURCE ALLOWANCE (CSRA)

A. Policy

When the Intent to Transfer form has been completed, the institutionalized spouse's eligibility is protected for 90 days to allow time for resources in the institutionalized spouse's name to be transferred to the community spouse for the community spouse's support.

The community spouse resource allowance (CSRA) is the amount of the resources in the institutionalized spouse's name (including *the applicant's* share of jointly owned resources) which can be transferred to the community spouse to bring the resources in the community spouse's name up to the PRA. This amount is disregarded in the institutionalized spouse's Medicaid eligibility determination during the protected period.

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B. CSRA Calculation Procedures

Use the following procedures for calculating the CSRA. The "Institutionalized Spouse Resource Eligibility Worksheet," available at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*, should be used to determine countable resources and the CSRA.

1. Determine Community Spouse's Resources

Determine the amounts of the couple's total resources which are in the community spouse's name only and the community spouse's share of jointly owned resources owned as of the first moment of the first day of the initial month for which eligibility was established.

2. Determine Institutionalize Spouse's Resources

Determine the amounts of the couple's total resources which are in the institutionalized spouse's name only and the institutionalized spouse's share of jointly owned resources owned as of the first moment of the first day of the initial month for which eligibility was established. If the institutionalized spouse's resources changed during initial month (after the first moment of the first day of the initial month which eligibility was established) verify the institutionalized spouse's resources owned as of the first moment of the first d of the month following the initial month.

3. Calculate CSR

To calculate the Community Spouse Resource Allowance (CSRA):

a. Determine PRA

Find the spousal PRA (determined in section M1480.232 above).

***b.* Subtract CS Resources from the PRA**

Subtract from the PRA an amount equal to the resources in the community spouse's name only and the community spouse's share of jointly owned resources as of the first moment of the first day of the initial month in which eligibility was established.

***c.* Remainder**

The remainder, if greater than zero, is the CSRA and the amount to be disregarded in the institutionalized spouse's Medicaid eligibility determination during the protected period. This is the amount to be transferred to the community spouse during the protected period.

If the remainder is $0 or a negative number, the CSRA = $0. The community spouse does not have a CSRA.

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C. Example CSRA Calculation

EXAMPLE #9*: (Using January 2008 figures)*

Mrs. Tea applied for Medicaid on *May 21, 2008*. She was admitted to the nursing facility on *January 20, 2008*. She is married to Mr. Tea who lives in their community home. This is her first application for Medicaid as an institutionalized spouse. The first day of the first month of the first continuous period of institutionalization is *January 1, 2008*. Eligibility is being determined for May 2008. *Mrs. Tea signs the Intent to Transfer from June 1, 2008.*

Step 1:

Determine the PRA

The couple's total countable resources as of *January 1, 2008* (the first moment of the first day of the first continuous period of institutionalization) were $50,000.

$25,000spousal share ($50,000 ÷ 2), *not to exceed the maximum spousal resource standard of $104,400, eff. 01-01-2008*

$20,880spousal resource standard in effect on January 1, 2008

$0 (amount actually transferred as court-ordered spousal support); or
$0 (DMAS hearing decision amount).

Since $25,000 is the greatest of the above, $25,000 is the PRA.

Steps 2. and 3:

Subtract CS Resources from the PRA to Determine CSRA

The couple's total *resources owned as of first moment of the first day of the month for which eligibility is being determined are $26,500. The community spouse has $7,000 in his name. The institutionalized spouse has $19,500 in her name. From the PRA of $25,000, deduct the community spouse resource amount of $7000. The remaining $18,000 is the CSRA that can be transferred to the community spouse and disregarded in the institutionalized spouse' Medicaid eligibility determination during the protected period.*

$25,000PRA
- 7,000 Resources in the CS name
$18,000 CSRA (amount that can be transferred to CS)

***D.* Community Spouse Acquires Additional Resources During Protected Period**

If the **community spouse** obtains additional resources during the protected period of eligibility, the institutionalized spouse's eligibility is NOT affected. The community spouse's new resources are not counted when determining the institutionalized spouse's eligibility during or after the protected period of eligibility. **Do NOT recalculate the CSRA.**

***E.* Reviewing Resource Eligibility**

When reviewing the institutionalized spouse's resource eligibility at the end of the protected period and at scheduled redeterminations, the community spouse's resources are NOT counted available.

***F.* Asset Transfers**

Instructions for treatment of asset transfers are found in subchapter M1450.



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Pages 35 through 46 have been deleted.

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M1480.260 SUSPENSION PROCEDURES

A. Policy

This section applies to institutionalized individuals who:

are enrolled in ongoing Medicaid coverage, have
Medicare Part A,
have a patient pay that exceeds the Medicaid rate, and have
resources between $2,000 and $4,000.

B. Procedures

If the conditions above are met, take the following actions:

1. Prepare and Send Advance Notice

Prepare and send an advance notice to reduce the recipient's full Medicaid coverage to the appropriate ABD covered group. Specify the effective date, which is the last day of the month in which the 10-day advance notice period expires. Write a note on the notice telling the recipient that if *verified resources* are less than or equal to the $2,000 resource limit before the specified date (specify the date which is 3 months from the cancel effective date), *the individual* should request reinstatement of Medicaid coverage.

2. Suspend Case Administratively

Suspend the case administratively for a maximum of 3 months; do not close the case statistically. The suspension effective date is the effective date of the Medicaid cancellation in the Virginia Case Management System (VaCMS). The case is counted as a "case under care" while suspended.
While suspended, the case remains open for a maximum of 3 months.

If, by the end of 3 months from the suspension effective date, the individual provides verification that resources have been reduced to or below the resource limit, update the latest application or redetermination form in the individual's case record. Reinstate his Medicaid coverage effective the first day of the month in which resources are less than or equal to the resource limit.

If the individual does NOT provide verification within 3 months of the suspension effective date that *the* resources *in the applicant's name* have been reduced to or below the resource limit, close the case administratively and statistically. Do not take any action on enrollment in the VaCMS because coverage has already been canceled. The individual will have to file a new Medicaid application.

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M1480.300 INCOME ELIGIBILITY OF INSTITUTIONALIZED SPOUSE

A. Introduction

The income rules in this section apply only to the institutionalized spouse's eligibility.

The rules in this section supersede all other manual chapters and sections wherever those chapters or sections conflict with these rules. The ABD income policy rules in Virginia DSS Volume XIII, Chapter S08 are used to determine income eligibility for married institutionalized individuals.

1. When Applicable

The income rules apply to an institutionalized spouse regardless of when the continuous period of institutionalization began.

2. When Not Applicable

If the institutionalized spouse no longer meets the definition of an institutionalized spouse in section M1480.010, the income rules in this subchapter do not apply effective the first day of the first full calendar month following the month in which he no longer meets the definition of an institutionalized spouse.

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These rules NEVER apply when determining the eligibility of the community spouse. The income rules applicable to non-institutionalized individuals, found in other sections and chapters of the manual, apply to the community spouse.

B. Policy

An institutionalized spouse's income shall be determined as follows without regard to state laws governing community property or division of marital property:

1. Income From Non-trust Property

Unless a DMAS Hearing Officer determines that the institutionalized spouse has proven to the contrary (by a preponderance of the evidence):

a. income paid to one spouse belongs to that spouse;

b. each spouse owns one-half of all income paid to both spouses jointly;

c. each spouse owns one-half of any income which has no instrument establishing ownership [1924(b)(2)(C)];

d. income paid in the name of either spouse, or both spouses and at least one other party, shall be considered available to each spouse in proportion to the spouse's interest. When income is paid to both spouses and each spouse's individual interest is not specified, consider one-half of their joint interest in the income as available to each spouse.

2. Income From Trust Property

Ownership of income from trust property shall be determined pursuant to regular income policy, except as follows:

a. Income is considered available to each spouse as provided in the trust.

b. If a trust instrument is not specific as to the ownership interest in the trust income, ownership shall be determined as follows:

1) Income paid to one spouse belongs to that spouse.

2) One-half income paid to both spouses shall be considered available to each spouse.

3) Income from a trust paid in the name of either spouse or both spouses, and at least one other party, shall be considered available to each spouse in proportion to the spouse's interest in the trust principal. When income from a trust is paid to both spouses and each spouse's individual interest in the trust principal is not specified, consider one-half of their joint interest in the income as available to each spouse.

3. Income Deeming

Do not deem a community spouse's income available to an institutionalized spouse for purposes of determining the institutionalized spouse's Medicaid eligibility for any month of institutionalization (including partial months). For the month of entry into institutionalization and subsequent months, only the institutionalized individual's income is counted for eligibility and patient pay purposes.



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The community spouse's income is used only to determine the community spouse monthly income allowance, if any.

4. Income Determination

For purposes of the income eligibility determination of a married institutionalized spouse, regardless of the individual's covered group, income is determined using the income eligibility instructions in section M1480.310 below and chapter S08.

For individuals who are within a spenddown budget period prior to the month in which they become institutionalized, prorate and shorten the spenddown budget period to include months **prior to admission** to long-term care services. A separate monthly budget period is established for each month of receipt of long-term care services.

5. Post-eligibility Treatment of Income

After an institutionalized spouse is determined eligible for Medicaid, his or her patient pay must be determined. See the married institutionalized individuals' patient pay policy and procedures in section M1480.400 below.

M1480.310 ABD 80% FPL AND 300% SSI AND INCOME ELIGIBILITY DETERMINATION

A. Introduction

This section provides those income requirements specific to determinations of eligibility for Medicaid participation in payment of long-term care services.

For ABD individuals, first determine the individual's eligibility in the ABD 80% FPL covered group. If the individual is ineligible in the ABD 80% FPL covered group, determine the individual's eligibility in the 300% SSI covered group.

For purposes of this section, we refer to the ABD and F&C covered groups of "individuals in medical facilities who have income less than or equal to 300% of the SSI individual payment limit" and *the ABD and F&C covered groups of*" individuals receiving Medicaid waiver services who have income less than or equal to 300% of the SSI individual payment limit" as one *comprehensive* covered group. We refer to this comprehensive group as "institutionalized individuals who have income within 300% of SSI" or the "300% SSI group."

B. 300% SSI Group

The income limit for ABD and F&C individuals in the 300% SSI group is 300% of the SSI individual payment limit (see M0810.002.A.3).

1. Gross Income

Income sources listed in section M1460.610 are not considered as income.

Income sources listed in section M1460.611 ARE counted as income.

All other income is counted. The institutionalized spouse's gross income is counted; no exclusions are subtracted.

To determine an income type or source and to determine how to count the income, use the policy and procedures in chapter S08 for all individuals (ABD and F&C) in the 300% SSI group.

Income is projected for the month for which eligibility for LTC is being determined. This calculation is based upon the income received in the past month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount expected to be received.

2. Income Less Than or Equal to 300% SSI Limit

If the individual's gross income is less than or equal to the 300% SSI income limit, enroll the individual in the appropriate CN *aid category (AC)* and determine patient pay according to the policy and procedures found in section M1480.400.

a. Individual Has Medicare Part A

If the individual has Medicare Part A, determine if his income is within the QMB income limit. Calculate the individual's countable income for QMB according to chapter S08, and compare to the QMB limit. If the individual's gross income is less than or equal to the QMB limit, enroll the recipient with the appropriate dual-eligible QMB AC:

- Aged = 022
- Blind = 042
- Disabled = 062

If the income is over the QMB limit, enroll the recipient with the appropriate CN non-QMB AC:

- Aged = 020
- Blind = 040
- Disabled = 060

b. Individual Does Not Have Medicare Part A

If the individual does NOT have Medicare Part A, enroll the ABD recipient with the appropriate CN AC:

- Aged = 020
- Blind = 040
- Disabled= 060

Enroll the F&C recipient with the appropriate CN AC:

- Institutionalized child under age 21= 082
- Institutionalized F&C individual age 21 or older = 060.

3. Income Exceeds 300% SSI Limit

If income exceeds the 300% SSI limit, evaluate the institutionalized spouse as MN. Go to section M1480.330 below.

C. ABD 80% FPL

The income limit for the ABD 80% FPL covered group is 80% of the federal poverty level (see M0810.002.A.5). See section M0320.210 for details about this covered group.

The ABD income policy in chapter S08 is used to determine countable income for the ABD 80% FPL covered group. Income is projected for the month for which eligibility for LTC is being determined. This calculation is based upon the income received in the past month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount expected to be received.

If the individual's countable income is less than or equal to the 80% FPL income limit, enroll the individual with the appropriate ABD 80% FPL Aid Category (AC) and determine patient pay according to the policy and procedures found in section M1480.400. The ABD 80% FPL ACs are:

- Aged = 029
- Blind = 039
- Disabled = 049

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A. Payments Made by Another Individual

Payment of an individual's bills (including Medicare supplementary medical insurance or other medical insurance premiums) by a third party directly to the supplier is not income.

Payments made directly to the service provider by another person for the individual's private room or "sitter" in a medical facility are NOT income to the individual. Refer all cases of Medicaid eligible enrollees in nursing facilities who have a "sitter" to DMAS, Division of Aging and Disability Services, for DMAS review to assure that DMAS is not paying the facility for services provided by the sitter.

B. LTC Insurance Policy Payments

The LTC insurance policy must be entered into the recipient's TPL file. The insurance policy type is "H" and the coverage type is "N." *Medicaid* will not pay the nursing facility's claim unless the claim shows how much the policy paid.

If the patient receives the payment from the insurance company, it is **not** counted as income. The patient should assign it to the provider. If the patient cannot do this, or the policy prohibits assignment, the payment should be given directly to the provider. The provider should report the payment as a third party payment on its claim form.

If the patient received the payment and cannot give it to the facility for some reason, then the patient should send the insurance payment to:

DMAS Fiscal Division, Accounts Receivable
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

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M1480 MARRIED INSTITUTIONALIZED INDIVIDUALS	**M1480.320**		**52**

A. Policy

The retroactive spenddown budget period is the three months immediately prior to the application month, when none of the months overlap (was included in) a previous MN spenddown budget period in which spenddown eligibility was established. When some of the months overlap a previous MN spenddown budget period in which spenddown eligibility was established, the retroactive spenddown budget period is shortened (prorated) to include only the month (s) which were not included in the previous MN spenddown budget period.

1. Institutionalized

For the retroactive months in which the individual was institutionalized, determine income eligibility on a **monthly basis** using the policy and procedures in this subchapter. A spenddown must be established for a month during which excess income existed.

2. Individual Not Institutionalized

For the retroactive months in which the individual was NOT institutionalized, determine income eligibility for ABD groups using the ABD policy and procedures in chapter S08. Determine income eligibility for F&C groups using policy and procedures in chapter M07. A spenddown must be established for a month(s) during which excess income existed.

3. Retroactive Entitlement

If the applicant meets all eligibility requirements, he is entitled to Medicaid coverage for the month(s) in which all eligibility factors were met.

B. Countable Income

Countable income is that which was actually received in the retroactive month(s). Count the income received in the months in which the individual meets all other Medicaid eligibility requirements.

The countable income is compared to the appropriate income limit for the retroactive month, if the individual was CN in the month. **For the institutionalized MN individual, Medicaid income eligibility is determined monthly.**

C. Entitlement

Retroactive coverage cannot begin earlier than the first day of the third month prior to the application month. When an applicant reports that a medical service *was received* within the retroactive period, entitlement for Medicaid will begin with the first day of the third month prior to the application month, provided all eligibility factors were met in all three months. If the applicant had excess income in the retroactive period and met spenddown, *enrollment begins* the first day of the month in which *the* retroactive spenddown was met. For additional information refer to section M1510.101.

D. Retroactive Example

EXAMPLE #15: A disabled institutionalized spouse applies for Medicaid on June 5 and requests retroactive coverage for unpaid medical bills that *were* incurred in March, April, and May. *The* disability onset date was April 10. *Institutionalization began* on April 10. The retroactive period is March, April and May. *Not* eligible for March because a covered group *was not met* in March. Countable resources are less than $2,000 in April, May and June. The income received in April and May is counted monthly because *the individual* was institutionalized in each month.

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April's income is calculated and compared to the monthly 300% SSI income limit. It exceeds that limit. May's income is calculated and compared to the monthly 300% SSI income limit; it is within the limit. Therefore, *the applicant* is placed on a one-month retroactive spenddown for April, and is enrolled in retroactive Medicaid in the 300% SSI covered group for May.

M1480.330 MEDICALLY NEEDY INCOME & SPENDDOWN

A. Policy

An institutionalized spouse whose income exceeds the 300% SSI income limit must be placed on a monthly MN spenddown if *the individual* meets a medically needy MN covered group and has countable resources that are less than or equal to the MN resource limit. I ncome is over the MN income limit because 300% of SSI is higher than the highest MN income limit for one person for one month.

MN countable income must be calculated to exclude income and portions of income that were counted in the 300% SSI income limit group calculation. Income is determined on a monthly basis and an institutionalized individual's spenddown budget period is one month. The certification period for all long term care cases is 12 months from the last application or redetermination month. This includes MN cases placed on spenddown.

B. Recalculate Income

Evaluate income eligibility for an institutionalized spouse who has income over the 300% SSI income limit using a one-month budget period and the following procedures:

1. ABD MN Covered Groups

The income sources listed in both sections M1460.610 "What is Not Income" and M1460.611 "Countable Income for 300% SSI Group" are NOT counted when determining income eligibility for the ABD MN covered groups.
Countable income is determined by the income policy in chapter S08; applicable exclusions are deducted from gross income to calculate the individual's countable income.

The income actually received in the retroactive period is considered for retroactive eligibility. The income expected to be received within the application month is considered when determining eligibility in that month.

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The income expected to be received within a month is counted in that month for ongoing eligibility.

a. Start with the gross monthly income figure countable for the ABD MN income determination.

b. Subtract the $20 general income exclusion. If the institutionalized spouse has earned income, subtract the ABD earned income exclusions found in section S0820.500. Subtract any appropriate unearned income exclusions in subchapter S0830.

c. The remainder is the monthly countable ABD MN income.

2. F&C MN Covered Groups

The income sources listed in both sections M1460.610 "What is Not Income" and M1460.611 "Countable Income for 300% SSI Group" are NOT counted when determining income eligibility for the F&C MN covered groups. Countable income is determined by the income policy in chapter M07; applicable exclusions are deducted from gross income to calculate the individual's countable income

Anticipated income is projected for the month for which eligibility is being determined. This calculation is based upon the income received in the prior month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount to be received

a. Start with the gross monthly income figure countable for the F&C MN income determination.

b. If the unit has earned income, subtract the F&C earned income exclusions in section M0720.500 **except** for the $30 + 1/3 exclusion which is not applicable to MN F&C covered groups.

c. If the Unit has child support income, subtract the $50 child support exclusion. See section M0730.400.

d. The remainder is the monthly countable F&C MN income.

D. MN Income Limits

The monthly medically needy (MN) individual income limits are *listed in Appendix 5 to subchapter M0710 and in section M0810.002 A. 4.*

E. Determine Spenddown Liability

Compare monthly countable income to the **monthly** MN individual income limit in the institutionalized spouse's locality.

The amount by which the institutionalized spouse's countable MN income exceeds the MN income limit is the **spenddown liability.**

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F. Spenddown Eligibility Procedures

To be eligible for Medicaid coverage, the institutionalized spouse must incur medical expenses in the month in an amount that equals or exceeds the spenddown liability. The policy and procedures for determining if an institutionalized spouse has met the spenddown are the "spenddown eligibility" policy and procedures.

The spenddown eligibility procedures for facility patients differ from the spenddown procedures for Medicaid CBC waiver patients. The expected monthly cost of the facility care (at the Medicaid rate) is projected at the beginning of the month. The cost of CBC is NOT projected.

1. Facility Patients

Facility patients in the MN classification fall into two distinct subgroups for the purpose of spenddown eligibility determination. These subgroups are:

* individuals with a spenddown liability less than or equal to the monthly Medicaid rate for the facility; and

* individuals with a spenddown liability greater than the monthly Medicaid rate for the facility.

a. Determine the Facility's Medicaid Rate

The facility's projected Medicaid rate is the Medicaid per diem multiplied by 31 days.

b. Compare Spenddown Liability

Compare the individual's spenddown liability to the facility's projected Medicaid rate.

c. SD Liability Is Less Than or Equal To Medicaid Rate

If the spenddown liability is **less than or equal to** the facility's projected Medicaid rate, the institutionalized spouse is income eligible as medically needy because he meets the spenddown based on the projected Medicaid rate alone.

1) Medicaid eligibility begins the first day of the month. Enroll as eligibility Type 1.

2) The institutionalized spouse has ongoing eligibility for the 12-month application certification period. The individual must file a redetermination after the 12-month certification period ends.

3) If the institutionalized spouse does **NOT** have Medicare Part A, enroll with the appropriate MN PD that follows:

* Aged = **18**
  - Blind = **38**

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- Disabled = **058**
- Child Under 21 in ICF/ICF-MR = **098**
- Child Under Age 18 = **088**
- Juvenile Justice Child = **085**
- Foster Care/Adoption Assistance Child = **086**
- Pregnant Woman = **097**.

4) If the institutionalized spouse has Medicare Part A, compare the individual's monthly MN countable income to the QMB monthly income limit for 1 person (see section M0810.002 for the current QMB limit):

a) When income is less than or equal to the QMB limit, enroll using the appropriate AC that follows:

- Aged = **028**
- Blind = **048**
- Disabled = **068**

b) When income is greater than the QMB limit, enroll using the appropriate AC that follows:

- Aged = **018**
- Blind = **038**
- Disabled = **058**

5) Patient Pay: Determine patient pay according to section M1480.400 below.

d. SD Liability Is Greater Than Medicaid Rate

If the spenddown liability is **greater than** the facility's Medicaid rate, the institutionalized spouse is NOT eligible unless he incurs medical expenses which meet the spenddown liability in the month. To determine if the spenddown is met, go to section M1480.335 below.

2. Medicaid CBC Waiver Patients

The institutionalized spouse meets the definition of "institutionalized" when *they are* authorized for Medicaid waiver services and the services are being provided. An institutionalized spouse who has been authorized for Medicaid waiver services and whose income exceeds the 300% SSI income limit is not eligible for Medicaid until the monthly spenddown liability *is met*.

To determine if the spenddown is met, go to section M1480.335 below.

3. PACE Recipients

The individual's spenddown liability and the PACE monthly rate (minus the Medicare Part D premium) establish whether the spenddown eligibility determination can be projected or must be determined retrospectively.

To determine if the spenddown is met, go to section M1480.340 below.

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M1480.*335* FACILITY PATIENTS WITH SPENDDOWN LIABILITY GREATER THAN MEDICAID RATE & ALL MN CBC PATIENTS

A. Facility Patients – SD Liability Is Greater Than Medicaid Rate

An MN institutionalized spouse whose spenddown liability is greater than the facility's Medicaid rate is not eligible for Medicaid until *the individual* incurs medical expenses that meet the spenddown liability within the month. These determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred. The institutionalized spouse's resources and income must be verified each month before determining if the spenddown was met.

To determine if the institutionalized spouse met the spenddown, use the following procedures:

1. Calculate Private Cost of Care

Multiply the facility's **private** per diem rate by the number of days the institutionalized spouse was actually in the facility in the month. Do not count any days the institutionalized spouse was in a hospital during the month.

The result is the private cost of care for the month.

2. Compare to Spenddown Liability

Compare the private cost of care to the institutionalized spouse's spenddown liability for the month.

3. Cost of Care Greater Than Spenddown Liability

When the private cost of care is **greater than** the institutionalized spouse's spenddown liability, the institutionalized spouse meets the spenddown in the month because of the private cost of care. He is entitled to **full-month coverage** for the month in which the spenddown was met.

Enroll the institutionalized spouse in Medicaid with the begin date of the first of the month, the end date the last day of the month. Go to section M1480.350 below for enrollment procedures. Determine patient pay according to section M1480.440 below.

4. Cost of Care Less Than or Equal To Spenddown Liability

When the private cost of care is less than or equal to the institutionalized spouse's spenddown liability, **determine spenddown on a day-by-day basis** in the month by deducting allowable incurred expenses from the spenddown liability.

To determine spenddown eligibility:

- Go to section M1480.341 below if the institutionalized spouse was NOT previously on a spenddown.
- Go to section M1480.342 below if the institutionalized spouse was previously on a spenddown.

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B. All MN CBC Patients

An MN institutionalized spouse who has been *authorized* for Medicaid CBC waiver services is not eligible for Medicaid until he actually incurs medical expenses that meet the spenddown liability within the month. These determinations are made monthly, retrospectively, **after** the month has passed and the expenses have actually been incurred. The private cost of his home-based medical care is deducted on a day-by-day basis as a noncovered medical expense, along with any other incurred medical expenses.

The institutionalized spouse's resources and income must be verified each month before determining if the spenddown was met. To determine if the institutionalized spouse met the spenddown:

* Go to section M1480.341 below if the institutionalized spouse was NOT previously on a spenddown.
* Go to section M1480.342 below if the institutionalized spouse was previously on a spenddown.

M1480.340 MN PACE RECIPENTS

A. Policy

1. Monthly Spenddown Determination

PACE recipients who have income over the 300% of SSI income limit are placed on a monthly spenddown as institutionalized individuals because they have been *authorized* for LTC services.

Unlike CBC, PACE has a capitated monthly rate that is due and payable on the first day of the month. The monthly PACE rate is available from the PACE provider. When a MN individual is in PACE, the amount of allowed PACE expenses is the rate that is due as of the first day of each month.

PACE recipients are not responsible for Medicare Part D premiums, which are included in the monthly PACE rate. **Therefore, the cost of the Medicare Part D premium cannot be used to meet a spenddown and must be subtracted from the monthly PACE rate when determining if the spenddown has been met.**

The individual's spenddown liability and the PACE monthly rate (minus the Medicare Part D premium) establish whether the spenddown eligibility determination can be projected or must be determined retrospectively.

2. Projected Spenddown Determination

If the MN individual's spenddown liability is less than or equal to the monthly PACE rate (minus the Medicare Part D premium), the individual is eligible for Medicaid effective the first day of the month in which the spenddown is met. As long as the individual's spenddown liability and the PACE monthly rate do not change, the individual is enrolled in ongoing coverage.

3. Retrospective Spenddown Determination

If the MN individual's spenddown liability exceeds the monthly PACE rate (minus the Medicare Part D premium), he is not eligible for Medicaid until he actually incurs medical expenses that meet the spenddown liability within the month. The monthly medical expenses are determined retrospectively; they cannot be projected for the spenddown budget period.

Retrospective spenddown eligibility determinations are made monthly after the month has passed and the expenses have actually been incurred. The PACE



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rate(minus the Medicare Part D premium) along with other allowable medical and dental expenses are deducted daily and chronologically as the expenses are incurred. The individual's income and resources must be verified each month before determining if the spenddown has been met. See M1470.530 for allowable medical deductions.

When incurred medical expenses equal or exceed the monthly spenddown liability, the individual is eligible for the full month of Medicaid coverage beginning the first day of the month and ending the last day of the month.

M1480.341 NOT PREVIOUSLY ON SPENDDOWN

A. Procedure

To determine eligibility in the one-month budget period for an institutionalized spouse who has NOT previously been on a spenddown, take the following actions:

* deduct old bills,
* deduct carryover expenses from the retroactive period,
* deduct medical/remedial care expenses incurred within the budget period (month).

Use the "Medical Expense Record-Medicaid" found in Appendix 1 to subchapter M1340 to document expenses and file it in the case record.

If the institutionalized spouse was on a spenddown in the retroactive period, whether or not the retroactive spenddown was met, go to section M1480.342 below.

B. Old Bills

Old bills for medical, dental, or remedial care services received prior to the retroactive period based on the initial application that can be deducted are:

1. Paid by Public Program

Expenses for medical services for which the applicant was legally liable received on or after December 22, 1987, which were provided, covered, or paid for by a public state or local government program, can be deducted. The amount deducted is the amount that the applicant would have been liable for if the service had not been covered by a public program, up to the spenddown liability amount.

2. Legally Liable

Expenses incurred for medical services that the applicant is legally liable to pay are deducted. For the expense to be deducted:

* the applicant must still owe the service provider a specific amount for the service and present current verification of the debt;

* the expense (or remainder of the expense) must not have been forgiven or written-off by the provider; and

  a claim for the expense must have been submitted to the liable third party and the applicant must provide evidence of the third party's payment denial or the amount paid for the expense.

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3. Amount Deducted

The amount deducted is the balance of the old bills owed by the applicant as of the first day of the first prospective budget period, less any portion of the amount that was used to meet the retroactive spenddown.

4. When Deducted

Allowable old bills are deducted on the first day of the budget period.

C. Carry-over Expenses from Retroactive Period

Paid or unpaid expenses incurred during the retroactive period of an initial application can be deducted IF:

* the individual established eligibility in the retroactive budget period **without having to meet a spenddown**, AND

* the expenses are allowable by kind of service.

1. Amount Deducted

The amount deducted is the amount of the expense owed as of the beginning of the budget period, up to the spenddown liability amount.

2. When Deducted

Allowable expenses carried over from the retroactive period are deducted on the first day of the one-month budget period.

D. Expenses Incurred Within the Budget Period

Allowable expenses incurred on or after the beginning of the one-month budget period that can be deducted are:

1. Paid By Public Program

Allowable incurred expenses for medical or remedial care which the applicant received after the beginning of the budget period which were provided, covered, or paid for by a public state or local government program can be deducted. The incurred expense amount that can be deducted is the amount that the applicant would have been liable for if the service had not been covered by a public program, up to the spenddown liability amount.

2. Legally Liable

Allowable expenses (paid or unpaid) incurred during the budget period for which the applicant is legally liable are deducted. To be deducted, the claim for the expense must have been submitted to the liable third party. The applicant must provide evidence of the third party's payment denial or the February spenddown eligibility evaluated.

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amount paid for the expense.

3. Amount Deducted

The amount that is deducted is the amount that was not or will not be paid by a third party, up to the spenddown liability amount. When determining the amount of long-term care expense incurred, use the daily private rate.

4. When Deducted

The incurred expenses are deducted in chronological order on the date the expense is incurred. The incurred expenses are deducted even if they have been paid.

EXAMPLE #16: Mr. Not lives in Group III and applied for Medicaid on November 21, 1999, as a disabled institutionalized spouse. He is in a nursing facility and was admitted on November 1, 1999. The MDU determined that he is disabled. He has not been on spenddown before. He has a $8,400 hospital bill and a $1,500 physician's bill for July 10 to July 20, 1998 (total $9,900) on which he still owes a total of $9,000. He has a $578 outpatient hospital bill for October 3, 1998. He has no health insurance. His income is $1,800 per month disability benefit from a private company. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His resources are within the Medicaid limit in November 1999 (application month).

He is not eligible as CN because his $1,800 gross income exceeds the 300% SSI income limit. The facility's Medicaid rate is $45 per day. His MN income eligibility is calculated:

$1,800	disability benefit
- 20	general income exclusion
1,780	MN countable income.
- 325	MNIL for 1 month for 1 person in Group III
$1,455	spenddown liability

The facility rate for the admission month is calculated as follows:

$ 45	Medicaid per diem
x 30	days
$1,350	facility Medicaid rate admission month

The $1,455 spenddown liability is greater than the Medicaid rate of $1,350.

Because he was not previously on spenddown, his verified old bills for July 1999 are deducted first from the spenddown liability. He owes the hospital $8,000 and the physician $1,000, total $9,000, as of November 1, 1999 (the first day of the budget period). His eligibility is calculated:

$1,455	spenddown liability
- 9,000	old bills owed 11-01-99
$ 0	spenddown balance on 11-1-99

Because the spenddown was met on November 1, Mr. Not is entitled to medically needy Medicaid for the budget period 11-1-99 through 11-30-99.

The old bills balance, or $7,545 ($9,000- 1,455 = $7,545) not used to achieve eligibility can be deducted in the subsequent month(s) from the subsequent spenddown liability if he continues to establish spenddown eligibility.

M1480.342 PREVIOUSLY ON SPENDDOWN

A. Procedure To determine spenddown eligibility for the budget period for an institutionalized spouse who has previously been on spenddown, take the following actions:

B. Prorate Spenddown Prior To Institutionalization If the institutionalized spouse is in a spenddown budget period when institutionalized, prorate the spenddown period and recalculate the spenddown liability for the months prior to the month in which *the individual* became institutionalized.

C. Old Bills Deduct the remaining balance on old bills incurred prior to the retroactive period if there has been no break between spenddown budget periods and no break in spenddown eligibility (each spenddown was met in all prior budget periods). Only the amount NOT deducted in a previous spenddown, and which remains the liability of the individual, can be deducted.

D. Current Payments on Bills Incurred Prior to Retroactive Period Deduct only the amount of the current payment(s) actually made on expenses incurred prior to the retroactive period, and which were not used previously to achieve eligibility, when there has been a break between spenddown budget periods or a break in spenddown eligibility (spenddown eligibility was NOT established in a prior spenddown budget period).

1. Legally Liable Current payments for expenses that the applicant is legally liable to pay are deducted. For the expense to be deducted:

* the applicant must still owe the service provider a specific amount for the service and present current verification of the payment amount and date(s) paid.

* a claim for the expense must have been submitted to the liable third party and the applicant must provide evidence of the third party's payment denial or the amount paid for the expense.

2. Amount Deducted The amount deducted is the amount of the payment.

3. When Deducted Allowable current payments are deducted on the date the payments are made.

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E. Expenses from Retroactive Spenddown Budget Period

Expenses from the retroactive spenddown budget period that were not used to achieve eligibility can be deducted from the spenddown liability balance.

1. Retroactive Spenddown Eligibility Achieved

Deduct expenses incurred during the retroactive period which were not previously used to establish eligibility, IF:

a. the individual established eligibility in the retroactive spenddown budget period AND

b. the expenses are:

* paid or unpaid;

* allowable by kind of service; and

* carried over from the retroactive spenddown budget period because the individual had a spenddown liability in the retroactive period that was met without deducting all such paid or unpaid expenses incurred in the retroactive spenddown budget period.

c. The amount deducted is the amount of the expense owed to the provider as of the beginning of the spenddown budget period, less the amount used to meet the retroactive spenddown, up to the spenddown liability amount.

d. Allowable expenses from the retroactive spenddown budget period are deducted on the first day of the prospective spenddown budget period.

2. Retroactive Spenddown Eligibility NOT Achieved

Deduct only **current payments** made on expenses incurred during the retroactive spenddown budget period. When there has been a break in spenddown eligibility, only current payments made on old bills based on a prior Medicaid application can be deducted from the current spenddown liability. For the current payment to be deducted:

a. the applicant must still owe the service provider a specific amount for the service and present current verification of the payment amount and date(s) paid,

b. a claim for the expense must have been submitted to the liable third party and the applicant must provide evidence of the third party's payment denial or the amount paid for the expense.

The amount deducted is the amount of the current payment made.

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Current payments on expenses from the retroactive spenddown budget period are deducted on the date the payment is made.

F. Expenses Incurred Within Spenddown Budget Period

Allowable expenses incurred within the spenddown budget period that can be deducted are:

1. Paid By Public Program

Allowable incurred expenses for medical or remedial care which the applicant received after the beginning of the spenddown budget period which were provided, covered, or paid for by a public state or local government program.

The incurred expense amount that can be deducted is the amount that the applicant would have been liable for if the service had not been covered by a public program, up to the spenddown liability amount.

2. Legally Liable

Allowable expenses (paid or unpaid) incurred after the beginning of the spenddown budget period for which the applicant is legally liable are deducted. See subsection M1340.100 B.1. for a description of legal liability. To be deducted, the claim for the expense must have been submitted to any liable third party. The applicant must provide evidence of the third party's payment denial or the amount paid for the expense.

3. Amount Deducted

The amount that is deducted is the amount that was not or will not be paid by a third party, up to the spenddown liability amount.

4. When Deducted

The incurred expenses are deducted in chronological order on the date the expense is incurred. The incurred expenses are deducted even if they have been paid.

G. When Spenddown Is Met

When the institutionalized spouse incurs medical expenses which meet the spenddown on any day in the month, he is entitled to **full-month coverage** for the month in which the spenddown was met.

Enroll the institutionalized spouse in Medicaid with the begin date of the first of the month, the end date the last day of the month, eligibility Type 4. Go to section M1480.350 below for enrollment procedures. Determine patient pay according to section M1480.440 below.

H. Example--Retroactive Spenddown, Institutionalized Spenddown In Admission Month

EXAMPLE #17: Ms. Was lives in Group I and applied for Medicaid on January 6, 2000, as disabled. She is in a nursing facility and was admitted on January 5, 2000. Mr. Was is her community spouse; he lives in their Group I locality home. Her countable resources are less than the Medicaid resource limit in January, and were less than the Medicaid resource limit in all months in the retroactive period. She applied for Medicaid in December 1998 and was on a spenddown from December 1, 1998 through May 31, 1999, which she met on December 1, 1998.

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She verifies that she has unpaid balances of $2,300 on a hospital bill and $1,500 on a physician's bill (total = $3,800) for services received August 10 to August 12, 1998 (prior to the retroactive period based on the December 1998 application) on which she pays $50 a month. These balances were not used to meet her December 1998 through May 1999 spenddown. She also has a $678 outpatient hospital bill for services dated November 13, 1999, in the retroactive period. She has no health insurance and is not eligible for Medicare. She has no old bills based on her January 2000 re-application (no unpaid medical expenses incurred in June, July, August or September 1999).

She was not institutionalized in the retroactive period. Her income in the retroactive budget period was $400 per month SSA disability. The retroactive budget period based on her January 2000 re-application is October, November and December 1999; the income limit is $650.

Her retroactive spenddown liability is $490.

$400	SSA disability
- 20	general income exclusion
380	countable income
x 3	months
$1,140	countable income for retroactive budget period
- 650	MNIL for retroactive budget period Group I
$ 490	retroactive spenddown liability

Since there was a break in her spenddown eligibility (the period June, July, August and September 1999 were not covered by a Medicaid application), only the current payments she is making on the August 1998 bills can be deducted from her retroactive spenddown liability. She paid the hospital and the physician $50 each ($100 total) on October 5, November 4 and December 5, 1999. Her retroactive eligibility is calculated:

$ 490	retroactive spenddown liability
- 100	current payment 10-5-99 (Aug.1998 hospital & physician bills)
390	spenddown balance on 10-5-99
- 100	current payment 11-4-99 (Aug.1998 hospital & physician bills)
290	spenddown balance on 11-3-99
- 678	outpatient expense 11-13-99 ($388 of expense carried over)
$ 0	spenddown balance on 11-13-99

The retroactive spenddown was met on November 13, 1999. Ms. Was' retroactive Medicaid entitlement was November 13, 1999 through December 31, 1999.

Her income starting January 1, 2000 increased. Her SSA is $620 per month and she began receiving a Civil Service Annuity of $1,300 per month; total income is $1,920 per month. Because this exceeds the 300% SSI income limit, her medically needy income eligibility is calculated as follows:

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$1,920.00 total monthly income
- 20.00 general income exclusion
1,900.00 countable income
- 216.67 MNIL for 1 month for 1 person in Group I
$1,683.33 spenddown liability

The facility's private rate is $58 per day; the Medicaid rate is $45 per day. The facility Medicaid rate for the admission month is calculated as follows:

$ 45 Medicaid per diem
x 27 days
$1,215 Medicaid rate admission month

Her spenddown liability of $1,683.33 is greater than the Medicaid rate of $1,215. Therefore, she is not eligible until she has actually incurred medical bills that equal or exceed her spenddown liability in January. The worker is processing the application on February 2. Mrs. Was was in the facility from January 5 through January 31. The facility's private cost is calculated:

$ 58 private per diem
x 27 days in facility in January
$1,566 private cost of care in January

The private cost of care for January, $1,566, is less than Mrs. Was's spenddown liability of $1,683.33. Therefore, her spenddown eligibility for January must be determined on a daily basis. The prospective budget period is January 1 through January 31, 2000. Since she had a break in spenddown eligibility, only the current payments she is making on the August 1998 bills can be deducted from her spenddown liability. She paid the hospital $50 and the physician $50 each ($100 total) on January 5, 2000. Her spenddown eligibility is determined:

$1,683.33 prospective spenddown liability
- 388.00 carry-over expense (balance of 11-13-99 outpatient expense)
- 100.00 current payment Aug,1998 hospital & physician bills 1-1-00
1,195.33 spenddown balance on 1-1-00
- 812.00 14 days private rate @ $58 per day (1-5 through 1-18)
383.33 spenddown balance on 1-19-00
- 348.00 6 days private rate @ $58 per day (1-19 through 1-23)
35.33 spenddown balance on 1-23-00
- 58.00 private cost of care for 1-24-00
$ 0 spenddown balance on 1-24-00

Mrs. Was met her spenddown on January 24, 2000. On February 3, the worker enrolls Mrs. Was in Medicaid as medically needy with eligibility begin date 1-1-2000 and end date 1-31-2000. The worker sends her a "Notice of Action on Medicaid" stating her Medicaid coverage dates and asking her to bring or send in her medical bills for February if she wants her *February spenddown eligibility evaluated.*

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M1480.350 SPENDDOWN ENTITLEMENT

A. Entitlement After Spenddown Met

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

B. Procedures

1. Coverage Dates

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

2. *Aid Category*

Enroll the institutionalized spouse in one of the following ACs:

- Aged = 018
- Blind = 038
- Disabled = 058
- Child Under 21 in ICF/ICF-MR = 098
- Child Under Age 18 = 088
- Juvenile Justice Child = 085
- Foster Care/Adoption Assistance Child = 086
- Pregnant *Individual* = 097

3. Patient Pay

Determine patient pay according to section M1480.400 below.

4. Notices & Re-applications

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

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M1480.400 PATIENT PAY

A. Introduction This section contains the policy and procedures for determining an institutionalized spouse's (as defined in section M1480.010 above) patient pay in all covered groups.

B. Married With Institutionalized Spouse in a Facility For a married long-term services and support (LTSS) patient with an institutionalized spouse in a facility, **NO** amount of the patient's income is deducted for the spouse's needs in the patient pay calculation.

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

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

B. Monthly Maintenance Needs Allowance	$2,288.75	7-1-22
	$2,465	7-1-23
	$2,555	7-1-24
	$2,643.75	7-1-25
C. Maximum Monthly Maintenance Needs Allowance	$3,435.00	1-1-22
	$3,715.50	1-1-23
	$3,853.50	1-1-24
	$3,948.00	1-1-25
	$4,066.50	*1-1-26*
D. Excess Shelter Standard	$686.63	7-1-22
	$739.50	7-1-23
	$766.50	7-1-24
	$793.13	7-1-25

E. Utility Standard Deduction (SNAP)	$369.00	1 - 3 household members	10-1-24
	$467.00	4 or more household members	10-1-24
	$375.00	1 - 3 household members	10-1-25
	$476.00	4 or more household members	10-1-25

M1480.420 PATIENT PAY FOR ABD 80% FPL AND 300% SSI INSTITUTIONALIZED SPOUSE

A. Policy After a 300% SSI or ABD 80% FPL institutionalized spouse has been found eligible for Medicaid, determine patient pay (post-eligibility treatment of income).

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B. What Is Patient Pay

The institutionalized spouse's gross monthly income, less all appropriate deductions according to this section, constitutes the patient pay - the amount of income the institutionalized spouse will be responsible to pay to the LTC facility or waiver services provider. The community spouse's and family member's monthly income allowances rules for patient pay apply to all institutionalized spouses with community spouses, regardless of when institutionalization began.

C. Dependent Allowances

A major difference in the institutionalized spouse patient pay policy is the allowance for a dependent child and for a dependent family member. If the institutionalized spouse has a dependent child, but the dependent child does NOT live with the community spouse, then **NO** allowance is deducted for the child. Additionally, an allowance may be deducted for other dependent family members living with the community spouse.

D. Home Maintenance Deduction

A major difference in the institutionalized spouse patient pay policy is the home maintenance deduction policy. A married institutionalized individual with a community spouse living in the home is **NOT allowed** the home maintenance deduction because the community spouse allowance provides for the home maintenance, **UNLESS**:

- the community spouse is not living in the home (e.g., the community spouse is in an ACR), and
- the institutionalized spouse still needs to maintain their former home.

***E. VaCMS* Patient Pay Process**

The patient pay is calculated in *VaCMS*. The patient pay must be updated in *in the system* whenever the patient pay changes, but at least once every 12 months. Refer to the *VaCMS Help feature* for information regarding data entry.

The Automated Response System (ARS) and the MediCall System convey the necessary patient pay information to the provider.

M1480.430 ABD 80% FPL and 300% SSI PATIENT PAY CALCULATION

A. Patient Pay Gross Monthly Income

Determine the institutionalized spouse's patient pay gross monthly income for patient pay. Use the gross income policy in section M1480.310 B.1 for both covered groups.

B. Subtract Allowable Deductions

If the patient has no patient pay income, he has no patient pay deductions.

When the patient has patient pay income, **deduct the following amounts in the following order** from the institutionalized spouse's gross monthly patient pay income. Subtract each subsequent deduction as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.

- personal needs or maintenance allowance,
- community spouse monthly income allowance,
- family member's income allowance,
- non-covered medical expenses,
- home maintenance deduction, if applicable.

C. Personal Needs or Maintenance Allowance

The personal needs allowance for an institutionalized spouse in a facility is different from the personal maintenance allowance of an institutionalized spouse in a Medicaid CBC waiver or PACE. The amount of the personal needs or maintenance allowance also depends on whether or not the patient has a guardian or conservator who charges a fee, and whether or not the patient has earnings from employment that is part of the treatment plan.

1. Facility Care

a. Basic Allowance

Deduct the $40 basic allowance, effective July 1, 2007. For prior months, the personal needs allowance is $30.

b. Guardian Fee

Deduct the actual fee a guardian or conservator charges, up to a maximum of 5% of the patient's actual gross income (including amounts not counted as income and excluded income) for guardianship fees, IF:

* the patient has a legally appointed guardian and/or conservator AND
* the guardian or conservator charges a fee.

Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

NOTES: No deduction is allowed for representative payee or "power of attorney" fees or expenses. No deduction is allowed if the patient's guardian receives a payment for providing guardianship services from a public agency or organization that receives funding for guardianship services. The guardianship filing fees CANNOT be deducted from the individual's income.

- **Special Earnings Allowance**

Deduct a special earnings allowance if the patient participates in a work program as part of treatment. The special earnings allowance is deducted from earned income only. Deduct:

* the first $75 of gross monthly earnings, PLUS
  * ½ the remaining gross earnings,
  * up to a maximum of $190 per month.

The special earnings allowance cannot exceed $190 per month.

d. Example - Facility Care Personal Needs Allowance

EXAMPLE #18: A patient in the nursing facility is employed as a telephone salesperson as part of his plan of care in the facility. He has a legally appointed conservator who charges a 2% fee. *The* only income is gross earnings of $875 per month. Special earnings allowance is calculated first:

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$875 gross earned income
- 75 first $75 per month
800 remainder
÷ 2
400 ½ remainder
+ 75 first $75 per month
$475 which is > $190

His personal needs allowance is calculated as follows:

$ 40.00 basic personal needs allowance
+190.00 special earnings allowance
+ 17.50 guardianship fee (2% of $875)
$247.50 personal needs allowance

2. Medicaid CBC Waiver Services and PACE

a. Basic Maintenance Allowance

For the Commonwealth Coordinated Care Plus (CC Plus) Waiver (formerly the Elderly or Disabled with Consumer Direction Waiver and the Technology-Assisted Individuals Waiver), Community Living (CL) Waiver (formerly Intellectual Disabilities Waiver), Family and Individual Supports (IS) Waiver (formerly Individual and Family Developmental Disabilities Support Waiver), Building Independence (BI) Waiver (formerly Day Support Waiver), or PACE, deduct the appropriate maintenance allowance for one person as follows:

- January 1, 2023 through December 31, 2023: $1,509
- January 1, 2024 through December 31, 2024: $1,556
- January 1, 2025 through December 31, 2025: $1,596
- *January 1, 2026 through December 21, 2026: $1,641*

Contact a Medical Assistance Program Consultant for the amount in effect for years prior to 20*23*.

b. Guardian Fee

Deduct the actual fee a guardian or conservator charges, up to a maximum of 5% of the patient's actual gross income (including amounts not counted as income and excluded amounts) for guardianship fees, IF:

* the patient has a legally appointed guardian or conservator AND

* the guardian or conservator charges a fee.

Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

NOTES: No deduction is allowed for representative payee or "power of attorney" fees or expenses. No deduction is allowed if the patient's guardian receives a payment for providing guardianship services from a public agency or organization that receives funding for guardianship services. The guardianship filing fees CANNOT be deducted from the individual's income.



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c. Special Earnings Allowance For CCC Plus, CL, IS, and BI Waivers

[EXAMPLE #19 was deleted]

For the CCC Plus, CL, IS, and BI waivers, deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

- for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (*$2,982 in 2026*) per month.

- for individuals employed at least 4 but less than 20 hours per week, all earned income up to 200% of SSI (*$1,988 in 2026*) per month.

The total of the basic maintenance allowance, the guardianship fee and the special earnings allowance cannot exceed 300% SSI.

EXAMPLE #20: (Using January 2000 figures)

A working patient in the CL Waiver is employed 18 hours per week. He has gross earnings of $928.80 per month and SS of $300 monthly. His special earnings allowance is calculated first:

$ 928.80	gross earned income
- 1,024.00	200% SSI maximum
$ 0	remainder

$928.80 = special earnings allowance

His personal maintenance allowance is calculated as follows:

$ 512.00	maintenance allowance
+ 928.80	special earnings allowance
$1,440.80	personal maintenance allowance

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D. Community Spouse Monthly Income Allowance

The community spouse monthly income allowance is the difference between the community spouse's gross monthly income and the minimum monthly maintenance needs allowance determined below.

1. Determine Minimum Monthly Maintenance Needs Allowance (MMMNA)

Calculate the minimum monthly maintenance needs allowance using the following procedures **(do NOT round any cents to a dollar)**:

a. the monthly maintenance needs standard, plus

b. an excess shelter allowance for the community spouse's principal place of residence, if applicable. The excess shelter allowance is the amount by which the total of verified allowable expenses in 1) through 5) below **exceeds** the excess shelter standard.

Allowable expenses are:

1) rent,
2) mortgage (including interest and principal),
3) taxes and insurance,
4) any maintenance charge for a condominium or cooperative, and
5) the utility standard deduction, unless utilities are included in the community spouse's rent or maintenance charges.

The utility standard deduction for a household of 1-3 members is different than the deduction for households of 4 or more members.

2. Maximum Allowance

The minimum monthly maintenance needs allowance calculated above cannot exceed the maximum.

3. DMAS Hearing Officer or Court Ordered Amount

The Eligibility Worker has no flexibility to calculate a minimum monthly maintenance needs allowance greater than the one calculated using the steps listed above. If the individual states there is a need for a greater amount, he has the right to file an appeal using the procedures in chapter M16. A Hearing Officer may increase the community spouse income allowance if it is determined that exceptional circumstances resulting in extreme financial duress exist. If the individual disagrees with the outcome of the appeal, he may then appeal the decision through his local circuit court.

The EW cannot accept a court order for a greater community spouse allowance unless the individual has exhausted the Medicaid administrative appeals process.

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4. Calculate Community Spouse Monthly Income Allowance

If no court order or DMAS Hearing Officer determination of the monthly maintenance needs allowance exists, use the following procedures to calculate the community spouse monthly income allowance:

a. Determine Gross Monthly Income

Determine the community spouse's gross monthly income using the income policy in section M1480.310. Do not count any payment that is made to the community spouse by the institutionalized spouse, such as the community spouse's portion of an augmented VA benefit which is included in the institutionalized spouse's VA check. This amount will be counted in the institutionalized spouse's income.

b. Subtract From MMMNA

Subtract the community spouse's gross income from the minimum monthly maintenance needs allowance from D.1. above. **Do NOT round any cents to a dollar.** The remainder is the community spouse monthly income allowance (a negative number equals $0).

c. Remainder Greater Than $0

If the remainder is greater than $0, the remainder is the amount of the community spouse monthly income allowance that is deducted from the institutionalized spouse’s patient pay.

d. Remainder Less Than or Equal To $0

If the remainder is $0 or less, the community spouse monthly income allowance is $0.

5. Deduct From Patient Pay

Deduct the community spouse monthly income allowance determined above from the institutionalized spouse's patient pay income UNLESS the institutionalized spouse or his authorized representative does not actually make it available to the community spouse or to another person for the benefit of the community spouse. *Should the community spouse opt to take a lesser amount than the amount to which the community spouse is entitled; deduct only the amount that the community spouse actually takes as an allowance. If the community spouse is a Medicaid applicant or enrollee, the income allowance is countable income to the community spouse.*

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6. Example--Allowance Not Deducted

EXAMPLE #21: (Using January 2000 figures)
A community spouse has $800 per month gross income; $600 from Civil Service and $200 VA pension. The community spouse's shelter expenses are: mortgage, taxes, and insurance of $439 per month, plus the standard utility allowance of $168 for a household of one person, totaling $607.
Total shelter costs of $607 exceed the excess shelter standard of $415 by $192. The excess shelter allowance is $192.

The minimum monthly maintenance needs allowance (MMMNA) is determined as follows:

$1,383.00		monthly maintenance needs standard
+	192.00	excess shelter allowance
$ 1,575.00		MMMNA (less than maximum)

The community spouse monthly income allowance is calculated:

$1,575.00		MMMNA
-	800.00	community spouse's monthly gross income
$ 775.00		community spouse monthly income allowance

The institutionalized spouse has monthly income of $1,100. However, refuses to give the monthly income allowance to *the* spouse at home; therefore, the community spouse monthly income allowance cannot be deducted. Patient pay is calculated:

$1,100		gross income
-	30	personal needs allowance
	$1,070	patient pay

7. Example--Allowance Deducted

EXAMPLE #22: (Using January 2000 figures)
A community spouse has $900 per month gross income from Social Security. The community spouse's shelter expenses are: mortgage, taxes, and insurance of $502 per month, plus the standard utility allowance of $168 for a household of one person, totaling $670. Total shelter costs of $670 exceed $415 by $255. The excess shelter allowance is $255.

The minimum monthly maintenance needs allowance (MMMNA) is determined as follows:

$1,383		monthly maintenance needs standard
+ 255		excess shelter allowance
	$1,638	MMMNA

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The community spouse monthly income allowance is calculated:

$1,638		MMMNA
	- 900	community spouse's gross income
$ 738		community spouse monthly income allowance

The institutionalized spouse has monthly income of $700. A grees to give the monthly income allowance to *the* spouse at home; therefore, the community spouse monthly income allowance is deducted. P atient pay is calculated:

$700	gross patient pay income	
	- 30	personal needs allowance
$670	remainder	
	- 670	community spouse income allowance
$	0	patient pay

NOTE: The community spouse monthly income allowance of $738 is greater than the income remaining after the personal needs allowance is deducted, so only $670 is deducted from patient pay for the community spouse monthly income allowance.

E. Family Member's Income Allowance

To be eligible for a family member's income allowance, the family member (as defined in section M1480.010) must live with the community spouse.

1. Minor Child NOT Living With Community Spouse

If an institutionalized spouse has a minor child who is **not** living with the community spouse, **no allowance** is calculated for that child and no deduction from the institutionalized spouse's income is made for that child.

2. Family Member Income Allowance Deductions

The family member income allowance is an amount equal to 1/3 of the amount by which the monthly maintenance needs standard exceeds the amount of the family member's gross monthly income: (maintenance needs standard - family member's income) ÷ 3 = family member's income allowance.

First, deduct the allowance(s) for minor child(ren) living with the community spouse in the home. Deduct other family members' allowances from patient pay after deducting the minor child(ren)'s allowance(s).

3. Calculate Family Member's Allowance

Calculate each family member's allowance as follows:

a. Subtract the family member's gross monthly income from the monthly maintenance needs standard. If the remainder is $0 or less, STOP. The family member is not entitled to an allowance.

b. Divide the remainder by 3.

c. The result is the family member's monthly income allowance. Do NOT round any cents to a dollar.



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4. Deduct Family Member's Allowance

Deduct the family member(s)' monthly income allowance(s) from the institutionalized spouse's patient pay income. Do NOT deduct the family member's allowance if the family member does not accept the allowance.

5. Example-- Family Member's Allowance

EXAMPLE #23: (Using July 2000 figures)
The couple's minor child lives with the community spouse. The child has no income. The child's family member maintenance allowance is 1/3 of $1,406.25 which is *$468.75.*

The community spouse's father lives with the community spouse and receives $300 per month SSA, which is his only income. The monthly family member allowance for the father is calculated as follows:

$1,406.25	monthly maintenance needs standard
- 300.00	father's income
$1,106.25	remainder
÷ 3	(divide by 3)
$ 368.75	family member maintenance allowance for father

The institutionalized spouse's income is $1,200. The community spouse has no community spouse monthly income allowance in this example, so the institutionalized spouse's patient pay is calculated as follows:

$1,200.00	institutionalized spouse's patient pay income
- 30.00	personal needs allowance
1,170.00	
- 468.75	child's family member's income allowance
701.25	
- 368.75	father's family member's income allowance
$ 332.50	patient pay

F. Noncovered Medical Expenses

Incurred medical and remedial care expenses recognized under State law, but not covered under the Medicaid State Plan and not subject to third party payment are deducted from patient pay after all allowances are deducted.

See section M1470.230 for facility patients, section M1470.430 for Medicaid CBC waiver patients *or section M1470.530 for PACE recipients* for specific instructions in determining allowable noncovered medical expense deductions from patient pay.

G. Home Maintenance Deduction

A married institutionalized individual with a community spouse living in the home is **NOT allowed** the home maintenance deduction, because the community spouse allowance provides for the home maintenance, **UNLESS**:

- the community spouse is not living in the home (e.g., the community spouse is in an ACR), AND
- the institutionalized spouse still needs to maintain their former home.

H. Patient Pay

Compare the **remaining income** (patient pay gross monthly income minus allowable deductions) to the Medicaid rate for the month. The patient pay is the lesser of the two amounts.



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I. Example--300% SSI Group Patient Pay

EXAMPLE #25: (Using July 2000 figures)
Mrs. Bay is a disabled institutionalized spouse who first applied for Medicaid for long term care services in July. She was admitted to the facility in June, but she is not eligible for Medicaid in the retroactive months because of excess resources. She has a monthly SSA benefit of $1,000 and a monthly private pension payment of $400. She has Medicare Parts A & B and private Medicare supplement health insurance which costs $75 per month. Her spouse, Mr. Bay, still lives in their Group II home with their dependent son, age 19 years. Mr. Bay has income of $1,500 per month from CSA. Their son has no income. Mrs. Bay's income is less than the 300% SSI income limit, so she is eligible for ongoing Medicaid coverage beginning July 1. She is enrolled in Medicaid in AC 060.

Her patient pay for July and subsequent months is determined. The community spouse monthly income allowance is calculated first:

$1,406.25	monthly maintenance needs standard
+ 200.00	excess shelter allowance
1,606.25	MMMNA (minimum monthly maintenance needs allowance)
-1,500.00	community spouse's gross income
$ 106.25	community spouse monthly income allowance

The family member monthly income allowance for their son is calculated:

$1,406.25	monthly maintenance needs standard
- 0	son's income
1,406.25	amount by which the standard exceeds the son's income
÷ 3	
$ 468.75	family member's monthly income allowance

Mrs. Bay has old bills totaling $200, dated the prior January. She has no noncovered expenses from the retroactive period because she paid the nursing facility in full through June. She is eligible in the 300% SSI group and is not a QMB; therefore, her Medicare premium is deducted from her patient pay for the first two months of Medicaid coverage (July and August). Her patient pay for July is calculated as follows:

$1,000.00	SSA
+ 400.00	private pension
1,400.00	total gross income

1,400.00	total gross income
- 30.00	PNA (personal needs allowance)
-106.25	community spouse monthly income allowance
-468.75	family member's monthly income allowance
795.00	
-120.50	Medicare premium & health insurance premium
-200.00	old bills
$474.50	remaining income for patient pay (July)

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The patient pay for August is calculated as follows:

$1,000.00	SS	
+ 400.00	private pension	
1,400.00	total gross income	
	- 30.00	PNA (personal needs allowance)
	- 106.25	community spouse monthly income allowance
	- 468.75	family member's monthly income allowance
	795.00	
	- 120.50	Medicare premium & health insurance premium
$ 674.50	remaining income for patient pay (August)	

Mrs. Bay's patient pay for September is calculated as follows:

$1,000.00	SS	
+ 400.00	private pension	
1,400.00	total gross income	
	- 30.00	PNA (personal needs allowance)
	- 106.25	community spouse monthly income allowance
	- 468.75	family member's monthly income allowance
	795.00	
	- 75.00	health insurance premium
$ 720.00	remaining income for patient pay (September)	

The worker completes the VaCMS Patient Pay process for July, August and September. VaCMS generates and sends a "Notice of *Patient Pay Responsibility*" to Mr. Bay showing Mrs. Bay's patient pay for July, August and September and each month's patient pay calculation.

M1480.440 MEDICALLY NEEDY PATIENT PAY

A. Policy

When an institutionalized spouse has income exceeding 300% of the SSI payment level for one person, he is classified as medically needy (MN) for income eligibility determination. Because the 300% SSI income limit is higher than the MN income limits, an institutionalized spouse whose income exceeds the 300% SSI limit will be on a spenddown. *The individual* must meet the spenddown liability to be eligible for Medicaid as MN. See sections M1480.330, 340 and 350 above to determine countable income, the spenddown liability, and to determine when an institutionalized spouse's spenddown is met.

Section 1924 (d) of the Social Security Act contains rules which protect portions of an institutionalized spouse's income from being used to pay for the cost of institutional care. Protection of this income is intended to avoid the impoverishment of a community spouse. In order to insure that an institutionalized spouse will have enough income for his personal needs or maintenance allowance, the community spouse income allowance and the family members' income allowance, an institutionalized spouse who meets a spenddown is granted a full month's eligibility. The spenddown determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred.



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An institutionalized spouse's resources and income must be verified each month before determining if the spenddown has been met. When the spenddown is met, an institutionalized spouse's patient pay for the month is calculated.

1. Patient Pay Deductions

Medicaid must assure that enough of an institutionalized spouse's income is "protected" for his personal needs, the community spouse and family member's income allowances, and noncovered medical expenses, NOT including the facility, CBC or PACE cost of care.

2. When Patient Pay Is Not Required

Intermediate Care Facility for the Mentally Retarded (ICF-MR) and Institution for Mental Diseases (IMD) services are not covered for medically needy (MN) eligible recipients. Therefore, a patient pay determination is not required when a MN enrolled recipient resides in an IMD or ICF-MR.

B. Patient Pay Procedures

Determine an MN institutionalized spouse's patient pay using the policy and procedures in the sections below:

* Facility Patient Pay - Spenddown Liability Less Than or Equal to Medicaid Rate (section M1480.450)

* Facility Patient Pay - Spenddown Liability Greater Than Medicaid Rate (section M1480.460)

- CBC - MN Institutionalized Spouse Patient Pay (section M1480.470)

- PACE - MN Institutionalized Spouse Patient Pay (section M1480.480).

M1480.450 FACILITY PATIENT PAY - SPENDDOWN LIABILITY LESS THAN OR EQUAL TO MEDICAID RATE

A. Policy

An MN institutionalized spouse in a facility whose spenddown liability is less than or equal to the Medicaid rate is eligible for a full month's Medicaid coverage effective the first day of the month, based on the projected Medicaid rate for the month. Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay *the* community spouse and family member allowances, and *the* personal needs and noncovered expenses not used to meet the spenddown. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability to the provider.

B. Procedures

Determine patient pay for the month in which the spenddown is met using the procedures below.

1. Patient Pay Gross Monthly Income

Determine the institutionalized spouse's patient pay gross monthly income according to section M1480.330 (including any amounts excluded in determining MN countable income and the spenddown liability).

2. Subtract Patient Pay Deductions

Subtract the following from the patient pay gross monthly income in the following order as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.

a. a personal needs allowance (per section M1480.430 C.),

b. a community spouse monthly income allowance, if appropriate (per section M1480.430 D.),

c. a family member's income allowance, if appropriate (per section M1480.430 E.),

d. any allowable noncovered medical expenses (per section M1470.230) **including** any old bills and carry-over expenses,

e. a home maintenance deduction, if appropriate (per section M1480.430 G.).

The result is the **remaining income** for patient pay.

3. Patient Pay

Compare the remaining income for patient pay to the Medicaid rate for the month. The patient pay is the lesser of the two amounts.

C. Example—Facility Spenddown Liability Less Than Medicaid Rate, Community Spouse Allowance

EXAMPLE #24: (Using July 2000 figures)
Mr. Hay is an institutionalized spouse who applied for Medicaid in July. He was admitted to the facility the prior November. He has a monthly CSA benefit of $1,700 and a monthly Seminole Indian payment of $235. He has Medicare Parts A & B and Federal Employees Health Insurance which costs $75 per month. He last lived outside the facility in a Group III locality. His wife, Mrs. Hay, still lives in their home; she has income of $500 per month from CSA. They have no dependent family members living with Mrs. Hay. Mr. Hay's total income exceeds the 300% of SSI income limit. His MN eligibility is determined for July. The MN determination results in a monthly spenddown liability of $1,355:

$1,700	monthly MN income (Seminole Indian payment excluded)
- 20	exclusion
1,680	countable MN income
- 325	MN limit for 1 (Group III)
$1,355	spenddown liability for month

The facility's Medicaid rate is $45 per day, or $1,395 for a 31-day month. By projecting the month's cost of facility care, Mr. Hay meets his spenddown effective the first day of the month and is eligible for Medicaid effective July 1. He is enrolled in Medicaid effective July 1 in AC 018.

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The community spouse monthly income allowance is calculated:

$1,406.25	monthly maintenance needs standard
+ 0	no excess shelter allowance
1,406.25	MMMNA (minimum monthly maintenance needs allowance)
- 500.00	community spouse's gross income
$ 906.25	community spouse monthly income allowance

His patient pay is calculated as follows:

$1,700.00	CSA
+ 235.00	Seminole Indian payment (counted for patient pay)
1,935.00	total patient pay gross income
- 30.00	PNA (personal needs allowance)
- 906.25	community spouse monthly income allowance
998.75	
- 45.50	Medicare premium (not paid by Medicaid)
- 75.00	health insurance premium
$ 878.25	remaining income for patient pay (July)

The facility's Medicaid rate for July is $1,395. Because Mr. Hay's remaining income for patient pay is less than the Medicaid rate for July, his patient pay for July is $878.25. From his July income of $1,935, Mr. Hay must pay $878.25 patient pay to the facility, leaving him $1,056.75 from which he can pay the community spouse income allowance of $906.25, his personal needs allowance of $30 and his Medicare and health insurance premiums of $120.50 (total of $1,056.75). Medicaid will pay $476.75 of his spenddown liability ($1,355 spenddown liability - 878.25 patient pay = $476.75). **This is allowed under section 1924 of the Social Security Act (Special Treatment For Married Institutionalized Spouses).**

D. Example-Facility Spenddown Liability Less Than Facility Rate, Community Spouse & Family Member Allowance

EXAMPLE #25: (Using July 2000 figures)
Mrs. Zee is a disabled institutionalized spouse who applied for Medicaid for long term care services in July. She was admitted to the facility in June, but she is not eligible for Medicaid in the retroactive month because of excess resources. She has a monthly SSA benefit of $1,200 and a monthly private pension payment of $600. She has Medicare Parts A & B and private Medicare supplement health insurance which costs $75 per month. Her spouse, Mr. Zee, still lives in their Group II home with their dependent son, age 19 years. Mr. Zee has income of $1,500 per month from CSA. Their son has no income. Mrs. Zee's income exceeds the 300% SSI income limit. Her MN eligibility is determined for July. She has old bills totaling $300 dated the prior January. The MN determination results in a spenddown liability of $1,530:

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$1,200.00	SSA
+ 600.00	monthly private pension
1,800.00	total monthly income
- 20.00	exclusion
1,780.00	countable MN income
- 250.00	MN limit for 1 (Group II)
$1,530.00	spenddown liability for July

The facility's Medicaid rate is $55 per day, or $1,705 for the month. By projecting the month's cost of facility care, she meets the spenddown effective the first day of the month. Mrs. Zee is eligible for Medicaid, effective July 1. She is enrolled in Medicaid in AC 058.

The community spouse monthly income allowance is calculated:

$1,406.25	monthly maintenance needs standard
+ 200.00	excess shelter allowance
1,606.25	MMMNA (minimum monthly maintenance needs allowance)
- 1,500.00	community spouse's gross income
106.25	community spouse monthly income allowance

The family member monthly income allowance for their son is calculated:

$1,406.25	monthly maintenance needs standard
- 0	son's income
1,406.25	amount by which the standard exceeds the son's income
÷ 3	
468.75	family member's monthly income allowance

Her patient pay for July is calculated as follows:

$1,200.00	SSA
+ 600.00	private pension
1,800.00	total gross income
- 30.00	PNA (personal needs allowance)
- 106.25	community spouse monthly income allowance
- 468.75	family member's monthly income allowance
1,195.00	
- 120.50	Medicare premium & health insurance premium
- 300.00	old bills
$ 774.50	remaining income for patient pay (July)

The facility's Medicaid rate for July is $1,705. Because Mrs. Zee's remaining income for patient pay is less than the Medicaid rate, her patient pay for July is $774.50. From her July income of $1,800, she must pay $774.50 to the facility, leaving her $1025.50 left to pay her personal needs, community spouse and family member's monthly income allowances, the old

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bills and her medical insurance premiums, totaling $1025.50. M edicaid will pay $755.50 of her spenddown liability ($1,530 spenddown liability - 774.50 patient pay = $755.50). This is allowed under section 1924 of the Social Security Act (Special Treatment For Married Institutionalized Spouses).

M1480.460 FACILITY PATIENT PAY - SPENDDOWN LIABILITY GREATER THAN MEDICAID RATE

A. Policy

An MN facility institutionalized spouse whose spenddown liability is greater than the Medicaid rate is not eligible for Medicaid unless he incurs additional medical expenses that meet the spenddown liability within the month. If he meets the spenddown liability, Medicaid coverage begins the first day of the month in which the spenddown is met and ends on the last day of that month. A patient pay for the month is calculated.

Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay his personal needs, community spouse and family member allowances, and noncovered expenses. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability. Payment of part or all of the spenddown liability is permitted under Section 1924 (d) of the Social Security Act.

B. Procedures

The institutionalized spouse's spenddown eligibility was determined in section M1480.340 above. Because the spenddown *was met* in the month, the *individual* is enrolled in a closed period of coverage for the full month. Patient pay for the month must be determined using the procedures below.

1. Calculate Remaining Income for Patient Pay

a. Determine Gross Monthly Patient Pay Income

Determine the institutionalized spouse's patient pay gross monthly income according to section M1480.330 (including any amounts excluded in determining MN countable income and the spenddown liability).

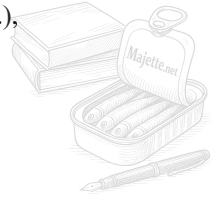
b. Subtract Allowable Deductions

Deduct the following from the patient pay gross monthly income, in the following order as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.

1) a personal needs allowance (per section M1480.430 C.),

2) a community spouse monthly income allowance, if appropriate (per section M1480.430 D.),

3) a family member's monthly income allowance, if appropriate (per section M1480.430 E.),



4) allowable noncovered medical expenses (per section M1470.230) including any old bills, carry-over expenses and other noncovered expenses that were used to meet the spenddown, but NOT including the cost of the facility care, and

5) a home maintenance deduction, if appropriate (per section M1480.430 G.).

The result is the **remaining income** for patient pay.

2. Patient Pay

Compare the remaining income for patient pay to the Medicaid rate for the month. The patient pay is the lesser of the two amounts.

C. Example--Facility Spenddown Liability Greater Than Medicaid Rate, Less Than Private Cost of Care

EXAMPLE #26: (Using July 2000 figures)
Mr. L is an institutionalized spouse who applied for Medicaid in July. He was admitted to the facility the prior December. He has a monthly CSA benefit of $1,900 and a monthly Seminole Indian payment of $200. He has Medicare Parts A & B and Federal Employees Health Insurance which costs him $75 per month. He last lived outside the facility in a Group III locality.

His wife, Mrs. L, still lives in their home with their dependent child age 20 years. Mrs. L has income of $500 per month from CSA. Their child has no income. Mr. L's income exceeds the CNNMP 300% SSI income limit. His MN eligibility is determined for July. The MN determination results in a spenddown liability of $1,555:

$1,900	monthly MN income (Seminole Indian payment excluded)
- 20	exclusion
1,880	countable MN income
- 325	MN limit for 1 (Group III)
$1,555	spenddown liability for month

The facility's Medicaid rate is $45 per day, or $1,395 for a month. The private pay rate is $80 per day. By projecting the month's Medicaid rate, he does not meet his spenddown in July. He has no old bills. He is placed on a monthly spenddown of $1,555 for each month in the 12-month certification period beginning July 1.

On July 31, he submits expenses for July. The worker verifies that his resources were below the limit in July. His spenddown liability of $1,555 is compared to $2,480, the private rate for July ($80 per diem x 31 days). Because the private cost of care for July is greater than his spenddown liability for July, he met his spenddown in July. He is eligible for the full month of July. On August 1, the worker enrolls him in Medicaid with coverage beginning July 1 and ending July 31.

His patient pay is determined. The community spouse and family member allowances are calculated first:

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$1,406.25	monthly maintenance needs standard
+ 0	no excess shelter allowance
1,406.25	MMMNA (minimum monthly maintenance needs allowance)
- 500.00	community spouse's gross income
$ 906.25	community spouse monthly income allowance

$1,406.25	monthly maintenance needs standard
- 0	child's income
1,406.25	amount by which standard exceeds child's income
÷ 3	
$ 468.75	child's family member monthly income allowance

$1,900.00	CSA income
+ 200.00	Seminole Indian payment (not excluded for patient pay)
2,100.00	total patient pay gross income
- 30.00	personal needs allowance
- 906.25	community spouse monthly income allowance
- 468.75	family member allowance
695.00	
- 45.50	noncovered Medicare Part B premium
- 75.00	noncovered health insurance premium
$ 574.50	remaining income (July)

The facility's Medicaid rate for July is $1,395. Because Mr. L's remaining income for patient pay is less than the Medicaid rate for July, his patient pay for July is $574.50.

From his July income of $2,100, he must pay the patient pay of $574.50. He has $1,525.50 left with which to meet his personal needs ($30), pay the community spouse and family member allowances, and pay his Medicare and health insurance premiums, a total of $1,525.50. In accordance with Section 1924 of the Social Security Act, Medicaid will assume responsibility for $980.50 of his spenddown liability ($1,555 - 574.50 patient pay = $980.50).

D. Example—Facility Spenddown Liability Greater Than Medicaid Rate and Private Cost of Care

EXAMPLE #27: (Using July 2000 figures)
Mrs. Bee is an institutionalized individual who files an initial application for Medicaid on July 6. She has a monthly SSA benefit of $2,000 and a monthly private pension payment of $500. She has Medicare Parts A & B and private Medicare supplement health insurance which costs her $100 per month. Mrs. Bee last resided outside the facility in a Group II locality. Her spouse, Mr. Bee, still lives in their home. He has income of $1,800 per month from CSA. Mrs. Bee's income exceeds the 300% SSI income limit.

Her MN eligibility is determined for July. The MN determination results in a spenddown liability of $2,230:

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$2,000.00	SSA
+ 500.00	monthly private pension
2,500.00	total monthly income
- 20.00	exclusion
2,480.00	countable MN income
- 250.00	MN limit for 1 (Group II)
$2,230.00	spenddown liability for month

The facility's Medicaid rate is $55 per day, or $1,705 for a month. By projecting the month's Medicaid rate, she does not meet her spenddown. She is placed on a monthly spenddown for each month in the 12-month certification period beginning July 1. On August 2, she submits expenses for July. The private facility rate is $70 per day, or $2,170 for July (31 days). The private cost of care, $2,170, is less than her spenddown liability of $2,230. Therefore, the worker must complete a day by day calculation to determine Mrs. Bee's spenddown eligibility for July:

$2,230.00	spenddown liability 7-1
- 140.00	private pay rate for 7-1 & 7-2 @ $70 per day.
2,090.00	spenddown balance on 7-3
- 145.50	45.50 Medicare + 100.00 health ins. premium paid 7-3
- 1,890.00	private pay for 27 days @ $70 per day 7-3 through 7-29
54.50	spenddown liability balance at beginning of 7-30
- 70.00	private pay for 7-30
$ 0	spenddown met on 7-30

Mrs. Bee met her spenddown on July 30. On August 3, the worker enrolls her in Medicaid with a begin date of July 1 and end date of July 31. To determine her patient pay, the community spouse monthly income allowance is calculated:

$1,406.25	monthly maintenance needs standard
+ 525.00	excess shelter allowance
1,931.25	MMMNA (minimum monthly maintenance needs allowance
- 1,800.00	community spouse's gross income
$ 131.25	community spouse allowance

Mrs. Bee's patient pay for July is calculated as follows:

$2,000.00	SSA
+ 500.00	private pension
2,500.00	gross patient pay income
- 30.00	personal needs allowance
- 131.25	community spouse allowance
2,338.75	
- 145.50	noncovered Medicare & health ins. premium
$2,193.25	remaining income (July)

greater than the Medicaid rate for of July $1,705. The facility can only collect the Medicaid rate; therefore, her patient pay for July is the Medicaid rate of $1,705.

From her July income of $2,500, she must pay the Medicaid rate of $1,705. Medicaid will not pay for any of her facility care in July because she is responsible for the whole Medicaid rate; Medicaid will cover all other medical services except her Medicare & health insurance premiums. She has $795 left with which to meet her personal needs ($30), pay the community spouse allowance, and pay her Medicare and health insurance premiums, a total of $306.75. She has $488.25 left from her July income. Medicaid will assume responsibility for $525 of her spenddown liability ($2,230 - 1,705 Medicaid rate = $525).

Since Mrs. Bee paid the private rate of $2,170 to the facility in July, the facility is responsible to reimburse her for the difference between the private rate and the Medicaid rate ($465). On August 25, she requests evaluation of her spenddown for August. She was reimbursed $465 on August 20, which was deposited into her patient fund account. The worker verifies that her resources exceed the Medicaid resource limit in August. The worker sends her a notice denying Medicaid for August because of excess resources, and stating that she must reapply for Medicaid if she reduces her resources and wants to be placed on spenddown again.

M1480.470 CBC - MN INSTITUTIONALIZED SPOUSE PATIENT PAY

A. Policy

When the Medicaid community-based care (CBC) institutionalized spouse has been authorized for waiver services and has **income less than or equal to 300% of the SSI income limit** for one person, *the applicant* is eligible for Medicaid as CNNMP and entitled to Medicaid for full-month, ongoing Medicaid coverage.

An institutionalized spouse who is authorized for waiver services, and whose income **exceeds the 300% SSI income limit**, is placed on a monthly spenddown. **The monthly CBC costs cannot be projected** for the spenddown budget period. The CBC costs, along with any other spenddown deductions, are deducted daily and chronologically as the costs are incurred. If the spenddown is met any day in the month, Medicaid coverage begins the first day of the month in which the spenddown is met, and ends on the last day of that month. A patient pay for the month is calculated.

Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay his personal needs, community spouse and family member allowances, and noncovered expenses. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability. Payment of part or all of the spenddown liability is permitted under Section 1924 (d) of the Social Security Act.

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B. Procedures

The institutionalized spouse's spenddown eligibility was determined in section M1480.340 above. Because he met the spenddown in the month, he is enrolled in a closed period of coverage for the full month. His patient pay for the month must be determined for the month using the procedures below.

1. Calculate Available Income for Patient Pay

a. Determine Gross Monthly Patient Pay Income

Determine the institutionalized spouse's patient pay gross monthly income according to section M1480.330 (including any amounts excluded in determining MN countable income and the spenddown liability).

b. Subtract Allowable Deductions

Deduct the following from the patient pay gross monthly income, in the following order as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.

1) a personal maintenance allowance (per section M1480.430 C.),

2) a community spouse monthly income allowance, if any (per section M1480.430 D.),

3) a family member's monthly income allowance, if any (per section M1480.430 E.),

4) any allowable noncovered medical expenses (per section M1470.430) including any old bills, carry-over expenses and other noncovered expenses that were used to meet the spenddown, but NOT including the cost of the community-based care.

5) a home maintenance deduction, if any (per section M1480.430 G.).

The result is the **remaining income** for patient pay.

2. Patient Pay

Compare the remaining income for patient pay to the Medicaid rate for the month. The patient pay is the lesser of the two amounts.

C. Example--CBC Institutionalized Spouse on Spenddown

EXAMPLE #28: (Using July 2000 figures)
Mr. T is an institutionalized spouse who applied for Medicaid in July. He was *authorized* for Medicaid E & D waiver services on July 1, and began receiving those services on that date. He has a monthly CSA benefit of $1,900 and a monthly Japanese-American Restitution payment of $200. He has Medicare Parts A & B and Federal Employees Health Insurance which costs him $75 per month. He last lived outside the facility in a Group III locality.

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His wife, Mrs. T, lives in their home with Mr. T and their dependent child age 18 years. Mrs. T has income of $500 per month from CSA. Their child has no income. Mr. T's income exceeds the 300% of SSI income limit. His MN eligibility is determined for July. The MN determination results in a spenddown liability of $1,555:

$1,900	monthly MN income (Japanese-American Restitution payment excluded)
- 20	exclusion
1,880	countable MN income
- 325	MN limit for 1 (Group III)
$ 1,555	spenddown liability for month

He has no old bills. He is placed on a monthly spenddown of $1,555 for each month in the 12-month certification period beginning July 1.

On July 31, he submits expenses for July. The worker verifies that his resources were below the limit in July. His spenddown liability of $1,555 is compared to $2,400, the total private rate for July ($16 per hour private rate x 5 hours per day x 31 days = $2,480). Because the private cost of CBC care for July is greater than his spenddown liability for July, he met his spenddown in July. He is eligible for the full month of July. On August 1, the worker enrolls him in Medicaid beginning July 1 and ending July 31.

His patient pay is then calculated. The community spouse and family member allowances are calculated first:

$1,406.25	monthly maintenance needs standard
+ 0	no excess shelter allowance
1,406.25	MMMNA (minimum monthly maintenance needs allowance)
- 500.00	community spouse's gross income
906.25	community spouse monthly income allowance

$1,406.25	monthly maintenance needs standard
- 0	child's income
1,406.25	amount by which standard exceeds child's income
÷ 3	
$ 468.75	family member monthly income allowance

$1,900.00	CSA income
+ 200.00	Japanese-American Restitution payment (not excluded for patient pay)
2,100.00	total patient pay gross income
- 512.00	personal maintenance allowance
- 906.25	community spouse monthly income allowance
- 468.75	family member allowance
213.00	
- 45.50	noncovered Medicare Part B premium
- 75.00	noncovered health insurance premium
$ 92.50	remaining income for patient pay

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The CBC provider's Medicaid rate is $9.50 per hour, 5 hours per day or $47.50 per day, a total of $1,472.50 for July (31 days). Because Mr. T's remaining income is less than the Medicaid rate, his patient pay for July is $92.50.

From his July income of $2,100, Mr. T must pay the patient pay of $92.50. He has $2,007.50 left with which to meet his maintenance needs ($512), pay the community spouse and family member allowances, and pay his Medicare and health insurance premiums, a total of $2,007.50. In accordance with Section 1924 of the Social Security Act, Medicaid will assume responsibility for $1,462.50 of his spenddown liability ($1,555 - 92.50 patient pay = $1,462.50). Because he paid all of his income to the CBC provider in July, his resources are within the limit in August.

D. Example-CBC Institutionalized Spouse on Spenddown

EXAMPLE #29: (Using July 2000 figures)
Mrs. Bly is an aged individual who files an initial application for Medicaid on July 1. She was *authorized* for Medicaid E & D waiver services on July 1, and began receiving those services on July 1. She has a monthly SSA benefit of $2,000 and a monthly private pension payment of $500. She has Medicare Parts A & B and private Medicare supplement health insurance which costs her $100 per month. Mrs. Bly resides in a Group II locality. Her spouse, Mr. Bly, lives with her in their home. He has income of $1,800 per month from CSA. Mrs. Bly's income exceeds the 300% of SSI income limit.

Her MN eligibility is determined for July. The MN determination results in a spenddown liability of $2,230:

$2,000.00	SSA
+ 500.00	monthly private pension
2,500.00	total monthly income
- 20.00	exclusion
2,480.00	countable MN income
- 250.00	MN limit for 1 (Group II)
$2,230.00	spenddown liability for month

She is placed on a monthly spenddown for each month in the 12-month certification period beginning July 1. On August 2, she submits expenses for July. The private CBC rate is $14 per hour, 5 hours per day or $70 per day, for a total of $2,170 for July (31 days). The private cost of care, $2,170, is less than her spenddown liability of $2,230. Therefore, the worker must complete a day-by-day calculation to determine Mrs. Bly's eligibility for July:

$2,230.00	spenddown liability 7-1
- 140.00	CBC private pay rate for 7-1 & 7-2 @ $70 per day.
2,090.00	spenddown balance on 7-3
- 145.50	45.50 Medicare + 100.00 health ins. premium paid 7-3
- 1,890.00	private pay for 27 days @ $70 per day 7-3 through 7-29
54.50	spenddown balance at beginning of 7-30
- 70.00	CBC private pay for 7-30
$ 0	spenddown met on 7-30

Mrs. Bly met her spenddown on July 30. On August 3, the worker enrolls her in Medicaid with the begin date of July 1 and end date July 31, application date July 1. To determine her patient pay, the community spouse monthly income allowance is calculated:

$1,406.25	monthly maintenance needs standard
+ 525.00	excess shelter allowance
1,931.25	MMMNA (minimum monthly maintenance needs allowance)
- 1,800.00	community spouse's gross income
$ 131.25	community spouse allowance

Mrs. Bly's patient pay for July is calculated as follows:

$2,000.00	SSA
+ 500.00	private pension
2,500.00	gross patient pay income
- 512.00	maintenance allowance
- 131.25	community spouse allowance
1,856.75	
- 145.50	noncovered 45.50 Medicare + 100.00 health ins. premium
$1,711.25	remaining income

Mrs. Bly's remaining income of $1,711.25 is greater than the Medicaid rate for July of $1,705, so her patient pay for July is the Medicaid rate of $1,705.

From her July income of $2,500, Mrs. Bly must pay the Medicaid rate of $1,705 to the CBC provider. Medicaid will not pay for any of her CBC care in July because she is responsible for the whole Medicaid rate; Medicaid will cover all other medical services except her Medicare & health insurance premiums. She has $795 left with which to meet her maintenance needs ($512), pay the community spouse allowance, and pay her Medicare and health insurance premiums, a total of $788.75. She has $6.25 left from her July income. Medicaid will assume responsibility for $525 of her spenddown liability ($2,230 - 1,705 patient pay = $525).

On August 25, she requests evaluation of her spenddown for August. She was reimbursed $465 on August 22 by the CBC provider, which was deposited into her bank account. The worker verifies that her resources exceed the Medicaid resource limit in August. The worker sends her a notice denying Medicaid for August because of excess resources, and stating that she must reapply for Medicaid if she reduces her resources and wants to be placed on spenddown again.

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Manual Title	Chapter	Page Revision Date
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M1480 MARRIED INSTITUTIONALIZED INDIVIDUALS	**M1480.480**	**91**

M1480.480 PACE – MN INSTITUTIONALIZED SPOUSE PATIENT PAY

A. Policy

An institutionalized spouse who is authorized for PACE services, and whose income exceeds the 300% SSI income limit, is placed on a monthly spenddown. The individual's spenddown liability and the PACE monthly rate (minus the Medicare Part D premium) establish whether the spenddown eligibility determination can be projected or must be determined retrospectively. The instructions for determining spenddown eligibility for MN institutionalized spouse PACE recipients are in M1480.340.

If the spenddown is met, Medicaid coverage begins the first day of the month in which the spenddown is met and a patient pay for the month is calculated. If spenddown eligibility is projected, the patient pay is not calculated monthly as long as the monthly PACE rate (minus the Medicare Part D premium), income and allowances remain the same. If spenddown eligibility is determined retrospectively, the patient pay is calculated month- by-month.

Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay personal needs, community spouse and family member allowances, and noncovered expenses. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability. Payment of part or all of the spenddown liability is permitted under Section 1924 (d) of the Social Security Act.

B. Procedures

The institutionalized spouse's spenddown eligibility was determined in section M1480.340 above. Patient pay must be determined using the procedures below.

1. Calculate Available Income for Patient Pay

a. Determine Gross Monthly Patient Pay Income

Determine the institutionalized spouse's patient pay gross monthly income according to section M1480.330 (including any amounts excluded in determining MN countable income and the spenddown liability).

b. Subtract Allowable Deductions

Deduct the following from the patient pay gross monthly income, in the following order as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.

1) a personal maintenance allowance (per section M1480.430 C.),

2) a community spouse monthly income allowance, if any (per section M1480.430 D.),

3) a family member's monthly income allowance, if *any* (per section M1480.430 E.),

4) any allowable noncovered medical expenses (per section M1470.530) including any old bills, carry-over expenses and other noncovered expenses that were used to meet the spenddown, but NOT including the cost of the community-based care.

5) a home maintenance deduction, if any (per section M1480.430 G.).

The result is the remaining income for patient pay.

2. Patient Pay Compare the remaining income for patient pay to the monthly PACE rate (minus the Medicare Part D premium) for the month. The patient pay is the lesser of the two amounts.

M1480.500 NOTICES AND APPEALS

M1480.510 NOTIFICATION

A. Notification Send written notices to the institutionalized spouse, the authorized representative and the community spouse advising them of:

- the action taken on the institutionalized spouse's Medicaid application and the reason(s) for the action;
- the resource determination, the income eligibility determination, and the patient pay income, spousal and family member allowances and other deductions used to calculate patient pay;
- the right to appeal the actions taken and the amounts calculated.

B. Forms to Use

1. Notice of Action on Medicaid The EW must send the "Notice of Action on Medicaid (Title XIX) and Children's Medical Security Insurance Plan (Title XXI Program)" or system-generated equivalent to the applicant/recipient and the person who is authorized to conduct business for the applicant to notify him of the Agency's decision on the initial Medicaid application, and on a redetermination of eligibility when a recipient starts Medicaid-covered LTSS services.

2. Notice of Patient Pay Responsibility The "Notice of Patient Pay Responsibility" notifies the patient of the amount of patient pay responsibility. The form is generated and sent by the enrollment system when the patient pay is used entered or changed.

3. Medicaid LTSS Communi-cation Form (DMAS-225) The Medicaid Long-term Services and Supports (LTSS) Communication Form (DMAS-225) is used to facilitate communication between the local agency and the LTSS services provider. The form may be initiated by the local agency or the provider. The form is available at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*.

The DMAS-225:

- notifies the LTC provider of a patient's Medicaid eligibility status;
- reflects changes in the patient's level of care or LTC provider;
- documents admission or discharge of a patient to an institution or community-based care services, or death of a patient;
- provides other information known to the provider that might cause a change in eligibility status or patient pay amount.

Do not use the DMAS-225 to relay the patient pay amount. Providers will be able to access the patient pay amount via the verification systems available to providers.

a. When to Complete the DMAS-225

Complete the DMAS-225 at the time of eligibility determination and/or the recipient's entry into LTC. Complete a new DMAS-225 when the enrollee's eligibility status changes, such as when the recipient's Medicaid coverage is canceled or changed to limited coverage (e.g. QMB coverage).

When a change in LTC providers occurs, complete a new DMAS-225 advising the new provider of the enrollee's eligibility status and that patient pay information is available through the verification systems.

b. Where To Send the DMAS-225

Refer to M1410.300 B.3.b to determine where the form is to be sent.

4. Resource Assessment Forms

The forms used for a resource assessment when no Medicaid application is filed are described in section M1480.210 (above). The resource assessment form that is used with a Medicaid application is described in section M1480.220. *The forms are generated by VaCMS when the resource assessment is completed in VaCMS.* Copies of the forms are included in Appendix 1 and Appendix 2 to this subchapter.

M1480.520 APPEALS

A. Client Appeals

The institutionalized spouse, the community spouse, or the authorized representative for either, has the right to appeal any action taken on a Medicaid application. The Medicaid client appeals process applies.

B. Appealable Issues

Any action taken on the individual's Medicaid **application** and receipt of Medicaid services may be appealed, including:

- spousal share determination,
- initial resource eligibility determination,
- spousal protected resource amount (PRA),
- resource redetermination,
- community spouse resource allowance (CSRA),
- income eligibility determination,
- patient pay and/or allowances calculations.

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AGENCY USE ONLY	
COUNTY/CITY	DATE RECEIVED
CASE NUMBER	WORKER
CASE NAME	

MEDICAID RESOURCE ASSESSMENT REQUEST

Mr. and Mrs. _____ request that an assessment be completed to determine the spousal share of countable resources using the resources listed below.

INSTITUTIONALIZED SPOUSE COMMUNITY SPOUSE

Name: _____ Name: _____
SS#: _____ SS#: _____

Address: _____ Address: _____
_____ _____
_____ _____

Date first admitted to a medical institution: _____
Admitted from where? _____

Provide the requested information on all resources owned, partially owned, or being bought on the first day of the month the institutionalized spouse was admitted to the institution or to Medicaid-covered community-based care. Include real estate (home, land, buildings), life insurance, cash on hand, stocks or bonds, savings and checking accounts, certificates of deposits, trusts, IRA or Keogh Plans, machinery, farming equipment, cemetery plots, burial funds, prearranged funerals, cars, mobile homes, and other real personal properties. If more room is needed, please attach another sheet of paper.

Description (Type of Resource)	Owned by Whom	Where Located	Value
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Signature: _____ Date: _____
(Spouse or Authorized Representative)

032-03-815

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MEDICAID RESOURCE ASSESSMENT REQUEST

FORM NUMBER - 032-03-815

PURPOSE OF FORM - To provide information on resources that will enable the department of social services to assess the countable resources of a couple and to determine the spousal share.

USE OF FORM - To be completed when an assessment of resources available to an institutionalized spouse (spousal share) is requested, and a Medicaid application is not filed or requested.

NUMBER OF COPIES - Three.

DISPOSITION OF FORMS - The original is filed in the case record with the Medicaid Resource Evaluation and the Notice of Medicaid Resource Assessment. The first copy is sent to the community spouse with the Notice of Medicaid Resource Assessment. The second copy is sent to the institutionalized spouse with the Notice of Medicaid Resource Assessment. If an individual other than one of the spouses requested the assessment, a photocopy of the request is sent to the individual making the request along with a photocopy of the Notice of Medicaid Resource Assessment.

INSTRUCTIONS FOR PREPARATION OF FORM - The information in the right-hand corner will be completed by the worker when the form is received in the agency. The remainder of the form will be completed by the couple making the request or by the authorized representative acting on their behalf.

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MEDICAID RESOURCE ASSESSMENT

COUNTY/CITY	CASE NUMBER
CASE NAME	
DATE INSTITUTIONALIZATION BEGAN	APPLICATION DATE

A. COUPLE'S RESOURCES AS OF (Date)

RESOURCE (Description)	Owner	Countable YES	Countable NO	Countable Value	Documentation
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

B. COMPUTATION OF SPOUSAL SHARE

θ Documentation of resources not supplied. Spousal share not determined.

θ Documentation of resources supplied.

$_____ Total Value of Couple's Countable Resources

$_____ Spousal Share

Worker's Signature: _____ Date: _____

032-03-816

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MEDICAID RESOURCE ASSESSMENT

FORM NUMBER - 032-03-816

PURPOSE OF FORM - To document the resources owned by a couple, to specify which resources are exempted, which resources are counted and their countable values, and to determine the spousal share of resources.

USE OF FORM - To be completed by the local agency eligibility worker when a Medicaid Resource Assessment Request is received by the local department of social services, or when a Medicaid application is filed by an institutionalized individual who has a community spouse.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The original is filed in the case record with the Medicaid Resource Assessment and the Notice of Medicaid Resource Assessment for assessments that are not parts of applications. The first copy is sent to the community spouse with the Notice of Medicaid Resource Assessment. The second copy is sent to the institutionalized spouse with the Notice of Medicaid Resource Assessment. If an individual other than one of the spouses requested the assessment, a photocopy of the evaluation is sent to the individual making the request, along with a photocopy of the Notice of Medicaid Resource Assessment.

For assessments that are part of Medicaid applications, the evaluation form is filed in the case record with the application evaluation. A copy of the Resource Evaluation is sent to the institutionalized spouse, the community spouse, and the individual making the request if applicable, along with the Notice of Medicaid Resource Assessment and the Notification of Action on Medicaid.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the identifying information in the upper right-hand corner of the form.

A. RESOURCES

From the resources identified on the Medicaid Resource Assessment Request, list the excluded resources first; the countable value(s) can be "N/A". Provide a description of the resource, list the owner(s), check whether the resource is countable, enter the countable value when it is a countable resource, and provide appropriate documentation information. If information was not provided, and owners or countable value, etc., cannot be documented, enter "not provided" in the appropriate columns.

B. COMPUTATION OF SPOUSAL SHARE

Check the appropriate box to indicate whether documentation was or was not supplied. If documentation was supplied, enter in the first line the value of countable resources, divide that figure by two and enter on the second line the spousal share.

C. The worker must sign the form and enter the date the form was completed.

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COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

NOTICE OF MEDICAID RESOURCE ASSESSMENT

AGENCY USE ONLY
CASE NAME
CASE NUMBER
COUNTY/CITY

ϒ The resource assessment you or your authorized representative requested was completed.

The spousal share is $ _____.

Enclosed are copies of the Medicaid Resource Assessment Request you submitted and the Medicaid Resource Assessment completed by the worker.

ϒ The resource assessment you or your authorized representative requested was not completed because you or your authorized representative did not provide the necessary verifications of your resources. The spousal share of your resources cannot be determined.

ϒ The resource assessment you or your authorized representative requested was not completed because the institutionalization began prior to September 30, 1989.

Worker's Name	Agency Name and Address	Date Mailed

032-03-817/2

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NOTICE OF MEDICAID RESOURCE ASSESSMENT

FORM NUMBER - 032-03-817

PURPOSE OF FORM - To provide notice that a resource assessment of a couple's countable resources, and the spousal share, was or was not completed.

USE OF FORM - To be prepared when the resource assessment is denied, evaluation is completed, or evaluation could not be completed.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The original is filed in the case record with the original Medicaid Resource Assessment Request and the original Medicaid Resource Evaluation. The first copy is sent to the community spouse with the first copy of the Medicaid Resource Assessment and the first copy of the Medicaid Resource Evaluation. The second copy is sent to the institutionalized spouse with the second copy of the Medicaid Resource Assessment and the second copy of the Medicaid Resource Evaluation.

If an individual other than one of the spouses requested the assessment, a photocopy of the notice is sent to the individual making the request along with a photocopy of the Medicaid Resource Assessment.

INSTRUCTIONS FOR PREPARATION OF THE FORM - Complete the identifying information in the upper right-hand corner. Enter the name and mailing address of the individual who will receive the form.

Check the appropriate box to show if the assessment was not completed because institutionalization began before 9-30-89, or if it was not completed because documentation was not provided, or if documentation of resources was provided and the assessment was completed. If documentation was provided, enter the spousal share of the countable resources.

Enter the worker's name, address, and the date the notice is or will be mailed.

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CHAPTER M15

ENTITLEMENT POLICY & PROCEDURES

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M15 Table of Contents Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-13	7/1/19	Table of Contents
TN #100	5/1/15	Table of Contents
TN #99	1/1/14	Table of Contents

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CHAPTER M15
ENTITLEMENT POLICY & PROCEDURES
SUBCHAPTER 10

MEDICAID ENTITLEMENT

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TN #DMAS-37	1/1/26	Page 9a
TN #DMAS-33	10/1/24	Pages 9a, 10, 12-15
TN #DMAS-32	7/1/24	Page 2b
TN #DMAS-31	4/1/24	Pages 7 and 8
TN #DMAS-30	1/1/24	Page 1, 2a, 8a,
TN #DMAS-24	7/1/22	Pages 8, 9a, 12-14
TN #DMAS-22	1/1/22	Page 8a Page 8 is a runover page.
TN #DMAS-21	10/1/21	Page 9a
TN #DMAS-19	4/1/21	Pages 6, 8
TN #DMAS-18	1/1/21	Pages 2b, 9, 12
TN #DMAS-17	7/1/20	Page 15
TN #DMAS-16	4/1/20	Pages 5, 6, 12, 13 Pages 14 and 15 are runover pages.
TN #DMAS-14	10/1/19	Pages 2b, 4, 5-7
TN #DMAS-12	4/1/19	Pages 7, 9a. Page 7a is a runover page.
TN #DMAS-11	1/1/19	Page 7

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TN #DMAS-10	10/1/18	Pages 7, 8a, 9a, 14 Pages 8b and 8c are runover pages.
TN #DMAS-9	7/1/18	Table of Contents Page 5. Page 9a was added.
TN #DMAS-8	4/1/18	Pages 2, 8a, 8b Page 8c was added.
TN #DMAS-6	10/1/17	Table of Contents Pages 1, 2 Page 2a is a runover page. Page 2b was added as a runover page.
TN #DMAS-5	7/1/17	Page 1 Page 2 is a runover page.
TN #DMAS-4	4/1/17	Pages 2a, 10
TN #DMAS-2	1/1/17	Table of Contents Pages 1, 8, 8a, 12-15 Page 11a was deleted.
TN #DMAS-2	10/1/16	On pages 3-15, corrected the subchapter number in the headers. Neither the dates nor the policies were changed.
TN #DMAS-1	6/1/16	Pages 2 Pages 1 and 2a are runover pages.
TN #100	5/1/15	Table of Contents Pages 1-2a, 5-8b
UP #10	5/1/14	Table of Contents Pages 7-8a Page 8b was added.
TN #99	1/1/14	Table of Contents Pages 1, 2, 8, 8a, 9-11 Page 11a was added.
UP #9	4/1/13	Pages 2-7, 10-12, 14
UP #7	7/1/12	Pages 8, 9
TN #96	10/01/11	Pages 8a, 10
TN #95	3/1/11	Table of Contents Pages 8, 11-15
TN #94	9/1/10	Pages 2a, 8-8a
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TN #91	5/15/09	Page 14

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M1510.000 ENTITLEMENT POLICY & PROCEDURES M1510.100 MEDICAID ENTITLEMENT

A. Policy

An individual's entitlement to Medicaid coverage is based on the individual meeting all nonfinancial and financial eligibility requirements for the individual's covered group during a month covered by the application, as well as any additional entitlement policies that are applicable to the covered group.

1. Spenddown Met

If the applicant had excess income and met the spenddown within the month, he remains responsible for his spenddown liability and his coverage begin date cannot be any earlier than the date he met the spenddown. *Medically needy pregnant women who apply for and are enrolled in Medicaid on or before the date the pregnancy terminates are eligible until the end of the 12th month after the pregnancy ends. MN children are eligible for 12 months coverage after they are determined eligible. Income increases are excluded for these MN children and pregnant women.*

2. Individual is Deceased

If an application is filed on behalf of a deceased individual or the applicant dies during the application process, his eligibility is determined only for the days he was alive. He must have been eligible for Medicaid while he was alive in order to be entitled to enrollment in Medicaid. Any changes in the individual's resources or income after his death do not affect the eligibility determination.

Example: An individual applies on July 23 for retroactive and ongoing Medicaid. The worker determines that the individual had excess resources (cash value of life insurance) throughout the retroactive period and the application month. The individual dies on August 5. The family asserts that he no longer owned the life insurance policies on August 5 and meets the resource requirements for the month of August. The worker determines that the individual owned the policies on the date of his death, the countable value exceeded the resource limit and he was not eligible for medical assistance on or before the date of his death.

3. Applicant Has Open MA Coverage in Another State

If an applicant indicates that he has been receiving Medical Assistance (MA--Medicaid or Children's Health Insurance Program) coverage in another state prior to moving to Virginia, instruct him to contact his eligibility worker there and request that his coverage be cancelled, if he has not already done so. He is no longer considered a resident of the other state once he has moved and intends to reside in Virginia, and he is no longer entitled to receive services paid for by the other state's MA program. His enrollment may begin with the month of application or the earliest month in the application's retroactive period that he met the residency requirement per M0230.

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4. PARIS Match Data

The Public Assistance Reporting Information System (PARIS) is a Federal computer matching initiative that the Virginia Department of Social Services (VDSS) participates in quarterly. VDSS participates in the data exchange with all active Medicaid enrollees and they are matched for the receipt of Veterans benefits and enrollment in multiple states' Medicaid programs. Each public assistance report is matched by social security number.

If a PARIS match is found, the worker will receive an alert in the Virginia Case Management System (VaCMS). The worker must evaluate all matches for current and ongoing eligibility and take appropriate case action within 30 days. Multiple matches must be assessed as a whole for the entire case. Workers must document findings in VaCMS under Case Comments. Procedures for researching and reporting PARIS matched individuals are found in the PARIS User Guide *available on the VDSS intranet.*

Once the evaluation of the match is completed and the case comments are documented, complete and send the Notice of Recipient Fraud/Non-Fraud Recovery (form #DMAS 751R), *located on the VDSS intranet*, to

Department of Medical Assistance Services
Recipient Audit Unit,
600 E. Broad Street, Suite 1300,
Richmond, Virginia 23219

The form may be faxed to 804-452-5472 or emailed to recipientfraud@dmas.Virginia.gov.

The DMAS Program Integrity Division will conduct steps to complete the match and Benefit Impact Screen (BIS).

B. SSI Entitlement Date Effect on Medicaid

SSI payments for eligible individuals are effective the first day of the month following the month in which the SSI application was filed. Medicaid coverage for eligible individuals is effective the first day of the month in which the Medicaid application is filed. When the Medicaid application is filed in the same month as the SSI application, the applicant is not eligible for Medicaid as an SSI recipient until the month in which his SSI entitlement began - the month following the application month. His eligibility for Medicaid in the application month must be determined in another covered group.

C. Procedures

The procedures for determining an eligible individual's Medicaid coverage entitlement are contained in the following sections:

- M1510.101 Retroactive Eligibility & Entitlement
- M1510.102 Ongoing Entitlement
- M1510.103 Hospital Presumptive Eligibility
- M1510.104 Disability Denials
- M1451.105 Foster Care Children
- M1510.106 Delayed Claims

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M1510.101 RETROACTIVE ELIGIBILITY & ENTITLEMENT

A. Definitions

1. Retroactive Period

The retroactive period is the three months immediately prior to the application month. Within this retroactive period, the individual may be Categorically Needy (CN) in one or two months and Medically Needy (MN) in the third month, or any other combination of classifications.

Retroactive Medicaid eligibility must be determined when an applicant for medical assistance indicates on the application that he, or anyone for whom he requests assistance, received a covered medical service within the retroactive period. The covered service may be listed by the applicant as an actual medical service on the application, or information on the application may indicate that a service was received, such as the birth of a child or Medicare coverage during the retroactive period.

2. Retroactive Budget Period

The "budget period" is the period of time during which an individual's income is calculated to determine income eligibility. The retroactive budget period depends on the individual's covered group.

B. Policy

An application for Medicaid or Auxiliary Grants (AG) is also an application for retroactive Medicaid coverage whenever the applicant reports that he/she received a Medicaid-covered service or had Medicare coverage in retroactive period. Eligibility for retroactive coverage is determined at the same time as the ongoing eligibility is determined, using the same application.

When an applicant reports that he/she, or anyone for whom he/she is applying, received a Medicaid covered service in any one of the three retroactive months, determine the applicant's eligibility for all three retroactive months, regardless of the service date. Determine nonfinancial, resource and income eligibility for each month in the retroactive period.

Pregnant women (with approved immigration status) who apply for and are enrolled in Medicaid on or before the date the pregnancy terminates are eligible until the end of the 12th month after the pregnancy ends. Children are eligible for 12 months coverage after they are determined eligible (at application and after each renewal). Income increases are excluded for these children and pregnant women.

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C. Budget Periods By Classification

1. CN

The retroactive budget period for CN covered groups (categories) is one month. CN eligibility is determined for each month in the retroactive period, including a month(s) that is in a prior spenddown that was not met. Do not determine eligibility for a retroactive month that was included in a previous Medicaid coverage period; the applicant has already received Medicaid for that month.

NOTE: There is never any retroactive eligibility or entitlement as a Qualified Medicare Beneficiary (QMB) only. An individual who is eligible as Special Low-income Medicare Beneficiary (SLMB) or Qualified Disabled & Working (QDWI) can have retroactive coverage as an SLMB or QDWI.

2. MN

For the retroactive period, the **MN budget period is always all three months**. Unlike the retroactive CN period, the retroactive MN budget period may include a portion of a prior Medicaid coverage or spenddown period, and may also include months in which he is eligible as CN.

D. Verification

The applicant must verify all eligibility requirements in a retroactive month in order to be eligible for Medicaid coverage in that month.

Income verification from available electronic sources is acceptable for retroactive eligibility determinations provided that reasonable compatibility is met (see M0420.100 B.9). For all case actions effective October 26, 2019, if the income attested to by the applicant is within *20*% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required.

If the attested income is under the income limit and the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return. If the applicant meets a Medically Needy (MN) covered group, verification of income **is required** to determine spenddown liability.

If the attested income is over the income limit and the individual does not meet a Medically Needy (MN) covered group, deny the application.

An applicant with a resource test must provide verification of resources held in the retroactive period.

An individual who provides proof of application for an SSN, after he applies for medical assistance, meets the application for SSN requirement in the three months retroactive to his medical assistance application.

If the applicant fails to verify any required eligibility factor for a retroactive month, coverage **for that month** must be denied because of failure to verify eligibility. If he verifies all eligibility factors for the other months in the retroactive period, he may be eligible for CN retroactive coverage for those months.

EXAMPLE #1: Ms. A applied for Medicaid for herself and her children on July 8. She reported receiving a Medicaid covered service in each retroactive month. The retroactive period is April 1 through June 30. She currently receives Unemployment Compensation as she lost her job in May. She provided all required verification for May and June, but did not provide income verification for April. Their application was approved for CN Medicaid coverage beginning May 1; April coverage was denied because of failure to verify income for April.



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1. Excess Income In One or More Retroactive Months

When an applicant has excess income in one or more of the retroactive months, he must verify that he met the nonfinancial and resource requirements in the month(s). He must verify the income he received in **all 3** retroactive months in order to determine his MN income or spenddown eligibility in the retroactive month(s).

If he fails to verify income in all three months, he CANNOT be eligible as MN in the retroactive period. His application for the retroactive months in which excess income existed must be denied because of failure to provide income verification for that month(s). However, coverage for the retroactive month(s) in which he was eligible as CN must be approved.

EXAMPLE #2: (Using July 200*6* figures)
A parent of a child under age 19 applies for Medicaid in April. She requests retroactive coverage for the child's medical bills incurred in January, February and March, including a hospital stay in February. She also has unpaid medical bills (old bills) from December. The retroactive period is January - March.

The eligibility worker determines that the child met all the Medicaid nonfinancial requirements in the retroactive period, and that the countable income of $3,250 per month in January and February exceeded the F&C, *CN* and the MN income limits. The income of $800 starting March 1 is within the F&C *CN* income limit. The parent verifies that the resources in January, February were within the MN resource limit, but does not verify the March resources because the income is within the *CN* income limits.

The application is approved for retroactive coverage as *CN* beginning March 1 and for ongoing coverage beginning April 1. The child's spenddown liability is calculated for January and February. The eligibility worker deducts the old bills and the incurred medical expenses, and a spenddown liability remains. The retroactive Medicaid coverage is denied for January and February because the spenddown was not met.

2. Excess Income In All 3 Retroactive Months

When excess income existed in all classifications in all 3 retroactive months, the applicant must verify that he met all eligibility requirements in all 3 months. If he fails to verify nonfinancial, resource or income eligibility in any of the retroactive months, the retroactive period cannot be shortened and he CANNOT be placed on a retroactive spenddown. His application for retroactive coverage must be denied because of excess income and failure to provide eligibility verification for the retroactive period.

EXAMPLE #3: (Using July 200*6* figures)
A parent of a child under age 19 applies for Medicaid in April. She requests retroactive coverage for the child's medical bills incurred in January, February and March, including a hospital stay in March. The retroactive period is January – March.

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The worker verifies that the child met all the Medicaid nonfinancial requirements in the retroactive period, and that their countable income of $3,250 in January, February and March exceeded the F&C CN and the MN income limits. The worker verifies that their resources in January and February were within the MN resource limits, but is unable to verify the resources for March.

The application is denied for retroactive coverage as CN Medicaid because of excess income and denied for MN spenddown because of failure to provide resource verification for all months in the retroactive period.

E. Disabled Applicants

If the applicant was not eligible for SS or SSI disability benefits during the retroactive period and the recipient alleges he/she was disabled during the retroactive period, follow the procedures in M0310.112 for obtaining an earlier disability onset date.

F. Excess Resources in Retroactive Period

If the applicant had excess resources during part of the retroactive period, retroactive resource eligibility exists only in the month(s) during which the resources were at or below the limit at any time within the month. The applicant's eligibility must be denied for the month(s) during which excess resources existed during the entire month.

EXAMPLE #4: (Using July 2006 figures)
Mr. A applied for Medicaid for himself on July 8. He reported receiving a Medicaid covered service in each retroactive month; no hospital service was received. The retroactive period is April 1 through June 30. He currently receives SS disability benefits of $1500 per month and received SS disability of $1500 monthly during the retroactive period. He is not eligible for Medicare Part A. His verified resources exceeded the MN limit in April and part of May; the resources were reduced to below the MN limit on May 20. He met the retroactive spenddown on April 5. His application was approved for retroactive MN coverage beginning May 1, and April coverage was denied because of excess resources.

G. Income Determination

Countable income for the applicant's unit is that income which was actually received *or determined reasonably compatible* in the three months prior to the application month.

1. Monthly Determination for CN

When an individual in the family unit meets a CN covered group, compare each month's countable income to the appropriate CN income limit for the month. When the countable income is within the CN income limit in the month, the CN individual meets the income eligibility requirement for that retroactive month. Enroll the eligible CN unit member(s) **for that month(s) only**, using the appropriate CN covered group program designation.

2. MN

When the family unit's *verified* countable income exceeds the CN income limit in one or more of the retroactive months, and all other

Medicaid medically needy eligibility factors are met in that month(s), determine if the unit meets the MN income limit for the **3-month** retroactive budget period.

When the unit's countable income exceeds the MN limit for 3 months, place the unit on a spenddown for the month(s) in which excess income existed. See subchapter M1330 for retroactive spenddown eligibility determination policy and procedures.

H. Retroactive Entitlement

Retroactive coverage can begin the first day of the third month prior to application month if all eligibility requirements are met. An exception is eligibility for a newborn; coverage will be effective on the child's date of birth.

QMB-only coverage for new applicants or individuals with closed coverage who reapply outside a renewal reconsideration period cannot be retroactive.

The applicant is entitled to Medicaid coverage for only the month(s) in which all eligibility factors were met. If all factors except income were met in all the retroactive months, then the applicant is placed on spenddown for the retroactive period. **See subchapter M1330 to determine retroactive spenddown eligibility.**

1. Retroactive Coverage Begin Date

If the applicant is eligible for retroactive coverage, he is enrolled effective the first day of the month in which he met all eligibility factors. When excess income existed in a retroactive month(s), entitlement begins the date the retroactive spenddown was met.

2. Retroactive Coverage End Date

The Medicaid recipient's retroactive Medicaid coverage expires after the last day of the retroactive month(s) in which he was entitled to Medicaid.

3. Example

EXAMPLE #5: Mr. B applied for Medicaid for himself on July 8. He reported receiving a Medicaid covered service in each retroactive month. The retroactive period is April 1 through June 30. He met all eligibility requirements in the retroactive period. He is entitled to retroactive Medicaid coverage beginning April 1 and ending June 30.

M1510.102 ONGOING ENTITLEMENT

A. Coverage Begin Date

Ongoing Medicaid entitlement for all covered groups except the QMB group begins the first day of the application month when all eligibility factors are met at any time in the month of application. Exceptions:

- when an applicant has excess income;
- when the applicant is eligible only as a QMB;
- when the applicant is age 21-64 years and is admitted to an institution for mental diseases (IMD;
- when the individual is incarcerated (see M0140.200.C.1 and M0140.300.D);
- for a newborn, coverage will begin on the child's date of birth.

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M1510 MEDICAID ENTITLEMENT	**M1510.102**	**6**

1. **Applicant Has Excess Income**

When all eligibility requirements are met except for income, entitlement begins the date the spenddown is met. Only medically needy applicants can be eligible after meeting a spenddown. See subchapter M1330 to determine retroactive spenddown eligibility.

2. **QMB Applicant**

Entitlement to Medicaid for QMB coverage begins the first day of the month **following** the month in which the individual's QMB eligibility is determined and approved, **not** the month of application. QMB-only coverage for new applicants or individuals with closed coverage who reapply outside a renewal reconsideration period cannot be retroactive.

EXAMPLE #6: Ms. C is 55 years old and is disabled. She applied for Medicaid on May 8, 2019, and requested retroactive coverage. She began receiving Medicare in May 2019. She is approved for QMB coverage on June 9; therefore, her QMB coverage will begin on July 1. She is eligible to receive coverage in the MAGI Adults covered group for the retroactive months of February, March, and April. However, she is not eligible for MAGI Adults coverage in May or June due to her Medicare enrollment. QMB eligibility cannot extend to the retroactive period (see M1510.101.H). If she did not opt out of Plan First, she should be enrolled in Plan First coverage for May and June, 2019.

3. **SLMB and QDWI**

Ongoing entitlement for the Special Low Income Medicare Beneficiary (SLMB) and the Qualified Disabled and Working Individuals (QDWI) covered groups is the first day of the application month when all eligibility factors are met at any time in the month of application.

4. **Applicant *Age 22 or Over, But Under Age 65* Is Admitted To An IMD *and Discharged From the IMD While the Application is Pending***

If an **applicant** *who is age 22 or over, but under age 65 is admitted to an IMD and discharged from the IMD while the application is pending, Medicaid entitlement begins the first day of the* application month (or retroactive month, if applicable) as long as he meets all other Medicaid eligibility requirements.

EXAMPLE #6a: Mr. A is a 50 year old man who applies for Medicaid at his local agency on October 1, *2020*. He was admitted to an IMD on October 20, *2020*, and was discharged from the IMD on November 2, *2020*, back to his home locality. The agency completes the Medicaid determination on November 5 and finds that he is eligible for Medicaid in October 2020. The worker enrolls him in Medicaid beginning October 1, 2020.

5. **Applications From *Current* IMD Patients *Age 22 or Over, But Under Age 65***

An **applicant** who is *who is age 22 or over, but under age 65* and who is *currently* in an IMD is not eligible for Medicaid while in the IMD. Process the application within the established time frames *in M0130.100*. Eligibility will be determined based on the type of living arrangement to which the patient will be discharged. If eligible, do not enroll the patient until the date the patient is discharged from the IMD.

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If the patient is discharged from the facility and the patient meets all eligibility factors, the agency will enroll the patient effective the date of discharge.

EXAMPLE #*6b*: Mr. A is a 50 year old patient at Central State Hospital (an IMD). He receives Social Security disability benefits. The CSB sends his local agency a Medicaid application which is received on August 18. The facility's statement notes that he will be discharged on September 17 to ABC Nursing Home, a nursing facility. The agency completes the determination on August 27 and finds that he will be eligible once he is discharged to the nursing facility.

The agency does not enroll Mr. A until the discharge is confirmed. The CSB case manager calls the agency on September 21 and informs the agency that the patient was discharged to the ABC Nursing Home on September 18. The patient is enrolled in Medicaid with a begin date of September 18.

6. Offenders (Incarcerated Individuals)

Individuals who meet all Medicaid eligibility requirements, including eligibility in a **full benefit** CN covered group, are eligible for Medicaid coverage limited to inpatient hospitalization while incarcerated. Enroll eligible MAGI Adults in aid category AC 108 and all other offenders in aid category AC 109 regardless of their covered group.

See M0140.000 regarding incarcerated individuals and M1520.102 for ongoing entitlement.

6. MAGI Adult Turns 65 or Eligible for Medicare

When an individual enrolled in the Modified Adjusted Gross Income MAGI Adults covered group turns 65 years old, begins to receive Medicare or is eligible to receive Medicare, he is no longer eligible in the MAGI Adults covered group. Evaluate the individual for eligibility in an Aged, Blind or Disabled covered group. If the individual is not eligible in any other covered group, cancel his coverage following the policy in M1510.102 B below.

B. Coverage End Date

Medicaid entitlement ends the last day of the month in which the recipient fails to meet all of the Medicaid eligibility requirements, unless the recipient is a CN pregnant woman or is age 22 or over, but under age 65 and was admitted to an IMD.

Medicaid coverage is canceled on the last day of the month in which the agency determines that the recipient no longer meets the eligibility requirements IF the agency can send an advance notice to the recipient at least 11 days before the last day of the month. If the agency cannot send the notice at least 11 days before the end of the month, coverage is canceled effective the last day of the next month.

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1. CN Pregnant Woman

After eligibility is established, a pregnant woman in any CN covered group continues to be eligible for Medicaid during the remainder of her pregnancy and for 12 months following the end of the month in which her pregnancy ends, regardless of any changes in family income, as long she continues to meet all non-financial criteria. If the woman becomes pregnant while she is in the 12 month coverage period, she is entitled to an additional 12 months of coverage following the end of the second pregnancy.

2. Individual Admitted to Ineligible Institution Other than an IMD

Cancel coverage as soon as possible after learning of the enrollee's admission to an ineligible institution. **DO NOT cancel coverage retroactively.** Cancel coverage effective the current date (date the worker enters the cancel transaction in the system)." **An Advance Notice of Proposed Action is not required.** Send a Notice of Action to the enrollee or his authorized representative informing him of the cancel date and the reason.

Note: An individual of any age who is **enrolled in Medicaid** at the time of admission to an **IMD** may remain enrolled in Medicaid. **Do not cancel coverage**. The Department of Medical Assistance Services (DMAS) will coordinate with the Centers for Medicare and Medicaid Services (CMS) to ensure that no unauthorized FFP occurs for individuals age 22 years or over but under age 65 years.

3. Spenddown Enrollees

Medicaid entitlement ends on the last day of the last month in the spenddown budget period, unless the individual's or family's circumstances change before that date.
Exceptions:

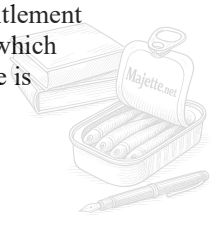
a. Medically Needy Pregnant Woman
Pregnant woman who meet a spenddown are entitled to MN coverage for 12 months following the end of the month in which the pregnancy ends.

b. *Medically Needy child*
After meeting s spenddown children under 19 receive 12 months of continuous eligibility unless they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.

C. Ongoing Entitlement After Resources Are Reduced

When an applicant has excess resources throughout the application month, he is not eligible for Medicaid for the month of application. An applicant who reduces excess resources during the month of application or a subsequent month before action is taken on the application may become eligible in the month in which the value of his resources is reduced to, or below, the Medicaid resource limit. In order to reduce resources, the resources must actually be expended and the expenditure documented. (For example: a receipt, a canceled check, or a bank statement).

Reduction of resources is an asset transfer and must be evaluated under asset transfer policy (subchapter M1450). When excess resources are reduced, entitlement to ongoing Medicaid may begin no earlier than the first day of the month in which the resources were reduced to the Medicaid limit. When retroactive coverage is requested, policy in M1510.101 above must be followed.



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M1510 MEDICAID ENTITLEMENT	**M1510.103**	**8a**

M1510.103 HOSPITAL PRESUMPTIVE ELIGIBILITY

A. Policy

Individuals enrolled on the basis of Hospital Presumptive Eligibility (HPE) are covered by Medicaid beginning with the date of the HPE determination through the last day of the following month or the date MA eligibility is determined by an LDSS, whichever comes first. For their coverage to continue beyond the HPE enrollment period, they must submit a full MA application. If the individual does not submit an MA application, no further action is necessary on the part of the LDSS. See M0120.500 C.

B. Procedures

When an HPE enrollee submits a full MA application and it is pended in VaCMS, the individual's coverage in the HPE AC is extended by the eligibility worker, as necessary, while the application is processed.

Applications submitted by pregnant women enrolled on the basis of HPE must be processed within 7 calendar days of the agency's receipt of the signed application. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) applications submitted by individuals enrolled on the basis of HPE must be processed within 10 work days of the agency's receipt of the signed application.

1. Enrollment

When an individual is determined eligible for MA coverage, his MA coverage under the appropriate MA AC includes any days to which he is entitled that are not already covered by HPE. If the individual submitted the MA application in the same month HPE coverage began and HPE began on any day other than the first day of the month, his MA coverage begins the first day of that month and the eligibility worker enrolls him in a closed period of coverage in the appropriate MA AC beginning with the first day of the month and ending the day before the HPE begin date. The worker is to enroll the eligible individual in ongoing coverage in the appropriate MA AC beginning the first day of the month after the effective date of the HPE coverage cancellation.
See M0120.500 C.2

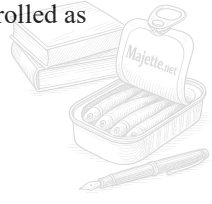
Children's 12 month continuous eligibility does not apply to children enrolled as HPE (unless they are found eligible for medical assistance after filing a full application).

2. Individuals Enrolled in HPE as Pregnant Women or in Plan First

If an individual who was enrolled in HPE with partial coverage as a pregnant woman or in Plan First is determined eligible for full MA coverage in the period covered by HPE, cancel HPE coverage retroactively and reinstate in full coverage for the retroactive months and ongoing, if eligible.
See M0120.500 C.2d

3. Retroactive Entitlement

An individual's eligibility for retroactive coverage for the three months prior to the month of the MA application is determined when the individual had a medical service within the three months prior to the month of the full MA application. If the individual had full coverage while enrolled as HPE, only enroll him for the portion of the retroactive period that he was not enrolled as HPE. See M0120.500 C.2e



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M1510 MEDICAID ENTITLEMENT	**M1510.104**	**8b**

4. HPE Enrollee Not Eligible for Ongoing Coverage

If the applicant is determined to not be eligible for ongoing MA coverage, his entitlement to HPE coverage ends. Cancel the HPE coverage effective the current date (i.e. day of the eligibility determination). See *M0120.500 C.2f*

Send a Notice of Action indicating that the individual's MA application was denied and that his HPE coverage was cancelled with the effective date. The individual receives notice of the HPE coverage period from the hospital at the time of the HPE enrollment; advance notice of the HPE cancellation is not required. There are no appeal rights for HPE.

M1510.104 DISABILITY DENIALS

A. Policy

When an individual concurrently applies for SSI or SS and Medicaid as disabled, and either the DDS or the Social Security Administration (SSA) denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.

When an individual applies for Medicaid as disabled or concurrently applies for SS/SSI and Medicaid as disabled, and DDS denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.

B. Procedures

1. Subsequent SSA/SSI Disability Decisions

The SSA disability decision takes precedence over a DDS decision (DDS will make a decision before SSA if SSA does not take action within the 90-day Medicaid application processing time). If SSA denies disability and the decision is appealed and subsequently reversed, reopen and re-evaluate the denied Medicaid application as long as the disability onset month is prior to the month of application or is no later than 90 days after the month of application.

2. Use Original Application

The original application is used as long as the application was denied because the individual was not disabled and the subsequent disability onset month is no later than 90 days from the month of application.

3. Entitlement

If the re-evaluation determines that the individual is eligible, the individual's Medicaid entitlement is based on the Medicaid application date including the retroactive period if *available documentation verifies that* all eligibility requirements were met during the retroactive period. However, eligibility as a disabled individual cannot begin prior to the disability onset date when the disability onset date falls after the application date.

4. Renewal

If, based upon the re-evaluation, the individual is determined to be eligible and more than 12 months have passed since the application was filed, complete a *renewal* to determine whether or not the individual remains eligible.

5. Original Application Was Purged

Closed cases may be purged after at least three years from the application date have passed (see M0130.400). If the case record was purged, in the absence of agency knowledge regarding the original application date (e.g. an application log), accept the individual's attestation of the application date.

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Send the individual two application forms. Instruct the individual to complete one application according to his circumstances at the time of the attested original application date and the other application according to his current circumstances. Request verifications for the attested original application month and retroactive period, as well as the current application according to the renewal policy in M1520.200 A, in order to evaluate ongoing eligibility

If verifications from the attested application month and retroactive period cannot be obtained, eligibility cannot begin until the earliest month that the individual was both disabled and his eligibility can be verified.

6. Spenddown

If, based upon the re-evaluation, the individual is determined not eligible but met the requirements in Chapter M13 for placement on a spenddown, a first prospective and additional 6 month spenddown budget period*(s)* are established to cover the period of time between the date of application and the date action is taken on his case.

A new application is not required for each 6 month spenddown budget period leading up to the date of processing; however, verification of all income and resources for those time periods must be obtained.

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M1510 MEDICAID ENTITLEMENT	**M1510.106**	**9**

M1510.105 FOSTER CARE CHILDREN

A. Policy

Entitlement begins the first day of the month of commitment or entrustment IF a Medicaid application is filed within 4 months of the commitment or entrustment date.

If the Medicaid application is filed more than 4 months after entrustment or commitment, entitlement begins the first day of the application month if retroactive coverage is NOT requested.

B. Retroactive Entitlement

If the Medicaid application is filed within 4 months of entrustment or commitment, retroactive eligibility exists only if the child met another covered group and all other Medicaid eligibility requirements in the retroactive period. If the Medicaid application is filed more than 4 months after entrustment or commitment, retroactive entitlement as a foster care child exists in the 3 months prior to Medicaid application. Entitlement cannot go back more than 3 months prior to the Medicaid application month.

M1510.106 DELAYED CLAIMS

A. When Applicable

Medicaid will not pay claims from providers that are filed more than 12 months after the date the service was provided, unless the reason for the delayed filing was a delay in the enrollee's eligibility determination and enrollment. If the applicant is eligible for Medicaid and the coverage begin date is 12 months or more prior to the month during which the enrollee is enrolled on the Medicaid computer, the agency must write a letter for the applicant to give to all medical providers who will bill Medicaid for services provided over 1 year ago.

B. Eligibility Delay Letter Requirements

The letter must:

* be on the agency's letterhead stationery and include the date completed.

* be addressed to the "Department of Medical Assistance Services, Claims Processing Unit."

* state the enrollee's name and Medicaid recipient I.D. number.

* state that "the claim for the service was delayed for more than one year because eligibility determination and enrollment was delayed."

C. Procedures

The "eligibility delay" letter and a sufficient number of copies must be given to the enrollee to give to each provider who provided a covered medical service to the recipient over one year ago. The provider must attach the letter to the claim invoice in order to receive Medicaid payment for the service. If the date the letter was prepared by the agency is not included on the letter, the claim will be denied. If the individual was enrolled in a closed period of coverage, include the dates of coverage in the letter.

A sample eligibility delay letter is available at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*.



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M1510 MEDICAID ENTITLEMENT	**M1510.107**	**9a**

M1510.107 Enrollment Changes

~~D~~. Enrollment Changes

VaCMS is the MA eligibility system of record, however some enrollment functions can only be handled by the DMAS Eligibility and Enrollment Unit. The VaCMS and MES [Medicaid Enterprise System (formerly MMIS)] systems **must** reflect correct coverage. Appropriate change requests include (but are not limited to):

- Coverage corrections unable to be handled through VaCMS
- Duplicate linking
- Erroneous death cancellations
- Same day void.

There may be instances when VaCMS should be able to successfully update the enrollment system but does not. When this occurs, the eligibility worker must follow the steps as listed below:

- First attempt to make the correction in VaCMS with the help of supervisors or other agency resources. If not successful;
    - Contact the VDSS Regional Practice Consultant (RC) for assistance. The RC will help the local worker make the correction in VaCMS.
- If either the agency resources or RC is unable to correct the enrollment in VaCMS, they can instruct the worker to submit a coverage correction to DMAS *by submitting a coverage correction request through the Coverage Correction Portal (CCP) on the MES website.*, *Home | MES*.

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M1510 MEDICAID ENTITLEMENT	**M1510.200**	**10**

M1510.200 NOTICE REQUIREMENTS

A. Policy

Federal regulations in 42 CFR 431.206 through 431.214 require the agency to inform every applicant or enrollee in writing

* of *their* right to a hearing;
* of the method by which *a* hearing *may be requested and obtained*; and
* that *the person* may represent *themself* or use legal counsel, a relative, a friend or other spokesperson.

The agency must provide the information required above at the time of any action affecting *the* claim for Medicaid benefits.

B. Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs

A system-generated Notice of Action or the "Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs" (Form 032-03-008) must be used to notify the applicant:

- that *the* application has been approved and the effective date(s) of Medicaid coverage.
- that retroactive Medicaid coverage was approved and the effective dates.
- that *the* application has been denied including the specific reason(s) for denial.
- that retroactive Medicaid coverage was denied, including the specific reason(s) for denial.
- of the reason for delay in processing *the* application.
- of the status of *the* request for reevaluation of his application in spenddown status.

When additional information is necessary to clearly explain the case action, suppress the system-generated notice and send a manual notice containing the necessary information.

When *an* authorized representative *is documented in the case or on the application*, a copy of the notification must be mailed to the applicant's authorized representative.

The notice must be generated in the applicant's preferred language designated on the application if the language is available for translation within VaCMS. All notices must contain the language supplement which is automatically generated with the notice of action in VaCMS.

1. CN Children or Pregnant Women

When the application of a medically indigent child or pregnant woman is denied because of excess income, the denial notice must state the reason for denial. The notice must also include the resource question pages from an MA application form *(Appendix D)* and must advise the applicant of the following:

a. that *they* may complete and return the enclosed form for a Medicaid spenddown to be evaluated, and

b. if the information is returned within 10 days of this notice, the medically indigent application date will be used as the Medicaid spenddown application date.



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M1510 MEDICAID ENTITLEMENT	**M1510.200**	**11**

2. Qualified Medicare Beneficiaries

a. Excess resources

When a Qualified Medicare Beneficiary's (QMB's) application for full benefit Medicaid coverage is denied because of excess resources, the denial notice must state that the applicant is not eligible for full Medicaid coverage because of excess resources.

b. Excess income

1) If the QMB's resources are within the Medicare Savings Program (MSP) limit but are over the MN limit, and the income exceeds the limit for full Medicaid coverage, the notice must state that the applicant is not eligible for QMB Medicaid because of excess income, and is not eligible for MN spenddown because of excess resources. The notice must specify the dollar amount of the appropriate MN resource limit.

2) If the QMB's resources are within the MN income limit, and income exceeds the limit for full Medicaid coverage, the notice must state that the applicant is not eligible for full-benefit Medicaid because of excess income, but that the applicant can become eligible by incurring medical or dental expenses that equal or exceed his excess income. The notice must specify the spenddown amount, the spenddown period begin and end dates, and include a copy of the Spenddown Fact Sheet.

3. Retroactive Entitlement Only or Limited Period of Entitlement

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

4. Example #7 Limited Period of Entitlement

A Medicaid application was filed on December 30. The client inherited real property on January 30. The agency processed the application on February 5 and determined the client was eligible for Medicaid for the months of December and January, but was ineligible for additional coverage beginning February because the countable value of the inheritance caused excess resources. One notice is sent to the applicant stating that his Medicaid application was approved beginning December 1 and ending January 31, and that he was denied coverage after January 31 because of excess resources (real property).

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M1510.300 FOLLOW-UP RESPONSIBILITIES

M1510.301 THIRD PARTY LIABILITY (TPL)

A. Introduction

Medicaid is a "last pay" program and cannot pay any claim for service until the service provider has filed a claim with the recipient's liable third parties such as health insurance companies or legally liable person. The procedures depend on the type of third party liability (TPL) the recipient has.

B. Private Health Insurance

Information on an eligible individual's private health insurance coverage must be obtained and recorded in the case record and in VaCMS. This must include the company name (code number for the TPL file), the policy number, and the begin date of coverage. This information does NOT require verification.

Health insurance policy or coverage changes must be updated in VaCMS.

1. Verification Required - Policy or Coverage Termination

Verification of the date the health insurance policy and/or a coverage type terminated is required. The verification of the termination date can be a written letter from, or verbal statement by, the insurance company that states the termination date. If verification is obtained, the worker is to **end-date** the TPL coverage in VaCMS (note: do not delete the TPL from VaCMS).

Absent receipt of documentation showing that the TPL coverage has ended, it must be left open in VaCMS and MES and cannot be ended by the worker. If the worker is unable to obtain verification of the coverage termination date from the insurance company or the enrollee/authorized representative, the worker is to notify DMAS that the enrollee's TPL coverage was terminated, but verification cannot be obtained. The notification should be sent via e-mail to: tplunit@dmas.virginia.gov. If it is determined that TPL coverage no longer exists, the coverage will be closed in MES by DMAS staff. The worker must then close the coverage in VaCMS.

2. Health Insurance Premium Payment (HIPP)Program

If an applicant or enrollee reports that he or a family member is employed more than 30 hours each week and is eligible for health insurance coverage under an employer's group health plan, he or she must be given a HIPP Fact Sheet which provides a brief description of the program and the contact information for the HIPP Unit at DMAS. The HIPP Fact Sheet is available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/References.

If the enrollee opts to enroll in HIPP, update **VaCMS** with the TPL information when it is provided by the enrollee. Call the HIPP Unit at 1-800-432-5924 *or email HIPPcustomerservice@dmas.virginia.gov* when an enrollee reports changes to the TPL information so that MES can be updated.

C. Medicare

Individuals are *not* required to apply for coverage under Medicare A, B or D, or any combination of Medicaid A, B, and D, *even* if it is likely that the individual would meet the eligibility criteria for any or all of those programs. The state *will* pay any applicable premiums and cost-sharing (except those applicable under Part D) for *Medicaid-eligible* individuals *who* apply for Medicare.



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Application for Medicare is *not* a condition of eligibility *for Medicaid.*

For persons age 65 or over, for persons under age 65 who have received SSA or Railroad Retirement benefits because of disability for 24 consecutive months, and for persons with chronic end-stage renal disease, the Department of Medical Assistance Services has a buy-in agreement with Medicare to provide to those eligible individuals who are also eligible for Medicare the medical services available under Medicare, Part B (Title XVIII of the Social Security Act) through payment of the Part B premium.

When the recipient has to pay a Medicare Part A premium, Medicaid will pay the Part A premium for

- all QMBs; the "dually-eligible" (those who are eligible in a CN or MN covered group and also are QMB), and the QMB-only (those QMBs who are not eligible for Medicaid in another covered group);
- Qualified Disabled and Working Individuals (QDWI).

1. Buy-In Procedure

The Centers for Medicare and Medicaid Services(CMS) maintains a current list of individuals for whom the State is paying the Part B premiums. The list is updated on a monthly basis by adding newly enrolled individuals and deleting those no longer eligible. Before CMS will admit an individual to the buy-in list for Part B coverage, the individual must have established eligibility for Medicare. *The* name and claim number, if one has been assigned, must be identical to the information in the SSA files. A difference between the name and number in MES and in the SSA files results in a mismatch and rejection of Part B premium coverage.

2. Medicare Claim Numbers

Only two types of claim numbers correctly identify an individual's entitlement to Medicare coverage: a *Medicare* claim number or a Railroad Retirement claim number. *The Medicare claim number contains 11 numbers and letters and is used to identify the services and goods that Medicare is billed on a recipient's behalf. The Medicare claim number is the same as the Medicare card number (the 11-character series of numbers and letters on the front of the red, white and blue Medicare card). Medicare uses this number to file and process claims, using the number to identify an individual as the beneficiary. The claim number is also known as a Medicare Beneficiary Identifier (MBI). The Centers for Medicare & Medicaid Services (CMS) sent new Medicare cards to all beneficiaries in 2018. On the new cards, the Social Security number was replaced by the Medicare claim number to help better protect the identity of each beneficiary and make it harder for someone to commit fraud.*

a. RR annuity-claim numbers have a letter (alpha) prefix followed by a six or nine digit number. The most common prefixes are A, M, H, WCD, NCA, CA, WD, WCH, and PD.

b. Certain letters following nine digit numbers identify an individual as an SSI recipient and are not acceptable as a Medicare claim number. These claim symbols are AI, AS, BC, BI, BS, DC, DI, and DS.



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3. Procedures for Obtaining Claim Numbers

a. Requesting Medicare Card

Each Medicaid applicant who appears to qualify for Medicare must be asked if he has applied for Medicare. Those that have applied and are eligible have received a white card with a red and a blue stripe at the top, with *their* name as it appears in the SSA files and the assigned claim number on the card. The name as it appears and the claim number must be included in the TPL section of the MES eligibility file maintained by DMAS.

b. Applicants Who Cannot Produce a Claim Number

Prior to requesting a *copy of the* Medicare card, inquire SSA via the SVES (State Verification Exchange System) *or SOLQ* using the applicant's own SSN.

If the applicant has never applied for Medicare *and requests help with doing so*, complete the Referral to Social Security Administration Form DSS/SSA-1 (form #032-03-099) and write in, "Buy-In" on the upper margin. Mail the form to the Social Security Office serving the locality in which the applicant resides. The SSA office will provide the correct claim number if the individual is on their records. Should the (local/area) SSA office have no record of an application for Medicare, a representative will contact the applicant to secure an application.

4. Buy-in Begin Date

Some individuals have a delay in Buy-in coverage:

Classifications	Buy-in Begin Date
SSI and AG recipients (includes dually-eligible)	1st month of eligibility
CN and MN with Medicare Part A who are dually-eligible as either Qualified Medicare Beneficiaries (QMB) or Special Low Income Medicare Beneficiaries (SLMB Plus)	1st month of eligibility
CN and MN with no Medicare Part A or who are not dually-eligible as either QMB or SLMB Plus	3rd month of eligibility

If the medically needy coverage begin date is other than the first day of a month, Buy-in is effective the first day of the month in which the 60th day after the begin date occurs.

D. Other Third Party Liability

When the agency identifies another third party which has responsibility to pay for a recipient's medical bill, the agency must report the third party to:

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Department of Medical Assistance Services
Third Party Liability Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Or email tplunit@dmas.virginia.gov.

Examples of other third parties include liability insurance settlements, trust funds established for the recipient's medical care, awards resulting from liability lawsuits, and persons ordered by the court to pay for the recipient's medical care.

E. Pursuing Third Party Liability and Medical Support

In order to continue to be eligible for Medicaid, an individual who is required to assign rights to, and cooperate in, pursuing medical support and third party liability must continue to cooperate with the local agency and DMAS. See subchapter M0250 for details.

M1510.302 SOCIAL SECURITY NUMBERS

A. Policy

Applicants must provide the Social Security number (SSN) of any person for whom they request Medicaid, or must apply for a Social Security number if he/she does not have one.

Exceptions – the SSN requirement does not apply to:

- an alien who is eligible only for Medicaid payment of emergency services, as defined in subchapter M0220, or
- a non-citizen who is only eligible to receive an SSN for a valid non-work reason, or
- a child under age one born to a Medicaid-eligible or FAMIS-covered mother (see M0330.301 B. 2 and M2220.100).

Individuals who *are* applying only for others and *are* not applying for *coverage are* not required to provide *their personal* SSN*(s)*.

When an individual has applied for an SSN and is determined eligible for medical assistance, the worker must take follow-up action to obtain the individual's SSN.

B. Procedures

See subchapter M0240 for the SSN application follow-up procedures required after enrolling an eligible individual who has applied for an SSN.

M1510.303 PATIENT PAY INFORMATION

A. Policy

After an individual *receiving* long-term *services and supports* is found eligible for Medicaid, the recipient's patient pay must be determined. When the patient pay amount is initially established or when it is changed, the worker enters the information in VaCMS. VaCMS sends the Notice of *Patient Pay Responsibility* to the enrollee or the enrollee's authorized representative.

B. Procedure

When patient pay increases, the Notice of *Patient Pay Responsibility* is sent in advance of the date the new amount is effective. *Patient pay cannot be increased in the past.*



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ENTITLEMENT POLICY & PROCEDURES
SUBCHAPTER 20

MEDICAL ASSISTANCE ELIGIBILITY REVIEW

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Changed With	Effective Date	Pages Changed
TN #DMAS-36	10/1/25	Pages 8a and 9
TN #DMAS-35	7/1/25	Pages 7 and 18
TN #DMAS-33	1/1/25	Page 9
TN #DMAS-33	10/1/24	Change List; Pages 1, 2a, 4a – 6, 10 – 11, 12a

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Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Appendix 2
TN #DMAS-31	4/1/24	Pages 15 and 16
TN #DMAS-30	1/1/24	Pages 3, 10, 10a, 13, 14, 18
TN #DMAS-29	10/1/23	Pages 3, 4, 7, 8, 12, 14, 15
TN #DMAS-28	7/1/23	Pages 1, 2, 2a, 4, 7, 8, 8a, 12, 13, 14 ; Appendix 2
TN #DMAS-27	4/1/23	Page 1, 15, 24a
TN #DMAS-26	1/1/23	Pages 15 and 24a
TN #DMAS-24	7/1/22	Pages 1, 3, 10 Pages 2 and 11 are a runover pages.
TN #DMAS-23	4/1/22	Pages 10, 11, 12, 13, 26, 27, 30 Appendix 2, page 1
TN #DMAS-22	1/1/22	Page 14
TN #DMAS-21	10/1/21	Pages 6, 12
TN #DMAS-20	7/1/21	Pages 2, 3. 5. 6, 13, 14 Page 2a is a runover page. Page 6a was added as a runover page
TN #DMAS-19	4/1/21	Appendix 2
TN #DMAS-18	10/1/19	Pages 1, 4, 4a, 5, 11, 13 Content that was inadvertedly deleted in a previous transmittal was restored. No policy was revised.
TN #DMAS-17	7/1/20	Pages 2, 4, 25, 30 Page 3 is a runover page.
TN #DMAS-16	4/1/20	Pages 3, 4, 7, 9 Appendix 2 Pages 3a and 4 were renumbered to pages 4 and 4a. Page 4a is a runover page.
TN #DMAS-15	1/1/20	Pages 8, 8a
TN #DMAS-14	10/1/19	Pages 2, 3, 4, 6a, 8, 9, 10, 13 Page 4a is a runover page. Page 10a was added as a runover page. Page 7a was deleted.
TN #DMAS-13	7/1/19	Page 14

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TN #DMAS-11	1/1/19	Pages 2, 5, 6, 7, 9
TN #DMAS-8	4/1/18	Pages 2, 18 Appendix 2
TN #DMAS-7	1/1/18	Pages 2, 3, 3a, 5, 6, 7 Pages 6a and 7a are runover pages.
TN #DMAS-5	7/1/17	Pages 1, 2, 6, 8 Pages 3, 7, 7a and 9 are runover pages.
TN #DMAS-4	4/1/17	Pages 25-27 Appendix 2, page 1 Pages 28-30 were added.
TN #DMAS-3	1/1/17	Pages 1, 2, 4, 6, 7, 8, 14, 26
TN #DMAS-2	10/1/16	Pages 1, 3, 6, 8, 12, 14, 15 Pages 19-24
TN #DMAS-1	6/1/16	Pages 3, 6, 7, 9, 11-14, 17 Appendix 2, page 1 Pages 3a and 7a were added. Page 8 is a runover page.
TN #100	5/1/15	Table of Contents Pages 1-27 (entire subchapter –pages 28-34 were deleted) Appendices 1 and 2 were added.
TN #99	1/1/14	Table of Contents Pages 1-34 (entire subchapter)
UP #9	4/1/13	Pages 7b and 10a
TN #97	9/1/12	Page 1
UP #7	7/1/12	Pages 1, 7, 7c, 7g
TN #96	10/1/11	Table of Contents Pages 1-7g Pages 11-13 Pages 21-24
TN #95	3/1/11	Pages 6a, 7, 21, 22
TN #94	9/1/10	Table of Contents Pages 3, 4b, 5, 6-6a, 10 Appendix 1 was removed.
UP #4	7/1/10	Page 4
TN #93	1/1/10	Pages 3, 4b, 5-6, 10, 15 Pages 21, 22
Update (UP) #2	8/24/09	Pages 1, 2, 13, 14, 17, 18
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M1520.000 MEDICAL ASSISTANCE ELIGIBILITY REVIEW M1520.001 GENERAL PRINCIPLE

A. Policy

A MA recipient's eligibility must be partially reviewed whenever the agency becomes aware of any change in the enrollee's circumstances that might affect the enrollee's continued eligibility. The timeframe for acting on a change is 30 calendar days from the date the change is reported or the agency becomes aware of the change.

Exception: Children meeting the definition of a newborn in M0330.802 or M2240.100.F are to be enrolled as soon as possible upon report of the birth.

An annual review of all of the enrollee's eligibility requirements is called a "redetermination" or "renewal." A renewal of the enrollee's eligibility must be completed at least once every 12 months. The renewal can be initiated in the 10th month to ensure timely completion of the renewal.

When an enrollee no longer meets the requirements for his current covered group, prior to cancelling his coverage, evaluate the enrollee in all covered groups for which he may meet the definition. If the enrollee is not eligible for full benefit Medicaid coverage and is not eligible in any other limited-benefit covered group (i.e. the Medicare Savings Programs), evaluate the enrollee for Plan First *if the individual has opted to be considered for* that coverage.

B. Procedures For Partial Review and Renewals

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

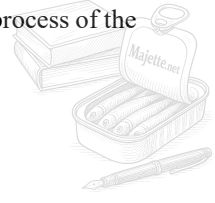
- Partial reviews – M1520.100;
- Renewals – M1520.200;
- Canceling coverage or Reducing the level of benefits – M1520.300;
- Extended Medicaid coverage – M1520.400;
- Transferring cases within Virginia – M1520.500.

C. Public Health Emergency (COVID)

On January 31, 2020, a public health emergency (PHE) was declared by the U.S. Department of Health and Human Services as a result of the continued consequences of the Coronavirus Disease 2019 (COVID-19) pandemic. Under the direction of the Centers for Medicare and Medicaid Services (CMS), state Medicaid agencies *did* not take action to cancel or reduce medical assistance coverage for enrolled individuals, regardless of eligibility changes, unless the individual die*d*, move*d* out of the state, or request*ed* cancelation of coverage. This was referred to as Medicaid continuous coverage. On May 11, 2023 Congress ended the federal COVID-19 public health emergency.

The Consolidated Appropriations Act of 2023 was enacted on 12/29/2022. This policy took effect on April 1, 2023 and affected Medicaid continuous coverage. This outlined *that* case closures or cancellations for those enrollees no longer eligible for Medicaid coverage would be effective as of April 30, 2023.

CMS provided post-pandemic guidance known as "Unwinding" and procedures were developed and implemented for agencies to begin the redetermination process of the majority of Medicaid enrollees.



These procedures began in March 2023 via an electronic Ex Parte process. A schedule of when redeterminations were to be processed was constructed and provided to all agencies. This was in order to handle the processing in a logical manner as the CMS instruction was that no more than one ninth of redeterminations could be initiated within any month.

Information was shared with the agencies that are involved with the processing of redeterminations. Broadcasts were available in Fusion and trainings were held for those involved.

M1520.100 PARTIAL REVIEW

A. Enrollee's Responsibility

Enrollees must report changes in circumstances that may affect eligibility and/or patient pay within 10 days from the day the change is known. For enrollees participating in the Health Insurance Premium Payment (HIPP) Program, changes that may affect participation in HIPP must be reported to the DMAS HIPP Unit within the 10-day timeframe.

B. Eligibility Worker's Responsibility

The eligibility worker is responsible for keeping a record of changes that may be anticipated or scheduled and for taking appropriate action on those changes.

Appropriate agency action on a reported change must be taken within 30 days of the report. If the enrollee reports any changes requiring verifications, such as changes in income or resources, or an asset transfer for enrollees receiving long-term services and supports (LTSS), if possible, use available online systems information to verify the reported change. If the online-information is compatible with the reported change, determine eligibility based upon the information available.

If verifications must be obtained from the enrollee, send a verification checklist, and allow at least 10 calendar days for the information to be returned. If information is not provided by the deadline and continued eligibility cannot be determined, send advance notice to the enrollee/ authorized representative stating the cancellation date and the reason. Document the information and evaluation in the VaCMS case record. If requested verifications are received after the deadline due to circumstances beyond the individual's control (e.g. a postal system delay), reopen the case, and complete processing of the change.

When an enrollee reports a change or the agency receives information indicating a change in the enrollee's circumstances (i.e. Supplemental Security Income [SSI] purge list, reported transfer of assets), the worker must take action to partially review the enrollee's continued eligibility.

The following changes must be verified:

- A decrease in income or termination of employment that causes the individual to move from limited Medicaid coverage to full Medicaid coverage,
- An increase in income that causes the individual to move from Medicaid to FAMIS, or to need a Medically Needy spenddown calculation.

If a reported change is not compatible with information obtained from online system searches, obtain verification from enrollee or authorized representative. The agency may not deny an increase in benefits, terminate coverage, or reduce benefits for any individual unless the agency has sought additional information from the individual and provided proper notification.

Children under age 19 are eligible for 12 months of continuous eligibility unless

- *they are no longer Virginia residents;*
- *the child or child's representative requests eligibility be closed;*
- *the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or*
- *the child is deceased.*

When a change is reported that impacts eligibility or a renewal is completed and the enrollee is no longer eligible, the Advance Notice of Proposed Action must be sent to the enrollee, before the enrollee's benefits can be reduced or his eligibility can be terminated (see M1520.301). Send the notice to the authorized representative if one has been designated.

1. Asset Transfers during the PHE

When an enrollee reports an uncompensated asset transfer that took place during the COVID-19 Continuous Eligibility Period (sometimes termed the PHE- Public Health Emergency) before April 1, 2023, the transfer should be evaluated and a penalty period calculated. The option to claim undue hardship must be given to the member. **If Undue Hardship is denied or not requested, apply the FULL penalty period going forward (after the 10 day advance notice period)**, send notice to the client and a 225 (LTSS Communication form) to the provider.

2. Negative Action requires a Notice

Adequate notice using the Notice of Action must be provided when an enrollee dies, enters an ineligible institution, is incarcerated and no longer meets a covered group, moves out of Virginia, requests termination of his coverage, or is unable to be located by the local agency. *See M0130.500 Returned Mail.*

3. Changes That Do Not Require Partial Review

Document changes in an enrollee's situation, such as the receipt of the enrollee's Social Security number (SSN), that do not require a partial review in the case record and take action any necessary action on the enrollee's coverage.

Example: An MA enrollee who did not have an SSN, but applied for one when he applied for MA, reports by calling the worker that he received his SSN. The worker records the telephone call and the enrollee's newly assigned SSN in the case record, verifies the SSN via SPIDeR and enters the enrollee's verified SSN in the eligibility determination/enrollment systems

No partial review *or verification* is required for a change in income (earned, unearned or self- employment) if the eligible individual's coverage remains within the equivalent coverage group (and there is no patient pay associated with the EDG).

Example: The individual is enrolled in a full coverage aid category prior to the reported change and remains in full coverage after the change. No verification is required as coverage remains within the equivalent coverage group after income change.



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4. HIPP

The eligibility worker must provide the enrollee with a copy of the HIPP FACT Sheet when it is reported that he or a family member is employed more than 30 hours per week and is eligible for coverage under an employer's group health plan. The HIPP Fact Sheet is available at https://fusion.dss.virginia.gov/bp/BP- Home/Medical-Assistance/References.

The eligibility worker must report to the HIPP Unit at DMAS any changes in an enrollee's situation that may affect the premium payment. The worker may report changes by e-mail to hipp@dmas.virginia.gov. This e-mail address is for use by the local agency staff only. See M0130.200 G for additional information about HIPP requirements.

5. Program Integrity

The MA eligibility of enrollees is subject to periodic review through the program integrity process (such as Medicaid Quality Control and the DMAS Recipient Audit Unit). It may be necessary for program integrity staff to request information, such as income verification, from the enrollee. The enrollee will be notified in writing and given a reasonable amount of time, as determined by the program integrity staff, to provide the information.

Should the enrollee not provide the requested information to the program integrity staff within the specified time, program integrity staff will notify the eligibility worker, and the worker must take action to follow up by requesting the appropriate verifications and/or sending advance notice, if necessary, to cancel coverage due to the inability to determine continued eligibility. An individual's failure to provide information to program integrity staff does not affect any future Medicaid applications.

C. Covered Group and Aid Category Changes

1. Enrollee's Situation Changes

When a change in an enrollee's situation results in a potential change in covered group, his eligibility in all other covered groups must be evaluated. Examples of such changes include when:

- a pregnant woman reaches the end of her 12th month of post-partum coverage,
- an infant who has been enrolled as a Newborn Child reaches age one year,
- *a child reaches age 19; is no longer a Virginia resident; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*
- a Families & Children (F&C) enrollee becomes entitled to SSI,
- an SSI Medicaid enrollee becomes a Qualified Severely Impaired Individual (QSII) (1619(b),
- an individual enrolled in a Modified Adjusted Gross Income (MAGI) Adults aid category turns 65 years old, or becomes entitled for/begins receiving Medicare.

***2.* Change in Level of Benefits**

When an individual who has been enrolled in limited coverage, such as Plan First, experiences a change, such as pregnancy or entitlement to Medicare, that results in eligibility for full coverage or a Medicare Savings Program, the individual's entitlement to the new level of coverage begins the month the individual is first eligible for the new level of coverage, regardless of when or how the agency learns of the change. If change in income is reported, the agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family.

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D. Child Moves From *Case* Home

When an enrolled child moves out of the home *in which he was living at application or last renewal* but is still living in Virginia, do not cancel MA coverage solely on the basis of the move, and do not require a new application. Complete a partial review to determine the child's continuing eligibility if any changes in income, such as the child becoming employed, are reported.

1. Case Management

The necessary case management actions depend on the child's age and whether or not the child has moved to an arrangement in which an authorized representative is necessary.

a. Child Age 18 years or Under 18 and Living with a Relative *or Legal Guardian*

If the child is age 18, he may be placed in his own MA case if he was previously on a case with other enrollees. If the child is under age 18 and moved in with an adult relative *or legal guardian*, the child may be placed on a case with the relative *or guardian* and *that individual* authorized to conduct MA business on behalf of the child..

b. Child Under Age 18 years Living with Non-relative

When a child under age 18 moves to the home of a non-relative adult without legal custody, the non-relative adult does not have to be an authorized representative to report changes in the child's situation. However, the worker cannot discuss the case or send the non-relative adult a copy of the child's MA card unless the person is authorized to handle the MA business for the child. Follow the procedures in M1520.100 D.2 through D.4 below.

2. Enrollment

a. Case Number

The child's member ID number does not change, but the child's Member ID number must be moved to a case number in the child's name as case head, if the person with whom the child is living does NOT have authority to act on the child's behalf.

b. Demographics Comment Screen

In VaCMS, enter a comment that will inform staff that information from the case cannot be shared with (the name of the person with whom the child lives) because he/she is NOT authorized to receive the information.

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c. Renewal Date

If establishing a new case for the child, enter the child's existing renewal date from his former case. *If enough information is available, re-evaluate the child's eligibility and give them another 12 months of eligibility.* If moving the child to the adult relative's already established case, *and enough information is not available to re-evaluate coverage,* the child's renewal date *can* be the adult relative's case renewal date if this action does not extend the child's renewal date past one year *or reduce the child's eligibility period to less than 12 months*.

d. Medicaid Card

A new ID card is only generated when the enrollee's name, SSN or gender changes, or when a worker requests a replacement ID card. Changing the child's address or case number does not generate a new card. The worker must request a replacement card if one is needed. The existing card will be voided when the replacement is issued.

3. Obtain Authorization from Parent Prior to Renewal

Prior to the next scheduled renewal, the agency should try to obtain an authorization from the parent to allow the agency to communicate with the adult. However, as long as the parent has not formally lost custody of the child, the parent is still the responsible party and can transact the Medicaid business if he is capable and willing, or until there is a guardian/custodian established. If the parent cannot or will not designate an authorized representative, refer the case to the agency's Family Services Unit is so that guardianship can be established per M0120.200 C.

4. Renewal

Follow the rules in M0120.200, which apply to both applications and renewals. If the adult is a relative, the adult can complete the renewal for the child. If the adult is a non-relative and not an authorized representative, then the adult cannot complete the child's renewal. If the child's parent cannot or will not complete the renewal, a referral to the agency's Family Services Unit is needed to pursue guardianship.

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E. Recipient Enters LTC

An evaluation of continued eligibility must be completed using the rules in chapter M14 when a Medicaid enrollee begins receiving Medicaid-covered LTC services or has been screened and approved for LTC services. Rules for determining Medicaid eligibility for married institutionalized recipients who have a community spouse are found in subchapter M1480.

If an annual renewal has been done within the past 6 months, a partial review to address factors pertinent to receipt of LTC, such as asset transfer, spousal resource assessment, etc., must be completed. If an annual renewal has not been done within the past 6 months, a complete renewal must be completed (see M1520.200). When the re-evaluation is completed, send all required notices to the enrollee/authorized representative, and send a DMAS-225 to the provider (see M1410.300).

If the individual is already enrolled in a full benefit Medicaid covered group, do not change the AC. If the individual is enrolled in a limited-benefit covered group, the individual must be evaluated for eligibility in one of the covered groups for institutionalized individuals (i.e. income $\leq$ 300% of SSI) (see M1460).

For an SSI recipient who has no community spouse and owns no countable real property, verify continued receipt of SSI through SOLQ-I or SVES, obtain information regarding asset transfer from the enrollee or authorized representative, and document the case record. As long as the individual continues to receive SSI, do not change the AC. If the individual loses SSI, evaluate his Medicaid eligibility in other covered groups. See M1430.103 for additional information regarding an SSI recipient who enters a nursing facility.

When an individual on a spenddown enters LTC, his Medicaid eligibility must be determined using the procedures in subchapter M1460. An individual on a spenddown in an assistance unit with a spouse and/or children becomes a separate assistance unit when he enters LTC. The spouse's and/or children's spenddown liability is recalculated to reflect a decrease in assistance unit size. See M1350.220 for additional information.

F. Woman Enrolled in FAMIS Prenatal Coverage Delivers Her Infant

For women enrolled in AC 110 under a fee for service (FFS) arrangement, labor and delivery services are paid as emergency services, and the newborn is considered a deemed-eligible newborn. When the birth of the child born to a women enrolled in FAMIS Prenatal Coverage is reported, review the available systems to determine if the mother is enrolled in AC110 under FFS. If so, the child is enrolled as a deemed newborn in AC 093. See M0330.400. *Since the child's eligibility can be verified, the child receives a 12 month certification period starting with the month of birth.*

An infant born to a woman enrolled in AC 111 and/or enrolled in managed care must be evaluated for ongoing coverage. The enrollment is treated as a change in circumstances. The infant is not considered a deemed-eligible newborn but has rather been enrolled prenatally through the mother's enrollment in FAMIS Prenatal Coverage. *Since the child's eligibility can't be verified t*he infant's birth is treated as an "add a person" case change in the enrollment system *and given a 12 month certification period starting with the mother's first month of enrollment.*

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1. Note re: SSN

The infant is not required to provide an SSN or proof of application for an SSN in order to be enrolled. Follow the procedures in M0240.200 B.3 90 days following the infant's enrollment to determine if an SSN has been assigned. If the

- SSN number has not yet been issued at 90 days, obtain the SSN or proof of application for an SSN at the first renewal of the infant's coverage *that occurs after the child turns one*.

Unless the agency has information about the infant's father living in the home (i.e. for another program), use only the mother's reported income to enroll the infant. Do not request information about the father or the father's income unless the agency has information about the father living in the home and his income.

2. Required Information

To enroll the infant, the worker must have the information below. Use existing case data if possible. If additional information is needed, send a request for verification.

- Name, date of birth, sex (gender)
- Information about the infant's MAGI household and income.

Unless the agency has information about the infant's father living in the home (i.e. for another program), use only the mother's reported income to enroll the infant. Do not request information about the father or the father's income unless the agency has information about the father living in the home and his income.

3. Enrollment and Aid Category

Update the case with the new infant's information, enrolling the child as a Medicaid child under 19 or in FAMIS, as appropriate based on the mother's countable income at the time of application. Use the appropriate AC below to enroll the infant:

- Medicaid AC 090 for income > 109% FPL < 143% FPL
- Medicaid AC 091 for income < 109% FPL
- FAMIS AC 006 for income > 150% FPL and < 200% FPL
- FAMIS AC 008 for income > 143% FPL and < 150% FPL

The infant's first renewal is due 12 months from the month of the infant's enrollment.

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M1520.200 RENEWAL REQUIREMENTS

A. Policy

The agency must evaluate the eligibility of all MA enrollees, with respect to circumstances that may change, at least every 12 months. Each renewal must be authorized by an eligibility worker or supervisor, although administrative staff may assist in the gathering of information.

The scope of renewals is limited to information that is necessary to determine ongoing eligibility and that relates to circumstances that are subject to change, such as income and resources. Verification of information that is not subject to change, such as date of birth and SSN, is not required at renewal, unless it has not been verified previously.

If an annual renewal has been done within the past 6 months, a partial review to address factors pertinent to receipt of LTC, such as asset transfer, spousal resource assessment, etc., must be completed. If an annual renewal has not been done within the past 6 months, a complete renewal must be completed (see M1520.200). When the re-evaluation is completed, send all required notices to the enrollee/authorized representative, and send a DMAS-225 to the provider (see M1410.300).

If the individual is already enrolled in a full benefit Medicaid covered group, do not change the AC. If the individual is enrolled in a limited-benefit covered group, the individual must be evaluated for eligibility in one of the covered groups for institutionalized individuals (i.e. income $\leq$ 300% of SSI) (see M1460).

For an SSI recipient who has no community spouse and owns no countable real property, verify continued receipt of SSI through SOLQ-I or SVES, obtain information regarding asset transfer from the enrollee or authorized representative, and document the case record. As long as the individual continues to receive SSI, do not change the AC (see M0320.101.C). If the individual loses SSI, evaluate his Medicaid eligibility in other covered groups. See M1430.103 for additional information regarding an SSI recipient who enters a nursing facility.

When an individual on a spenddown enters LTC, his Medicaid eligibility must be determined using the procedures in subchapter M1460. An individual on a spenddown in an assistance unit with a spouse and/or children becomes a separate assistance unit when he enters LTC. The spouse's and/or children's spenddown liability is recalculated to reflect a decrease in assistance unit size. See M1350.220 for additional information.

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For an SSI recipient who has no community spouse and owns no countable real property, verify continued receipt of SSI through SOLQ-I or SVES, obtain information regarding asset transfer from the enrollee or authorized representative, and document the case record. As long as the individual continues to receive SSI, do not change the AC (s*ee M0320.101.C).* If the individual loses SSI, evaluate his Medicaid eligibility in other covered groups. See M1430.103 for additional information regarding an SSI recipient who enters a nursing facility.

When an individual on a spenddown enters LTC, his Medicaid eligibility must be determined using the procedures in subchapter M1460. An individual on a spenddown in an assistance unit with a spouse and/or children becomes a separate assistance unit when he enters LTC. The spouse's and/or children's spenddown liability is recalculated to reflect a decrease in assistance unit size. See M1350.220 for additional information.

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B. Renewal Procedures Renewals may be completed in one of the following ways:

- ex parte,
- using a paper form,
- online,
- telephonically by calling the Cover Virginia Call Center.

1. Ex Parte Renewals

An ex parte renewal is an internal review of eligibility based on information available to the agency. Conduct renewals of ongoing Medicaid eligibility through the ex parte renewal process for all covered groups, including covered groups with a resource test and individuals receiving LTSS. If an automated ex parte renewal cannot be attempted, a manual ex parte renewal must be attempted and documented in VaCMS UNLESS the automated process leaves an ex parte attempt date.

a. MAGI-based *and Non-MAGI* Cases

For *all* cases an ex parte renewal should be completed when income verification is available through the federal Hub. An individual may authorize the use of Internal Revenue Services (IRS) data for up to five years on the application form and at each renewal. In order for the federal Hub to be used for income, there must be a valid authorization in the electronic or paper case record.

The agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family, and must make efforts to align renewal dates for all programs. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information, information from SSA through SVES or SOLQ-I and information from child support and childcare files. Verification of income from available sources, including the VEC, may be used if it is dated within the previous *6* months. See M0130.001.B.3.

The eligibility worker is to take every opportunity to renew Medicaid eligibility when information is reported/verified that will allow a renewal of eligibility to be completed. For example, when an ongoing Medicaid enrollee applies for SNAP or TANF or reports a change in income, use the income information obtained to complete an early ex parte Medicaid renewal and extend the Medicaid renewal for another 12 months.

The agency must include in each applicant's case record facts to support the agency's decision on the case. The eligibility worker must document the date and method used to obtain the verification information (viewed pay stub dated xx/xx/xxxx, telephone call on xx/xx/xxxx date, etc.), the type of verification, the source and a description of the information. If the renewal is not processed and documented electronically, the documentation must be placed and maintained in the case record.

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b. SSI Medicaid Enrollees

An ex parte renewal for an SSI recipient (including a LTSS recipient) can be completed by verifying the individual's continued receipt of SSI through SVES or SOLQ-I, checking AVS and other electronic verification sources, and documenting the case record. For a 1619(b) individual, check the Medicaid Test Indicator field in SVES or SOLQ-I to verify there is a code of A, B or F.

If the individual is no longer an SSI recipient or no longer has 1619(b) status a manual ex parte renewal must still be attempted. If the ex parte renewal is unsuccessful or results in negative action, a contact-based renewal must be completed and necessary verifications obtained to evaluate the individual's eligibility in all other covered groups prior to canceling his Medicaid coverage.

***c.* All other Medicaid Enrollees**

Evaluation for continued Medical Assistance for all covered groups must be attempted using the ex parte renewal process, including covered groups with a resource test and individuals receiving LTSS. If a case drops out of the automated ex parte renewal process, a manual ex parte renewal must be attempted and documented in VaCMS *UNLESS the automated process leaves an ex parte attempt date.*

d. Continuing Eligibility Not Established Through Ex Parte Process

If the ex parte renewal results in the individual no longer being eligible for coverage, the individual must be given the opportunity to submit current income information and verifications. Follow the steps in M1520.200 B.2 below for completing a paper-based renewal.

2. Paper Renewals

When an ex parte renewal cannot be completed and the enrollee has not completed a renewal telephonically or online, send the enrollee a pre-filled paper Administrative Renewal form to sign and return. If an authorized representative has been designated, the renewal form is sent to the authorized representative.

The form needs to be sent to the enrollee in time to allow for the return and processing periods prior to the system cut-off in the 12th month of eligibility. The enrollee must be allowed 30 days to return the renewal form and any necessary verifications; Administrative Renewal forms are pre-filled with the return date. The specific information requested and the deadline for receipt of the verification must be documented in the case record.

If the enrollee submits a completed application form, accept it as a renewal form and obtain any additional information needed to complete the renewal.

If a paper or electronic renewal application is submitted by the enrollee, the renewal should be evaluated even if the scheduled renewal date is in the future.

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New or revised information provided by the enrollee must be entered into the system. The enrollee is responsible for reporting any changes. If the enrollee does not check either "yes" or "no" in response to a particular question, there is considered to be no change with regard to that question.

Verifications must be copied or scanned into VaCMS using the Document Management Imaging System (DMIS) and preserved for the record. Notes by the eligibility worker that the verifications were viewed are not sufficient.

Renewals must be completed prior to cut-off in the 12th month of eligibility or within 30 calendar days from the receipt of the renewal, whichever is later.

When an individual does not return the renewal form and action is taken to cancel coverage, a three-month reconsideration period applies (see M1520.200 C.4). *The reconsideration period begins the month after the case closure date.*

Example: Case closed on June 12 (before cut-off) effective June 30, reconsideration period begins July 1. Case closed June 20 (after cut-off) effective July 31, reconsideration period begins August 1.

Note: Follow Auxiliary Grants (AG) policy regarding the appropriate renewal form to use for AG/Medicaid enrollees.

3. Online and Telephonic Renewals

Enrollees may opt to complete a renewal online using CommonHelp or by telephone through the Cover Virginia Call Center.

Renewals completed through CommonHelp are electronically signed by the enrollee or authorized representative. For cases in VaCMS, renewals completed through CommonHelp will automatically be entered into VaCMS for the worker to complete processing. For non-VaCMS cases, the renewal must be completed manually. It is not necessary to print a renewal completed through CommonHelp for the case record because it will be maintained electronically; however, the evaluation of eligibility and verifications must documented in the VaCMS case record. If the enrollee reports having no income ($0 income), follow the procedures in M1520.200 B.1.b).

If a paper or electronic renewal application is submitted by the enrollee, the renewal should be processed even if the scheduled renewal date is in the future. If the case is in a current certification period, the renewal should be evaluated for possible changes.

Telephonic renewals may be taken only by the Cover Virginia Call Center. Telephonic renewals cannot be taken directly by the local agency because a telephonic signature is required.

C. Disposition of Renewal

The enrollee must be informed in writing of the findings of the renewal and the action taken using the Notice of Action when continued eligibility exists. Advance written notice must be used when there is a reduction of benefits or termination of eligibility (see M1520.300).

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1. Renewal Completed

Notify the enrollee in writing of the findings of the renewal and the action taken. When eligibility continues, use the Notice of Action, and include the month and year of the next scheduled renewal. When the individual is no longer eligible, use the Advance Notice of Proposed Action and include spenddown information, if applicable. When there is a reduction of benefits, use the Advance Notice of Proposed Action and include the month and year of the next scheduled renewal.

2. Renewal Not Completed

If information necessary to redetermine eligibility is not available through online information systems that are available to the agency and the enrollee has been asked but has failed to provide the information, the renewal must be denied and the coverage cancelled due to the inability to determine continued eligibility. Action cannot be taken to cancel coverage until after the deadline for the receipt of verifications has passed, except for situations when the deadline falls on a weekend or holiday.

3. Referral to Virginia's Insurance Marketplace (VIM)

Unless the individual has Medicare, a referral to the VIM—also known as the State Based Exchange (SBE)--must be made when an individual's coverage is cancelled so that the individual's eligibility for the Advance Premium Tax Credit (APTC) in conjunction with a Qualified Health Plan (QHP) can be determined. If the individual's renewal was not processed in VaCMS, his case must be entered in VaCMS in order for the VIM referral to be made.

4. Renewal Filed During the Three-month Reconsideration Period

If the individual's coverage is cancelled because the individual did not return the renewal form (or complete an online or telephonic renewal) or requested verifications, the Affordable Care Act (ACA) requires a reconsideration period of 90 days be allowed for an individual to file a renewal or submit verifications. For MA purposes, the 90 days is counted as three calendar months. *The reconsideration period begins the month after the case closure date.* The individual must be given the entire reconsideration period to submit the renewal form and any required documentation. When the renewal or verifications are provided within the 90 day reconsideration period, process the renewal as soon as possible but at least within 30 calendar days from receipt.

The reconsideration period applies to renewals for all covered groups.

If the individual files a renewal or returns verifications at any time during the reconsideration period and is determined to be eligible, reinstate the individual's coverage back to the date of cancellation.

For individuals who were enrolled as Qualified Medicare Beneficiaries (QMB) at the time of cancellation, reinstate coverage back to the date of cancellation.

If an individual began receiving Medicare during the reconsideration period and is eligible as QMB, the QMB coverage is effective the month **in which Medicare began**. Evaluate eligibility for the other months of the reconsideration period in other possible covered groups, including Medically Needy.

Send a Notice of Action informing him of the reinstatement, his continued coverage and the next renewal month and year. See M1520, Appendix 1 for the Renewal Process Reference Guide.

If the individual is not eligible, send a Notice of Action indicating the correct reason for the cancellation (e.g. countable income exceeds the limit). Renewal forms filed after the end of the reconsideration period are treated as reapplications.
Accept the form and request any additional information needed to determine the individual's eligibility.

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D. Special Requirements for Certain Covered Groups

1. Pregnant Woman

Do not initiate a renewal of eligibility of a pregnant woman in other covered group during her pregnancy. Eligibility ends effective the last day of the 12th month following the month in which her pregnancy ends.

The renewal for a woman who has been enrolled in post-partum coverage will be due the 12th month following the month in which the pregnancy ended. The partial review "batch process" will attempt to re-evaluate the coverage at the end of the 12 months of postpartum coverage.

If the woman does not meet the definition and/or the income requirements for another full-benefit covered group, determine her eligibility in the limited benefit Plan First covered group using the eligibility requirements in M0320.302 *if she has opted in to be evaluated for Plan First*.

2. Newborn Child Turns Age 1

A renewal must be completed for a child enrolled as a Newborn Child Under Age 1 before Medicaid Enterprise System (MES—formerly the Medicaid Management Information System [MMIS]) cut-off in the last month in which the child meets the Newborn Child Under Age 1 covered group and must include:

- SSN or proof of application
- verification of income
- verification of resources for the MN

child. The ex parte process may be used if appropriate.

3. Child Under Age 19

Children under 19 receive 12 months of continuous eligibility unless

- they reach age 19;
- are no longer Virginia residents;
- the child or child's representative requests eligibility be closed;
- the agency determines that eligibility was incorrectly approved *with the information known to the agency at the time* because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or
- the child is deceased.

4. Child Under Age 19 - Income Exceeds FAMIS Plus Limit

At renewal if an enrolled FAMIS Plus child no longer meets the FAMIS Plus income limits and there is not an LIFC parent on the case, evaluate the child for the FAMIS, using the eligibility requirements in chapter M21. If the child is eligible for FAMIS, send the family an Advance Notice of Proposed Action that Medicaid will be cancelled effective the last day of the month in which the 10-day advance notice expires and the FAMIS coverage will begin the first day of the month following the Medicaid cancellation. Use cancel reason "042" when the child loses eligibility in Medicaid and is reinstated in FAMIS and there is no break in coverage.



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***5*. Child Receiving LTC Services Turns 18**

A child enrolled in the F&C 300% of SSI covered group no longer meets the covered group upon turning 18, unless he meets another F&C definition (e.g. pregnant woman or parent of a dependent child). A referral to Disability Determination Services (DDS) must be made at least 90 calendar days prior to the child's 18th birthday to allow the disability determination to be made prior to the child's 18th birthday.

***6*. FAMIS Plus Child Turns Age 19**

When a FAMIS Plus child turns age 19, redetermine the child's continuing Medicaid eligibility in other covered groups.

If information in the case record indicates that the child is disabled or may be disabled, verify the child's SSI benefits through SVES or SOLQ-I. If the child does not receive SSI, complete a referral to DDS following the procedures in M0310.112. The referral to DDS must be made at least 90 calendar days prior to the child's 19th birthday to allow the disability determination to be made prior to the child's 19th birthday.

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Do not use change transactions to move a child between Medicaid and FAMIS. If the child is not eligible for FAMIS, the worker must provide an opportunity for the child to be evaluated as medically needy (MN) **prior** to sending an advance notice and canceling the child's Medicaid coverage

If the child does not meet the definition for another covered group *and the applicant opted in to be evaluated for Plan First*, determine the child's eligibility in Plan First using the eligibility requirements in M0320.302. If the child is eligible for Plan First, reinstate coverage in Plan First and send the Advance Notice of Proposed Action indicating that *they have* been enrolled in Plan First. On the notice, state that if *the individual* does not wish to remain covered by Plan First, to contact the eligibility worker and request that the coverage be cancelled. Include a Plan First Fact Sheet, available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/References, with the Advance Notice of Proposed Action.

6. IV-E FC & AA Children and AA Children With Special Needs for Medical or Rehabilitative Care

The renewal of Medicaid coverage for Title IV-E foster care or adoption assistance children and non-IV-E adoption assistance children with special needs for medical or rehabilitative care requires only the following information:

- verification of continued IV-E eligibility status or non-IV-E special needs for medical or rehabilitative care status,
- the current address, and
- any changes regarding third-party liability (TPL).

7. Child Under 21 Turns Age 21

When an individual who is enrolled in the Child Under Age 21 covered group turns 21, redetermine his continuing Medicaid eligibility in other covered groups, including Plan First *if the applicant opted in to be evaluated for Plan First*.

This information can be obtained from agency records, *the individual,* the parent, or the Interstate Compact office from another state, when the child's foster care or adoption assistance agreement is held by another state. A renewal form is not required. The information must be documented in the *electronic* case record.

8. Foster Care Child in an Independent Living Arrangement Turns Age 18

A foster care child who is in an Independent Living arrangement with a local department of social services (LDSS) no longer meets the definition of a foster care child when he turns 18. Determine the child's eligibility in the Former Foster Care Children Under Age 26 Years covered group.

9. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)

The BCCPTA Redetermination Form (#032-03-653) is used to redetermine eligibility for the BCCPTA covered group. The form is available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms. The enrollee must provide a statement from *the* medical provider on the renewal form or else a separate written statement verifying continued treatment for breast or cervical cancer. There are no Medicaid financial requirements for the BCCPTA covered group.

10. Hospice Covered Group

At the annual renewal for an individual enrolled in the Hospice covered group (AC 054), the worker must verify the enrollee's continued election and receipt of hospice services, in addition to determining continued Medicaid eligibility.

11. Qualified Individuals

Funding for the QI covered group became permanent in 2015; the QI covered group is subject to the same policies regarding renewals as other ABD covered groups.



12. FAMIS Renewal Period Extension For Declared Disaster Areas

Effective January 1, 2017, if the Governor or the Federal Emergency Management Agency (FEMA) declares Virginia or any area in Virginia to be a disaster area, children enrolled in FAMIS who reside in the declared disaster area may be granted a 90-day extension of the continuous coverage period before their next renewal is due. The next 12-month continuous eligibility period begins the month after the renewal completion date.

The extension of the renewal period applies only to children in a declared disaster area (1) for whom an ex parte renewal cannot be completed and (2) who do not return a renewal form or complete an online or telephonic renewal prior to the renewal due date. The three-month reconsideration period outlined in M1520.200 C.4 also applies to these children if their coverage is cancelled upon not completing a renewal at the end of the 90-day extension period.

E. LTC

Evaluation for continued Medical Assistance for all covered groups must be attempted using the ex parte renewal process, including covered groups with a resource test and individuals receiving LTSS. If a case drops out of the automated ex parte renewal process, a manual ex parte renewal must be attempted and documented in VaCMS *UNLESS the automated process leaves an ex parte attempt date.*

The patient pay must be updated at least every 12 months, even if there is no change in patient pay. Send the provider a DMAS-225 when there has been a change in circumstances resulting in a change in eligibility. If there has been no change in circumstances, do not send a DMAS-225 to the provider.

F. Incarcerated Individuals

Incarcerated individuals who have active Medicaid are subject to annual renewals. Renewals for individuals in Department of Corrections and Department of Juvenile Justice facilities will be handled with assistance through the designated facility staff liaison.

- For individuals incarcerated in DOC facilities, send the renewal form and related correspondence to the DOC Health Services Reimbursement Unit, 6900 Atmore Drive, Richmond, Virginia 23225.
- For individuals in DJJ facilities, send the renewal form and related correspondence to the DJJ Re-entry Services Unit, 600 E. Main Street, Richmond VA 23219.

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Although benefits administered by the Social Security Administration are suspended while an individual is incarcerated, a disabled individual continues to meet the definition of a disabled individual while incarcerated.

M1520.300 MA CANCELLATION OR SERVICES REDUCTION

A. Policy

At the time of any action affecting an individual's MA coverage, federal regulations in 42 CFR 431.206 through 431.214 require the agency to inform every applicant or enrollee in writing

- of *the* right to a hearing;
- of the method by which a hearing *may be obtained*; and
- that *individuals* may represent *themselves* or use legal counsel, a relative, a friend or other spokesperson.

All notices and other correspondence *must be sent* to the authorized representative if one has been designated.

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B. Procedures

1. Change Results in Adverse Action

Following a determination that eligibility no longer exists or that the enrollee's Medicaid services must be reduced, the Advance Notice of Proposed Action, available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, or system-generated advance notice must be sent to the enrollee at least 10 days plus one day for mail, before action is taken to cancel or reduce Medicaid coverage.

If the action to cancel or reduce benefits cannot be taken in the current month due to MES cut-off, then the action must be taken by MES cut-off in the following month. The Advance Notice of Proposed Action must inform the enrollee of the last day of Medicaid coverage.

Unless the individual has Medicare, a referral to *Virginia's Insurance Marketplace* must be made when coverage is cancelled. The notice must state that the individual has been referred to *VIM* for determination of eligibility for the APTC.

2. Enrollee Appeals Action

If the enrollee requests an appeal hearing before the effective date of the action, subject to approval by the DMAS Appeals Division, the enrollee may choose to have eligibility continued at the current level of services until a decision is reached after a hearing. The DMAS Appeals Division will notify the local agency that the enrollee's coverage must be reinstated during the appeal process. **Do not reinstate coverage until directed to do so by the Department of Medical Assistance Services (DMAS) Appeals Division.**

If the decision is adverse to the recipient, the amount Medicaid paid on the services being appealed that were received by the recipient during the continuation is subject to recovery by DMAS.

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

When notification is received from DMAS that the agency's proposed adverse action was sustained, the recipient's eligibility must be terminated effective the date of the receipt of that letter. No further advance notice to the recipient is necessary since he/she is also informed of DMAS' decision.

3. Death of Enrollee

The eligibility worker must take the following action when it is determined that an enrollee is deceased:

The Social Security Administration will verify that an individual is dead, but not the date of death. A match with Social Security Administration data occurs when the individual's information is sent through the Hub in VaCMS.

Accept the date of death reported to the agency from a family representative or medical provider as accurate. If there is conflicting information regarding the date of death, contact the parent/caretaker relative or authorized representative to obtain the date of death. Information from a medical professional/facility is also acceptable. *If the worker is unable to determine the actual date of death, use the date that a HUB inquiry verifies that the member is deceased.*

The worker must document the VaCMS case record. Send adequate notice of cancellation to the estate of the enrollee at the enrollee's last known address and to any authorized representative(s) using the Notice of Action on Medicaid.

Cancel the enrollee's coverage, using the date of death *(or the date of the HUB inquiry)* as the effective date of cancellation.

4. Enrollee Enters an IMD

When an enrollee enters an institution for the treatment of mental diseases (IMD), **do not** cancel coverage. DMAS will coordinate with the Centers for Medicare and Medicaid Services (CMS) to ensure that no unauthorized FFP occurs.

5. Enrollee Becomes Incarcerated

If an enrollee becomes incarcerated, a partial review must be completed to determine if he continues to meet the requirements for coverage in a full-benefit CN covered group. If he continues to be eligible, cancel the existing coverage and reinstate in AC 109 for ongoing coverage the date of incarceration. If the individual no longer meets the requirements for a full benefit CN covered group, cancel the coverage, effective the day prior to entering incarceration. See M0140.000.

6. End of Spenddown Period

When eligibility terminates at the end of a six-month spenddown period, advance notice is not required. The individual is notified of the limited period of spenddown eligibility on the Notice of Action sent at the time the spenddown application is approved. Explanation of this limitation and information relative to re-application is provided at the time of the spenddown eligibility determination and enrollment.

7. Reason "012" Cancellations

DMAS staff *do not perform* cancellations due to returned mail. Cancellations for other reasons (such as aging out of the current aid category) are reported in the monthly System Cancellation Report (RS-O-112) available in the Data Warehouse Medicaid Management Reports. The report is issued between the 21st and 25th day of each month and *should* be monitored *by the LDSS worker for appropriate follow up.*

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8. **Enrollee Requests Cancellation**

An enrollee may request cancellation of his and/or his children's medical assistance coverage at any time. The request can be verbal or written. Documentation of a written withdrawal request must be placed in the case record. A verbal request for withdrawal can be accepted only from the enrollee or case head, or his authorized representative. A verbal request must be documented in the case record with the date and time the withdrawal request was received, the name of the person who made the withdrawal request, and the name of the agency staff person who took the call.

When the enrollee requests cancellation of Medicaid, the local department must send adequate notice using the Notice of Action to the enrollee no later than the effective date of cancellation.

On the notice:

- check the "other" block and list the reason as "Medicaid coverage cancelled at the enrollee's request,"
- include the effective date of cancellation and instruct the enrollee to discontinue using the card after that date, and
- instruct the enrollee to retain the Medicaid card for future use in case coverage is reinstated within the next 12 months (the system will generate a new card after 12 months).

M1520.400 EXTENSIONS OF MEDICAID COVERAGE

A. Policy

Medicaid families may be eligible for an extended period of Medicaid coverage when the family meets all the requirements for the Low Income Families with Children (LIFC) covered group except income.

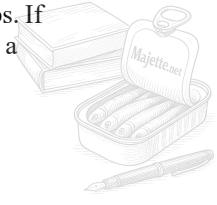
LIFC families who received Medicaid in three of the last six months and who became ineligible for Medicaid due to increased income from spousal support may be eligible for a four-month extension.

LIFC families who received Medicaid in three of the last six months and who became ineligible for Medicaid due to an increase in earnings may be eligible for a twelve-month extension. Earnings could increase because of a new job, a raise in the rate of pay or more hours are being worked.

Prior to evaluating the case for the Medicaid extensions, review the household's eligibility in the MAGI covered groups. If eligible, update the renewal date. If anyone in the household is ineligible in a MAGI group, evaluate eligibility for the Medicaid extensions.

MAGI methodology for the formation of households does not apply to individuals in Extended Medicaid. The family unit policies in M0520 apply to Extended Medicaid.

If ineligible *in a MAGI group or* the Medicaid extensions, individuals must be must be evaluated for eligibility *in any other applicable* covered groups. If a child under 18 is ineligible, the child must be given an opportunity for a



medically needy determination prior to the worker taking action to cancel the Medicaid coverage. Unless the child has Medicare, a referral to the *Marketplace* must be made *if the coverage is closed*.

B. Procedure

The policy and procedures for the four-month extension are in section M1520.401 below.

The policy and procedures for the twelve-month extension are in section M1520.402 below.

M1520.401 FOUR-MONTH EXTENSION

A. Policy

An LIFC Medicaid family is entitled to four additional months of Medicaid coverage after the family loses Medicaid LIFC eligibility when the following conditions are met:

- The parent or caretaker-relative received Medicaid as LIFC in at least three of the six months immediately preceding the month in which they became ineligible for LIFC;
- The parent or caretaker-relative lost eligibility solely or partly due to receipt of or increased **countable** spousal support income; and
- All other Medicaid eligibility factors except income are met.

Effective January 1, 2019, alimony or spousal support is not countable as income. Alimony received prior to January 1, 2019 is countable.

An individual whose divorce decree was finalized prior to January 1, 2019, has the option with the IRS to adopt the new rule by modifying the divorce agreement. A copy of the modified divorce agreement must be provided to the eligibility worker; otherwise, the alimony or spousal support continues to be countable.

B. Procedures

1. Received in Error

For purposes of this subsection, "received Medicaid as LIFC" does not include received Medicaid erroneously. Therefore, a family who received Medicaid erroneously during three or more of the six months before the month of ineligibility does **not** qualify for the Medicaid extension and must be evaluated for eligibility in other covered groups.

2. New Family Member

A new member of the family, other than a newborn, is eligible for Medicaid under this provision if he/she was a member of the family in the month the unit became ineligible for LIFC Medicaid. A newborn born to an eligible member of the family at any time during the 4-month extension is eligible under this provision because the baby meets the CN newborn child under age 1 covered group.

3. Moves Out of State

Eligibility does not continue for any member of the family who moves to another state.

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4. Coverage Period and AC

Medicaid coverage will continue for a period of four months beginning with the month in which the family became ineligible for LIFC Medicaid because of the receipt of or increase in spousal support. The AC for the enrollees in the family receiving the four-month extension is "081" for an LIFC family with one parent or caretaker-relative or "083" for a two-parent family.

5. Case Handling

Prior to the end of the fourth month of the extension, evaluate the individuals in the family for continuing Medicaid eligibility. Cancel coverage for any individuals in the family who are no longer eligible and send advance notice of the cancellation. Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made so that the individual's eligibility for the APTC in conjunction with a QHP can be determined.

M1520.402 TWELVE-MONTHS EXTENSION

A. Policy

An LIFC Medicaid family is entitled to six additional months, with possible extension to twelve months, of Medicaid coverage after they lose Medicaid LIFC eligibility when the following conditions are met:

- The parent or caretaker-relative received Medicaid as LIFC in at least three of the six months immediately preceding the month in which they became ineligible for LIFC;
- The parent or caretaker-relative lost eligibility solely or partly due to receipt of or increased income from earnings; and
- All other Medicaid eligibility factors except income are met.

The family consists of those individuals included in *the **non-MAGI F&C* **family unit** as defined in M0520.100 at the time that the LIFC Medicaid eligibility terminated. It *includes non-married parents with a child in common. Because non-married parents have different MAGI LIFC households, it is possible that one parent will remain eligible in the LIFC covered group even through the other is no longer eligible as LIFC and must be evaluated for Extended Medicaid. The LIFC parent's income is counted in the Extended Medicaid family unit per M0520.100.*

The family unit also includes individuals born, adopted into, or returning to the family after extended benefits begin who would have been considered a member of the family at the time the LIFC Medicaid eligibility terminated.

The earned income received by a member of the family unit added after the loss of LIFC eligibility must be counted in determining the family's gross income.

B. Eligibility Conditions

The following conditions must be met:

1. Received LIFC Medicaid in Three of Six Months

The family received LIFC Medicaid in at least three of the six months immediately before the month in which the *change occurred making the* family ineligible for LIFC. A family who received Medicaid erroneously during three or more of the six months before the month of ineligibility does **not** qualify for the Medicaid extension. Months during which the family received Extended Medicaid are not considered months in which the family received LIFC Medicaid, and the family must be evaluated for eligibility in other covered groups.

2. Cancel Reason

LIFC Medicaid was canceled solely because of:

- the parent's or caretaker/relative's new employment,
- the parent's or caretaker/relative's increased hours of employment, or

the parent's or caretaker/relative's increased wages of employment.

3. Has A Child Living in Home

There continues to be at least one child under age 18 or if in school, a child who is expected to graduate before or in the month he turns 19, living in the home with the parent or caretaker/relative.

4. No Fraud

The family has not been determined to be ineligible for LIFC Medicaid at any time during the last six months in which the family received LIFC Medicaid because of fraud.

C. Entitlement & Enrollment

The AC for enrollees in the family receiving the twelve-month extension is "081" for an LIFC family with one parent or caretaker-relative or "083" for a two-parent family. Entitlement does not continue for any member of the family who moves to another state.

If a parent becomes eligible for extended Medicaid, the child(ren) remains in the current Aid Category until the end of the previous 12 month continuous eligibility period. Then, if no longer eligible, they are moved into extended Medicaid for the remainder of the extended period. Children under 19 remain eligible for 12 months unless a child reaches age 19; is no longer a Virginia resident; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.

1. Determining Extension Period

a. Establishing Initial Month of Eligibility
Medicaid coverage will continue for six months beginning with the first month following the month in which the *change occurred making the* family no longer eligible for LIFC Medicaid because of excess income due to the increased earnings of the parent or caretaker/relative AND the Benefits Worker can give 10 days notice prior to taking action.

b. Extension for an additional six-month period is possible if the reporting and financial requirements below are met.

For example, if the increased earnings were received in April, but were not reported or discovered until a review of eligibility in June, the 12-month extension period begins with July if the Benefits Worker takes action prior to June 20. The screening period to determine if the family received LIFC Medicaid in at least three of the six months immediately preceding the month in which the *change occurred making the* family ineligible for LIFC Medicaid is November through April.



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b. Simultaneous Income Changes

In situations where a case has simultaneous income changes which cause LIFC Medicaid ineligibility, such as new or increased earned income plus an increase in spousal support, the eligibility worker must determine if the case would have been ineligible due to new or increased earnings. This requires that the eligibility worker recalculate the LIFC income eligibility only considering the increased earned income.

1) If the family would have been ineligible solely due to the increase in earned income, it will be considered the reason for LIFC Medicaid ineligibility and the family is eligible for the twelve-month Medicaid extension.

2) If, however, the family would have continued to be eligible for LIFC Medicaid if the only change had been increased earnings, the other changes which occurred simultaneously will be the reason for LIFC Medicaid ineligibility. The family is **not** eligible for the twelve-month Medicaid extension. If the reason for LIFC Medicaid ineligibility was due to the receipt of or increase in spousal support, evaluate the family's eligibility for the four-month extension in M1520.401.

2. Extension Ends

Entitlement to Medicaid under this extension terminates at the end of the first month in which there is no longer a child under 18 (or if in school, a child who is expected to graduate before or in the month he turns 19), living in the home, the family fails to comply with the reporting requirements in 1520.402 D below, or at the end of the extension period.

The individuals must be evaluated for continuing Medicaid eligibility prior to cancellation. Cancel coverage for any individuals in the family who are no longer eligible and send advance notice of the cancellation. Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.

D. Notice and Reporting Requirements

The Virginia Case Management System (VaCMS) generates the appropriate report forms and notices when the worker has approved extended Medicaid in the system. Instructions for managing an extended Medicaid case are contained in the "Extended Medicaid in the VaCMS" Quick Reference Guide (QRG) available in VaCMS.

1. LIFC Medicaid Cancellation Month

When LIFC Medicaid is canceled, the family must be notified of its entitlement to extended Medicaid coverage for six months, and that Medicaid coverage will terminate if the child(ren) in the home turns age 18, or turns age 19 if the child is in school and is expected to graduate before or in the month he turns 19. Use the VaCMS-generated Notice of Extended Medicaid Coverage form.

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a. Notice and Instructions

The family must be instructed to retain verifications of all earnings received during each month of the extension and attach verifications of the first three-month period's earnings to the agency by the 21st day of the fourth month in the extension period. The instructions are on the Notice of Extended Medicaid Coverage and on the second page of the notice, which is the Medicaid Extension Earnings Report.

2. Third Month of Extension

In the third month of extension, the unit must be notified again that it must return the Medicaid Extension Earnings Report, with the earnings verifications attached, to the agency by the 21st of the following month (the fourth month).

This notice will be generated by VaCMS if the correct Follow-up Code and effective date of the 12-month extension are entered.

The notice will state that if the earnings report and verifications are not received by the 21st day of the fourth month, Medicaid coverage will be canceled effective the last day of the sixth month, and that the family will not be eligible for any additional Medicaid extension.

3. Fourth Month of Extension

***a.* Report Received Timely**

If the first three-month period's report is received by the 21st day of the fourth month, and the family continues to include a child, entitlement to Extended Medicaid continues. The worker must update VaCMS when the report is received in order for Extended Medicaid to continue. No action is taken on the first three-month period's earnings.

*VaCMS will cancel coverage at **cut-off** of the sixth extension month. If the worker receives the report prior to cutoff and the family continues to include a child, reinstate the Extended coverage. If the report is not received,* the agency must reopen coverage for any individuals who remain eligible in another Medicaid covered group or in FAMIS and must notify the individual of the reopened coverage.

b. Notice Requirements

VaCMS will generate the advance notice and cancel coverage at the end of the sixth month if the initial Follow-up Code and Date were entered correctly, and the code is **not** updated because the report was not received on time. If the code was not entered correctly, the agency must manually send the Advance Notice of Proposed Action and must cancel the ineligible individual's coverage after the Medicaid cut-off date in the fifth month. The effective date of cancellation will be the last day of the sixth month in the extension period.

c. Report Not Received Timely

If the first three-month period's report is not received by the 21st day of the fourth month, the family is not eligible for the additional six-month extension. Medicaid must be canceled effective the last day of the sixth month in the extension period for any individuals who are not eligible for coverage in another Medicaid covered group or for FAMIS. Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.

4. Sixth Month of Extension

In the sixth month of extension, the family must be notified that it must return the "Medicaid Extension Earnings Report" for the previous three-month period (the fourth through the sixth month), with the earnings verifications for those three months attached, to the agency by the 21st day of the seventh month of extension.

The notice must state that if this three-month period's report and verifications are not returned by the 21st day of the seventh month, Medicaid coverage will be canceled effective the last day of the eighth month of extension.

VaCMS will generate this notice if the Follow-up Code in the base case information is correct. If it is not correct, the agency must manually send this notice.

5. Seventh Month of Extension

a. Report Received Timely

If the second three-month period's report is received by the 21st of the seventh month, update VaCMS immediately upon receipt of the report and verifications. The family will continue to be eligible for extended Medicaid coverage unless:

1) no child under age 18, or if in school, a child who is expected to graduate before or in the month he turns 19, lives with the family;

2) the parent or caretaker/relative had no earnings in one or more of the previous three months, unless the lack of earnings was due to:
   - the parent's or caretaker/relative's involuntary lay-off,
   - the business closed,
   - the parent's or caretaker/relative's illness or injury,
   - other good cause (such as serious illness of child in the home which required the parent's or caretaker/relative's absence from work);

3) the family's average gross monthly **earned** income (earned income only; unearned income is not counted) less costs for child care that was necessary for the employment of the caretaker/relative, during the preceding three-month period exceeds the 185% Federal Poverty Level (FPL) appropriate to the family unit size. See M1520, Appendix 2, for the 185% FPL income limits.

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b. Calculate Family's Gross Earned Income

1) The family's gross earned income means the earned income of all family members who worked in the preceding three-month period. "Gross" earned income is total earned income before any deductions or disregards and profit from self-employment. All earned income must be counted, including students' earned income, Workforce Investment Act (WIA) earned income, children's earned income, etc. No exclusions or disregards are allowed. Use policy in M0720.200 for determining profit from self-employment.

2) child care costs that are "necessary for the caretaker/relative's employment" are expenses that are the responsibility of the caretaker/relative for child care that if not provided would prevent the caretaker/relative from being employed.

2) To calculate average gross monthly income:

- add each month's cost of child care necessary for the caretaker/relative's employment; the result is the three-month period's cost of child care necessary for the caretaker/relative's employment.
- add the family unit's total gross earned income received in each of the 3 months; the result is the family's total gross earned income.
- subtract the three-month period's cost of child care necessary for the caretaker/relative's employment from the family's total gross earned income.
- divide the remainder by 3; the result is the average monthly earned income.
- compare the average monthly earned income to the monthly 185% FPL for the appropriate number of family unit members (see M1520, Appendix 2).

c. Family No Longer Entitled To Extended Medicaid

If the family is not entitled to further Medicaid coverage because of one of the reasons in item M1520.402 D.5.a above, each individual's eligibility for Medicaid in another covered group or for FAMIS must be determined before canceling coverage. Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.

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d. Family Remains Entitled To Extended Medicaid

If the family remains eligible for Extended Medicaid, no action is required until the ninth month of extension, except to be sure that the extended Medicaid information in VaCMS is up to date.

e. **Report Not Received Timely**

If the second three-month period's report and verifications are not received by the 21st day of the seventh month, the family's Medicaid coverage must be canceled for individuals who are not eligible for Medicaid in another covered group or for FAMIS unless the family establishes good cause for failure to report on a timely basis. Examples of good cause for failure to report timely are:

- illness or injury of family member(s) who is capable of obtaining and sending the material;
- agency failure to send the report notice to the family in the proper month of the extension.

Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.

VaCMS will generate the advance notice and cancel coverage if the report is not received on time and the code is not changed. Cancellation is effective the last of the eighth month of extension.

If an individual's continuing eligibility is not reviewed by the **cut-off date** of the eighth extension month and coverage is cancelled, the agency must then reopen coverage and notify the recipient if he is subsequently found eligible. If an individual remains eligible, change the individual's enrollment to the appropriate aid category before the **cut-off date** of the eighth extension month.

6. Ninth Month of Extension

In the ninth month of extension, the family must be notified that it must return the "Medicaid Extension Earnings Report" with earnings verifications attached, for the previous three-month period (seventh through ninth month) to the agency by the 21st day of the tenth month of the extension.

The notice must state that if the report and verifications are not returned by 21st day of the tenth month, Medicaid coverage will be canceled effective the last day of the eleventh month of extension.

VaCMS will generate this notice if the correct Follow-up Code is in the base case information.

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7. Tenth Month of Extension

a. Report Received Timely

If the third three-month period's report is received by the 21st of the tenth month, update VaCMS immediately upon receipt of the report and verifications. The family continues to be eligible for Medicaid unless one of the items in M1520.402 D.5 above applies. Calculate the family's income using the procedures in M1520.402 D.5 above.

b. Family No Longer Entitled To Extended Medicaid

If the family is not entitled to **extended** Medicaid coverage, review each individual's eligibility for Medicaid in another category or for FAMIS. If the individual is not eligible, cancel Medicaid after sending the **Advance Notice of Proposed Action**. Cancellation is effective the last day of the eleventh month of extension. Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.

c. Family Remains Entitled To Extended Medicaid

If the family remains entitled to Extended Medicaid coverage, a redetermination of the family's Medicaid eligibility must be completed by the Medicaid cut-off in the twelfth month.

d. Report Not Received Timely

If the third three-month period's report and verifications are not received by the 21st of the tenth month, Medicaid coverage must be canceled for individuals who are not eligible for Medicaid in another covered group or for FAMIS unless the family establishes good cause for failure to report timely (see M1520.402 D.5 above for good cause). Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.

VaCMS will cancel coverage and generate the advance notice if the report is not received on time and the Follow-up Code is not changed. Cancellation is effective the last day of the eleventh month of extension.

8. Twelfth Month of Extension

Before Medicaid cut-off in the twelfth month, complete the family's redetermination. VaCMS will cancel coverage and generate the advance notice after cut-off of the twelfth month, if the Follow-up Code was updated correctly. Therefore, for any of the family members that remain eligible for Medicaid or FAMIS, the AC and the Follow-up Code must be changed before cut-off of the twelfth month.

Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.



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Manual Title	Chapter	Page Revision Date
Virginia Medical Assistance Eligibility	**M15**	**April 2023**
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M1520 MEDICAL ASSISTANCE ELIGIBILITY REVIEW	**M1520.500**	**24a**

M1520.500 CASE TRANSFERS

A. Introduction

Applications and ongoing cases are transferred only when the individual retains residence in Virginia.

B. Nursing Facility and Assisted Living Facility (ALF)

When an individual is admitted to a nursing facility or an ALF from a community living arrangement, the case is not transferred, but remains with the Virginia locality in which the individual last lived outside of an institution. Community living arrangements do not include medical facilities, ALFs or group homes with four or more beds.

When an applicant/recipient is discharged from a nursing facility or ALF to a community living arrangement not in the Virginia locality that had responsibility for the individual's case while he was in the nursing facility or ALF, the case is transferred to the new locality.

If the local agencies involved agree the case should remain with the original agency, then the case would not be transferred.

C. Auxiliary Grant (AG)

See M0320.102 regarding a recipient receiving an Auxiliary Grant (AG) and eligible for Medicaid. The approved member's case should be retained by the agency (locality) which is issuing the grant. Eligibility workers should refer to processing guidelines provided by VDSS and DARS.

Exception: If the individual is receiving AG Supportive Housing (AGSH) payments (clients live in the community and still receive AG payments) the case should transfer to the locality in Virginia based on where the client currently resides (like LTSS CBC cases).

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D. Cases From Outstationed Workers

Medicaid applications taken and Medicaid cases approved by outstationed workers, such as the workers stationed at the University of Virginia (UVA) and Virginia Commonwealth University-Medical College of Virginia (VCU-MCV) hospitals, must be transferred to the LDSS where the applicant/enrollee lives. Medicaid cases and applications are **not** transferred from LDSS **to** outstationed workers.

1. Confirm Receipt

The receiving LDSS must confirm receipt of the case by completing the Case Record Transfer Form and returning the copy to the outstationed worker.

2. Review Eligibility

LDSS workers must review (partial review) the Medicaid eligibility determination in approved cases transferred from an outstationed worker, and must take any necessary corrective action.

3. Corrective Action

If an eligibility error(s) is found, do not send the case back. Correct the error(s), send the notice to the case head if required, and refer the case to the LDSS supervisor for possible contact with the outstationed worker's supervisor.

E. Local Agency to Local Agency

When a Medicaid applicant/enrollee (including a Medicaid CBC waiver services enrollee) moves from one locality to live in a community living arrangement (not a medical facility, an ALF, or group home with 4 or more beds) in another locality within the state of Virginia, the following procedures apply:

1. Sending Locality Responsibilities

a. Medical Assistance Case with No Other Benefit Programs Attached

The sending locality must ensure that the ongoing case is current and complete before transferring the case. If the annual renewal has been completed within the past 10 months, a partial review based on known information, as to whether or not the enrollee will meet a covered group and the income and resource limits in the new locality, must be completed before transferring the case.

If the case is in a current case action in VaCMS, the agency must complete the case action before transferring the case. If the individual applies for other benefits programs in another locality, the sending LDSS has 7 calendar days from the time they receive information indicating the individual has moved to complete the case action and transfer the case to the new locality.

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If the annual renewal is due in the month the LDSS plans to transfer the case, the following month, or is overdue, the renewal must be completed before transferring the case. If the enrollee applies for other benefit programs in another locality, the sending LDSS must transfer the case to the new locality by the end of the next business day after they receive information indicating the enrollee has moved, provided the agency has not started the redetermination case action in VaCMS

If the individual applies for other benefits in the new locality and the case is in the redetermination case action in VaCMS, the sending LDSS has 7 calendar days from the time they receive information indicating the individual has moved to complete the case action and transfer the case to the new locality. The worker will update VaCMS immediately with the new address so the information transfers over to *MES* to assure managed care continuity but will maintain ownership of the case in their FIPS until the renewal is completed.

The sending LDSS must process the renewal if a renewal or application is submitted during the reconsideration period and the enrollee indicates he has moved on the application or renewal form.

If the case is closed and in the reconsideration period, and the individual applies for other benefits programs in another locality, the case will be transferred to the new locality automatically when the new locality associates the application for other benefits with the closed case. The new locality will be responsible for processing the renewal if it is submitting within the reconsideration period.

b. Medical Assistance Case with Other Benefit Programs Attached

The sending locality must ensure that the MA program attached to the ongoing case is current and complete before transferring the case. If the annual renewal has been completed within the past 10 months, a partial review based on known information, as to whether or not the recipient will meet a covered group and the income and resource limits in the new locality, must be completed before transferring the case. If the case is in a current case action the agency must complete the case action before transferring the case.

If the annual MA renewal is due in the month the LDSS plans to transfer the case, the following month, or is overdue, the renewal must be completed before transferring the case. If the individual submits his interim or renewal for other benefit programs in another locality, the sending LDSS must transfer the case to the new locality by the end of the next business day after they receive information indicating the individual has moved, provided the agency has not started the redetermination case action in VaCMS.

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If the individual submits his renewal for other benefits in the new locality and the case is in the redetermination case action, the sending LDSS has 7 calendar days from the time they receive information indicating the individual has moved to complete the case action and transfer the case to the new locality. The worker will update VaCMS immediately with the new address so the information transfers over to *MES* to assure managed care continuity but will maintain ownership of the case in their FIPS until the renewal is completed.

The sending LDSS must process the renewal if a renewal or application is submitted during the reconsideration period and the individual indicates he has moved on the application or renewal form.

If the MA is closed and in the reconsideration period, and the individual submits a renewal for other benefit programs in another locality, the sending LDSS will transfer the case to the new locality and the new locality will be responsible for processing the renewal if it is submitted within the reconsideration period.

c. Transfer Pending Medical Assistance Applications

Pending applications or cases in Intake/Screening in VaCMS must be transferred to the new locality for an eligibility determination.

d. Foster Care & Adoption Assistance

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

e. Sending Transferred Cases

If the renewal or the partial review indicates that the enrollee(s) will continue to be eligible for Medical Assistance in the new locality, the sending locality must update the enrollment system. Transfer the electronic case, and if applicable, send the additional case record materials to the enrollee's locality of residence with a completed Case Record Transfer Form.

Required Document Management Imaging System (DMIS) items must be uploaded to VaCMS before case transfer. Document within VaCMS to indicate if there are documents uploaded to DMIS and/or additional case record materials outside of VaCMS. If additional case record materials exist, the materials and a completed Case Record Transfer Form must be sent by certified mail, delivered personally and a receipt obtained or, at the agency's discretion, the case may be sent via the courier pouch.

If the annual renewal or the partial review finds that eligibility no longer exists for one or all enrollees in the case, the agency must take the necessary action, including advance notice to the individuals, to cancel the ineligible individuals' coverage.



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2. Receiving Locality Responsibilities

a. Confirm Receipt

The receiving agency must confirm receipt of the additional case record materials by completing the Case Record Transfer Form and returning the copy to the sending agency. If VaCMS indicates no additional case record materials, no follow up action is required.

b. Process Pending Applications

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

c. Review Eligibility

LDSS workers must review (partial review) the Medicaid eligibility determination for cases transferred from other LDSS and must take any necessary corrective action.

d. Corrective Action

If an eligibility error(s) is found or the case is overdue for renewal, do not send the case back. Correct the error(s), and/or complete the renewal, send the notice to the case head if required, and refer the case to the LDSS supervisor for possible contact with the sending agency's supervisor.

3. Decision Pathway for Case Transfers

When an enrollee reports a change of address, use the steps below as guidance. ***If a case is held before transfer to complete an action, immediately update the address to ensure managed care continuity.***

a. Enrollee Reports Change of Address

Step 1:
Is the case current and complete? This means the case is not in any case action and the renewal has been completed within the last 10 months.
-If Yes, go to Step 2.
-If No, go to Step 4.

Step 2:
Has the person applied for other programs?
-If yes, the worker has 7 calendar days to complete a partial review and transfer the case.
-If no, go to Step 3.

Step 3:
Has the person submitted an interim or renewal for other programs?
-If yes, the worker has by the end of the next business day to transfer the case.
-If no, the worker has 30 days to transfer the case per change policy.

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Step 4:
What is incomplete?
-If the case is in a case action, go to Step 5.
-If the case is coming due, due or overdue for a renewal, go to Step 6.

Step 5:
Has the person applied for other programs?
-If yes, the worker has 7 calendar days to complete the action, a partial review, and transfer the case.
-If no, the worker has 30 days to transfer the case per change policy.

Step 6:
Has the person submitted an application, interim or renewal for other programs?
-If yes, go to step 7.
-If no, the worker must complete the renewal before transferring the case.

Step 7:
Is the case in redetermination action?
-If yes, the worker has 7 calendar days to complete the action, a partial review, and transfer the case.
-If no, the worker has by the end of the next business day to complete the action and transfer the case.

b. Enrollee Submits Renewal During Reconsideration Period That Includes a Change of Address:

Step 1:
Are there other benefit programs other than MA active on the case?
-If yes, go to Step 2.
-If no, go to Step 4.

Step 2:
Has the person submitted an interim or renewal for other programs?
-If yes, go to Step 3.
-If no, the worker must complete the renewal before transferring the case.

Step 3:
Is the case in any action?
-If yes, the worker has 7 calendar days to complete the action, a partial review, and transfer the case.
-If no, the worker has by the end of the next business day to complete the action and transfer the case.



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M1520 MEDICAL ASSISTANCE ELIGIBILITY REVIEW	**M1520.500**	**30**

Step 4:
Has the person submitted an application for other programs?
-If yes, the worker has 7 calendar days to complete a partial review and transfer the case.
-If no, the worker must complete the renewal before transferring the case.

F. Spenddown Cases

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

1. Sending Locality Responsibilities

Within 10 working days of notification that the applicant has moved, the case must be transferred to the new locality, following the policies in M1520.500 E.1.e. The sending agency must:

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

2. Receiving Locality Responsibilities

The receiving locality must review the case following the policies in M1520.500 E.2.

G. Receiving LDSS Case Management Procedure

To identify and manage transferred Medicaid cases, use the report titled "Caseworker Alpha Case/Enrollee Listing." This report is posted in the Data Warehouse Medicaid Management Reports. It is updated on or about the 22nd of each month. The LDSS can also use the Case Assignment function in VaCMS to view current caseloads.

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Renewal Process Reference Guide

Renewal Due	Renewal Grace Period	Renewal Completed & Individual Remains Eligible	Next Renewal Period	Next Renewal Due
November 2013 (overdue renewal)	N/A	May 2014	June 2014-May 2015	May 2015
May 2014	N/A	May 9th (before cutoff)	June 2014-May 2015	May 2015
May 2014	N/A	May 19th (after cutoff)	June 2014-May 2015	May 2015
June 2014	N/A	In May (any day)	July 2014-June 2015	June 2015
July 2014	N/A	In May (any day)	August 2014-July 2015	July 2015
April 2014 Client does not return renewal form and coverage is cancelled effective April 30, 2014.	May, June, July Renewal form returned in May 2014	In May (any day) Coverage is reinstated back to May 1	May 2014-April 2015	April 2015
April 2014 Client does not return renewal form and coverage is cancelled effective April 30, 2014.	May, June, July Renewal form returned in June 2014	In June (any day) Coverage is reinstated back to May 1.	July 2014-June 2015 (May is treated as retro month)	June 2015
April 2014 Client does not return renewal form and coverage is cancelled effective April 30, 2014.	May, June, July Renewal form returned in July 2014	July (any day) Coverage is reinstated back to May 1.	August 2014-July 2015 (May and June treated as retro months)	July 2015
April 2014 Client does not return renewal form and coverage is cancelled effective April 30, 2014.	May, June, July Renewal form returned in August 2014	Treat as new application since grace period expired (a new application form is not required). Application date is date of receipt, retroactive period is May-July.	August 2014-July 2015	July 2015

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TWELVE MONTH EXTENDED MEDICAID INCOME LIMITS 185% of FEDERAL POVERTY LIMITS EFFECTIVE 1-*17-24* ALL LOCALITIES	
# of Persons in Family Unit/Budget Unit	**185% FPL Monthly Limit**
1	*$2,322*
2	*$3,152*
3	*$3,981*
4	*$4,810*
5	*$5,640*
6	*$6,469*
7	*$7,299*
8	*$8,128*
Each additional person add	*$830*

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CHAPTER M15
ENTITLEMENT POLICY & PROCEDURES
SUBCHAPTER 50
DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES (DBHDS) FACILITIES

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M1550 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-23	4/1/22	Page 1
TN #DMAS-20	7/1/21	Appendix 1
TN #DMAS-19	4/1/21	Pages 1, 2
TN #DMAS-17	7/1/20	Table of contents Pages 1, 2 Appendix 1, page 1 Pages 3-9 and Appendix 1, page 2 were deleted.
TN #DMAS-16	4/1/20	Page 2 Appendix 1, page 1
TN #DMAS-14	10/1/19	Appendix 1, page 1 Appendix 1, page 2 was added.
TN #DMAS-8	4/1/18	Page 3
TN #DMAS-7	1/1/18	Page 1 Appendix 1, page 1
TN #DMAS-4	4/1/17	Appendix 1,page 1
TN #DMAS-3	1/1/17	Pages 4-6, 8, 9
TN #100	5/1/15	Appendix 1,page 1
UP #9	4/1/13	Appendix 1, page 1
Update (UP) #7	7/1/12	Appendix 1, page 1
TN #96	10/1/11	Appendix 1, page 1
TN #93	1/1/10	Title page Table of Contents Pages 1-9 Appendix 1, page 1
TN #91	5/15/09	Appendix 1

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M1550.000 DBHDS FACILITIES

M1550.100 GENERAL PRINCIPLES

A. Introduction

This subchapter contains a list and a brief description of the DBHDS facilities (M1550.200).

Prior to July 1, 2020, the Virginia Department of Social Services (VDSS) had eligibility workers, called Medicaid Technicians, located in Department of Behavioral Health and Developmental Services (DBHDS) facilities to determine the patients' eligibility for Medicaid. On July 1, 2020, VDSS suspended operations of the Medicaid Technicians.

Effective July 1, 2020, local DSS will process applications submitted by patients of DBHDS facilities and maintain cases for enrolled individuals who reside in DBHDS facilities.

M1550.200 DBHDS FACILITIES

A. Introduction

Three types of medical facilities are administered by DBHDS: training centers, psychiatric hospitals, and a general hospital with nursing facility beds. Below is a brief description of each type of facility.

1. *South-eastern Virginia* Training Center

Southeastern Virginia Training Center in Chesapeake is an institution and medical center for individuals diagnosed with an intellectual or developmental disability. Some patients may be employed and have earned income. Patients of any age may be Medicaid eligible if they meet all nonfinancial and financial Medicaid eligibility requirements.

2. Psychiatric Hospitals

Psychiatric hospitals are medical facilities – institutions for the treatment of mental diseases (IMDs) – which provide care and services to mentally ill patients. There are two types of psychiatric hospitals: intensive psychiatric and psychiatric/chronically mentally ill. These hospitals may have patients of any age, although two of them are dedicated to geriatric patients and one serves only adolescents.

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Federal regulations in 42 CFR 435.1008 prohibit federal financial participation (FFP) in most Medicaid services provided to patients residing in a psychiatric hospital unless they are:

- under age 21 years (if treatment began before age 21 and continues, they may be eligible up to age 22), or
- age 65 years or older,

and they meet all non-financial and financial Medicaid eligibility requirements.

An individual who is age 22 or over, but under age 65 and who is enrolled in a Medicaid at the time of admission to an IMD may remain enrolled in Medicaid. Do not cancel coverage. The Department of Medical Assistance Services (DMAS) will coordinate with the Centers for Medicare and Medicaid Services (CMS) to ensure that no unauthorized FFP occurs.

The following are psychiatric hospitals, offering differing levels of care:

Eastern State Hospital – Williamsburg
Central State Hospital – Petersburg

c. Western State Hospital – Staunton
d. Northern Virginia Mental Health Institute – Falls Church
e. Southern Virginia Mental Health Institute – Danville
f. Southwestern Virginia Mental Health Institute – Marion
g. Piedmont Geriatric Hospital – Burkeville
h. Catawba Hospital – Catawba
i. Commonwealth Center for Children and Adolescents (CCCA) – Staunton (formerly Dejarnette Center)

   CCCA is a psychiatric hospital for adolescents between the ages of 4 and 18. Children are provided schooling, counseling and medication. Most children have not been determined disabled. A child in CCCA can be Medicaid-eligible if the child meets all nonfinancial and financial Medicaid eligibility requirements.

2. General Hospital

General hospitals are medical facilities which provide care and services to acutely physically ill patients in the DBHDS facilities. The general hospitals may have patients of any age. There are general hospital acute care units within Eastern State and Western State Hospitals, and the Hiram Davis Medical Center general hospital located on the campus of Central State Hospital in Petersburg. Hiram Davis provides medical and surgical treatment for patients from any DBHDS facility. Hiram Davis also has some beds certified for nursing facility level of care.

Patients in the general hospitals may be Medicaid eligible if they meet all non-financial and financial Medicaid eligibility requirements.

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DBHDS FACILITIES
PSYCHIATRIC HOSPITALS

Central State Hospital – Petersburg
Western State Hospital – Staunton
Northern Virginia *State* Mental Health *Hospital* – Falls Church
Southern Virginia Mental Health Institute – Danville
Southwestern Virginia Mental Health Institute – Marion
Piedmont Geriatric Hospital – Burkeville*
Catawba Hospital – Catawba*
Commonwealth Center (for Children and Adolescents) –Staunton
*Eastern State Hospital**

**These facilities admit for Temporary Detention Orders (TDOs); stays are not covered by Medicaid.*

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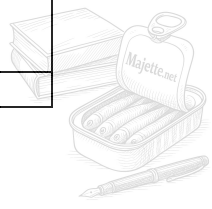
CHAPTER M17

MEDICAID FRAUD AND *NON-FRAUD* RECOVERY

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M17 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-25	10/1/22	Page 4
TN #DMAS-23	4/1/22	Page 4 Page 4a was added.
TN #DMAS-20	7/1/21	Page 7
TN #DMAS-16	4/1/20	Appendix 4, page 1 Appendix 4, page 2 was added
TN #DMAS-15	1/1/20	Page 7 Page 8 was added as a runover page.
TN #DMAS-14	10/1/19	Table of Contents Pages 1, 2, 4, 6, 7 Appendix 1, pages i and ii Appendix 2, pages i and ii Appendix 4 was added.
TN #DMAS-7	1/1/18	Table of Contents, page i Appendix 1, pages i and ii Appendix 2, pages i and ii Appendix 3 was added.
TN #DMAS-6	10/1/17	Table of Contents Pages 4. Appendix 1 was deleted Appendices 2 and 3 were renumbered Appendices 1 and 2, respectively.
TN #DMAS-5	7/1/17	Table of Contents Pages 1, 2, 4 Appendix 2 Appendix 3 was added.
TN #DMAS-4	4/1/17	Pages 4, 5 Pages 6 and 7 are runover pages.
TN #DMAS-2	10/1/16	Table of Contents, page i Pages 1-7 Appendix 2 Page 8 was deleted.
TN #97	9/1/12	Page 3 Appendix 1, page 1
UP #7	7/1/12	Table of Contents Pages 1-8 Appendix 1 Appendices 3 and 4 were removed.
TN #94	9/1/10	Title Page Table of Contents pages 1-7 Appendix 1 Appendix 2
TN #93	1/1/10	Page 3



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M1700 MEDICAID FRAUD AND NON-FRAUD RECOVERY

M1700.100 INTRODUCTION

A. Administering Agency

The Department of Medical Assistance Services (DMAS) investigates and accepts referrals regarding fraudulent and non-fraudulent payments made by the Medicaid Program. DMAS has the authority to recover any payment incorrectly made for services received by a Medicaid recipient or former Medicaid recipient. DMAS will attempt to recover these payments from the recipient or the recipient's income, assets, or estate, unless such property is otherwise exempt from collection efforts by State or Federal law or regulation.

The DMAS Recipient Audit Unit (RAU) is responsible for the investigation of allegations of acts of fraud or abuse committed by recipients of the Medicaid and the Family Access to Medical Insurance Security Plan (FAMIS) programs. The RAU recovers overpayments due to recipient fraud, abuse, and overpaid benefits through voluntary repayments and criminal prosecution of recipient fraud.

The Third Party Liability Unit (TPL) at DMAS is responsible for investigating and recovering funds paid by DMAS from recipients' estates, trust accounts, annuities and/or other health insurance policies. This unit performs investigations to find "third party resources" that result when Medicaid pays medical costs that a third party should have paid. Medicaid is always the payer of last resort.

B. Utilization Review

The DMAS Recipient Monitoring Unit is responsible for reviewing all Medicaid and FAMIS covered services of recipients who utilize services at a frequency or an amount that is not medically necessary in accordance with utilization guidelines established by the state. Only recipients who are excluded, pursuant to 12VAC30-120-370 B, from receiving care from a managed care organization are reviewed and evaluated.

M1700.200 FRAUD

A. Definitions

Fraud is defined as follows:

An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR 455.2)

Abuse is defined as follows:

Beneficiary practices that result in unnecessary cost to the Medicaid program (42 CFR 455.2)

B. DMAS Authority

DMAS has sole authority over cases of suspected Medicaid fraud when eligibility for a public assistance payment is not involved (Medicaid only cases). The local department of social services (LDSS) must refer all Medicaid cases involving suspected fraud to the DMAS Recipient Audit Unit, 600 E. Broad Street, Suite 1300, Richmond, Virginia 23219, using the Notice of Recipient Fraud/Non-Fraud (form #DMAS 751R) available at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*. The following information must be provided when making a referral:

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- confirmation that ongoing eligibility has been reviewed (in relation to the allegation) with evaluation results attached;
- reason(s) for and estimated period of ineligibility for Medicaid;
- the recipient's name and Medicaid enrollee identification number;
- the recipient's Social Security number;
- applicable Medicaid applications or review forms for the referral/ineligibility period;
- address and telephone number of any attorney-in fact, authorized representative, or other individual who assisted in the application process;
- relevant covered group, income, resource, and/or asset transfer documentation for the time period in question;
- any record of communication between the agency and the client or representative, such as case narratives, letters, and notices; and
- information obtained from the agency's fraud investigation, including names and addresses of knowledgeable individuals for testimony and/or interviews.

1. Amount of Loss

There is no fiscal threshold for any case for fraudulent and non-fraudulent erroneous payments made by the Medicaid Program.

In order to determine the amount of the loss of Medicaid funds related to the enrollee's eligibility when LDSS has jurisdiction because of participation in another public assistance program, a Medicaid Claims Request (form #DMAS 750R, available at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*, must be sent to DMAS to obtain the amount of the loss. The local agency should allow a three-week turnaround for the documents. There may be exceptional circumstances when claims can be provided within a shorter time, i.e., expedited trial dates. Once the information is received and the agency determines that it will not make a joint criminal prosecution referral, the LDSS must send DMAS the Notice of Recipient Fraud/Non-Fraud. DMAS will determine if administrative non-fraud recovery is appropriate.

2. Recipient Fraud

a. Medical Assistance Only

The LDSS must refer cases of suspected fraud involving only medical assistance to the RAU for investigation using the DMAS 751R form. The LDSS must provide the RAU with the recipient's identifying information, address, and information regarding the circumstances of the suspected fraud. The LDSS is also responsible for reviewing and taking appropriate action for ongoing eligibility or termination of coverage, as appropriate. The RAU will determine the amount of the misspent funds and pursue recovery and/or legal action as appropriate.

b. Cases in which Medicaid is received with TANF, AG, and other money payment public assistance programs.

The LDSS is responsible for the investigation of suspected fraud involving cases with combined Medicaid and Auxiliary Grant (AG); Medicaid and TANF; and other money payment public assistance programs. The final disposition on all money payment fraud cases shall be communicated to the RAU no later than 5 business days after disposition.

c. Cases in which Medicaid is received with Supplemental Nutrition Assistance Program (SNAP), Energy Assistance, and other non money payment public assistance programs

The LDSS must refer suspected fraud involving Medicaid cases combined with SNAP, Energy Assistance or other non money payment public assistance programs to the RAU using the DMAS 751R form. The local agency shall coordinate cases pending referral for prosecution with the RAU so that Medicaid may take concurrent action.

3. Provider Fraud

Cases of suspected fraud involving enrolled providers of medical services to Medicaid recipients shall be referred to the Medicaid Fraud Control Unit in the Office of the Attorney General, and a copy of the referral correspondence shall be sent to the Provider Review Unit at the Department of Medical Assistance Services.

C. Medicaid Ineligibility Following Fraud Conviction

1. Period of Eligibility

An individual who has been convicted of Medicaid fraud is ineligible for Medicaid for a period of 12 months beginning with the month of fraud conviction. Action to cancel the individual's Medicaid coverage shall be taken in the month of conviction or in the month the agency learns of the conviction, using cancel reason 014 (42 United States Code §1320a-7b.(a)(6)(ii); 12 Virginia Administrative Code 30-10-70).

2. Who is Ineligible

a. TANF or Families and Children (F&C) Cases

Only the parent/caretaker of a TANF/Medicaid or F&C Medicaid case is ineligible for Medicaid when the parent/caretaker has been convicted of Medicaid fraud. The TANF payment made to the caretaker on a child's behalf shall not be affected.

b. Aged, Blind, Disabled (ABD) or Pregnant Women Cases

In an ABD or pregnant woman case, only the individual found guilty of Medicaid fraud will be ineligible. If only one spouse of a married couple is convicted, the eligibility of the innocent spouse is not affected.

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2. Family Unit

If both spouses of an eligible couple are found guilty of fraud, neither is eligible for Medicaid. If only one member of a family unit is convicted of fraud, only that member's Medicaid coverage is canceled. The fraud conviction does not affect the composition of the family unit or the treatment of the family unit's income or resources. The convicted individual is included in the family unit according to Medicaid policy, but is not eligible for Medicaid coverage and is not enrolled.

M1700.300 NON-FRAUD RECOVERY

A. Authority

Any person who, without intent to violate this article, obtains benefits or payments under medical assistance to which he is not entitled shall be liable for any excess benefits or payments received. (COV 32.1-321.2)

B. Recovery of Erroneous Payments

DMAS has the authority to investigate cases and recover expenditures made for services received by ineligible enrollees without fraudulent intent. Examples of when recovery of expenditures is possible include, but are not limited to:

- eligibility errors due to recipient misunderstanding,
- agency errors,
- medical services received during the appeal process, if the agency's cancellation action is upheld.

C. Post-eligibility Investigations

Method-ology

1.

The RAU conducts post eligibility investigations. Medicaid nonfinancial and financial requirements are reviewed and applied in accordance to Medicaid policy. See Chapter M02 for the nonfinancial eligibility requirements, and Chapters M06 and M11 for resource requirements.

RAU investigations are based on projected income consistent with the eligibility polices for counting ongoing income referenced in Chapters M04, M07, and M08. Post-eligibility determinations are made using a point-to-point method in which the income estimation period begins with an event that would have triggered a partial review under *M1520.100*. The end point is the next scheduled renewal that the LDSS actually completed.

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2. ***Non-financial Issues***

Investigations or audits of non-financial attestations by an enrollee (such as residency, pregnancy and household composition), that later become questionable due to the receipt of information that puts their eligibility into question, RAU has the discretion to request verification from the enrollee or obtain a third party statement. The following are some common non-financial circumstances where the RAU may require additional verifications when the recipient eligibility is questionable:

a. Residency

If an enrollee's Virginia residency is questionable, RAU may request or obtain documents such as school records, receipt of social service benefits and medical records as sources of evidence to validate the recipient's Virginia resident or non-resident status. RAU utilizes the PARIS match to identify recipients who have received benefits in other states and Virginia concurrently.

b. Pregnancy

When a recipient's pregnancy is questionable, the RAU may require the recipient to provide verification of pregnancy or the termination of her pregnancy. The RAU may also use medical records, if available, to verify termination of pregnancy.

c. Household composition

If the enrollee's household composition is in question (such as undeclared spouse, parent, or a unreported change of status of a child in the home, the RAU may require a written statement from the enrollee, a third party or other verifying evidence.

D. Uncompensated Asset Transfers

Individuals receiving long-term care services (LTC) who transfer assets and do not receive adequate compensation are subject to the imposition of a penalty period during which Medicaid cannot pay for long-term care services. When an uncompensated

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transfer resulted in a penalty period during which LTC services were received, a referral must be made to the RAU to recover the misspent dollars. RAU staff will contact the recipient or the recipient's authorized representative to pursue recovery.

Section §20-88.02 of the Code of Virginia also allows DMAS to seek recovery from the **transferee** (recipient of the transfer) if the amount of the uncompensated transfer is $25,000 or more and occurred within 30 months of the individual becoming eligible for or receiving Medicaid LTC services. The transferees may be liable to reimburse Medicaid for expenditures up to the amount of funds spent on the enrollee or the amount of the uncompensated transfer, whichever is less.

E. Recovery of Correctly Paid Funds

Within specific restrictions, DMAS may recover funds correctly paid for medical services received by eligible recipients.

1. Deceased Recipient's Estate

Under federal regulations and state law, DMAS may make a claim against a deceased enrollee's estate when the recipient was age 55 or over. The recovery may include any Medicaid payments made on his/her behalf. This claim may be waived if there are surviving dependents. **(42 CFR §433.36; Va. Code §32.1-326.1 and 32.1-327).**

Section 1917(b)(1)(C)(ii) of the Social Security Act was amended by the Deficit Reduction Act of 2005 to exempt assets disregarded under a "qualified" Long-term Care (LTC) Partnership Policy from estate recovery, as defined in clause (iii) of 1917(b)(1)(C). The same amount of assets that was disregarded in the Medicaid eligibility determination for an individual under an LTC Partnership Policy will be protected during estate recovery.

Referrals should be made to DMAS for estate recovery when the deceased recipient is over 55, has no surviving spouse, no children under 21 or a disabled/blind child of any age.

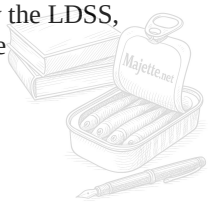
2. Insurance Settlements and Similar Recoveries

Settlements related to personal injuries are a form of third party liability (TPL). When a Medicaid enrollee has received an insurance settlement or similar settlement from a law suit related to a medical condition or injury, DMAS may seek recovery of any amount of medical assistance expended on the enrollee prior to the receipt of the settlement. Generally, the insurance company notifies DMAS of the settlement; however, if an agency discovers that an enrollee received a settlement, the agency shall report it to DMAS. An insurance settlement that is sent directly to a recipient, in his name only, should be reviewed for its impact on the recipient's eligibility.

3. Trusts

Refer trust documents, including irrevocable, discretionary, pooled, and special needs trusts, to DMAS TPL for potential recovery at the time of recipient's (beneficiary's) death. Refer trust documents in all instances in which a Medicaid recipient is a beneficiary of a trust and the trustee refuses to make the assets available for the medical expenses of the recipient. Include a copy of the Medical Assistance Program Consultant's evaluation of the trust with the referral form, if available.

Include in the referral any corrective action that has been or will be taken by the LDSS, as well as the name of the supervisor of the person submitting the form. The supervisor's signature is not required.



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4. Notification to DMAS

Referrals must be made to the Third Party Liability Unit when: a recipient has received funds from a settlement; DSS has received information concerning a recipient being in an accident; DSS has information where a recipient has other third party payers; or the recipient is the beneficiary of a trust. The cases should be referred to DMAS using the Notice to DMAS of Estate Recovery/TPL/Trust Form (DMAS 753R) located at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*, to make referrals to the TPL unit. The form should be completed and sent to:

Department of Medical Assistance Services
Third Party Liability Unit
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

The form may be faxed to 804-786-0729.

M1700.400 RECOVERY RESPONSIBILITIES: LDSS AND DMAS

A. VDSS/LDSS Responsibilities in Loss Prevention Efforts

VDSS Medicaid operates under an interagency agreement with DMAS which lists specific responsibilities of VDSS and, by extension, the LDSS, for active participation in loss prevention efforts. The responsibilities of the LDSS fall under the interagency agreement and are neither optional nor discretionary for the LDSS. VDSS shall supervise the programmatic activities of the LDSS to ensure compliance.

B. LDSS Requirements

LDSS must participate in the identification, tracking, and correction of eligibility errors. LDSS must also determine and review ongoing or current recipient eligibility. **The DMAS RAU does not determine ongoing recipient eligibility, but rather reviews recipient eligibility in relation to allegations of fraud**. LDSS shall:

1. Report Individuals

Report to DMAS RAU every known instance relating to a non-entitled individual's use of Medicaid services, regardless of the reason for non-entitlement such as:

- instances where evidence of fraud may exist;
- errors involving eligibility discovered by the LDSS in which it appears there has been deliberate misrepresentation by an applicant/recipient with intent to defraud;
- eligibility errors discovered by the LDSS, independent of other audit or quality control functions, including cases in which the individual was enrolled incorrectly, added in error, not cancelled timely, allowed to remain on Medicaid during the conviction sanction period or when information known to the agency would render ineligibility;
- cases in which the LDSS discovers that the enrollee failed to report information that impacts eligibility; and

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2. PARIS Match Data

The Public Assistance Reporting Information System (PARIS) is a Federal computer matching initiative that the Virginia Department of Social Services (VDSS) participates in quarterly. VDSS participates in the data exchange with all active Medicaid enrollees and they are matched for the receipt of Veteran benefits and enrollment in multiple state's Medicaid programs. Each public assistance report is matched by social security number.

The worker must evaluate all matches for current and ongoing eligibility and take appropriate case action within 30 days. Multiple matches must be assessed as a whole for the entire case. Workers must document findings in VaCMS under Case Comments. Once the evaluation of the match is completed and the case comments are documented, send the **Public Assistance Reporting Information System (PARIS) Notice of Recipient Fraud/Non-Fraud Recovery, (form #DMAS 754R)** to the DMAS Program Integrity Division, where steps will be conducted to complete the match and Benefit Impact Screen (BIS). Procedures for researching and reporting PARIS matched individuals are found in the PARIS User Guide at *https://fusion.dss.virginia.gov/ac/Compliance-Home/FRAUD-MANAGEMENT/PARIS-Public-Assistance-Reporting-Information-System*.

Complete and send the **Public Assistance Reporting Information System (PARIS) Notice of Recipient Fraud/Non-Fraud Recovery (form #DMAS 754R)** located at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, to

Department of Medical Assistance Services
Recipient Audit Unit,
600 E. Broad Street, Suite 1300,
Richmond, Virginia 23219

The form may be faxed to 804-452-5472 or emailed to recipientfraud@dmas.Virginia.gov.

3. Corrective Action

Report to the DMAS RAU corrective action taken on all discovered eligibility errors. Corrective action is a function of the loss prevention process. All corrected errors shall be reported to DMAS.

4. Cancel Coverage

Cancel the eligibility of all persons convicted of public assistance fraud or medical assistance fraud to the extent allowable under federal and state regulations, using the cancel code for fraud convictions (Cancel Code 014).

5. Incarcerated Individuals/ Offenders

The Cover Virginia Incarcerated Unit (CVIU) is responsible for evaluating PARIS matches for offenders whose cases are being held at the CVIU and reporting findings to the RAU as outlined in M1700.400 B.1 above.

C. DMAS Response

The RAU shall send a referral acknowledgement letter to the LDSS worker making the referral. RAU may send out additional communication to the LDSS should additional verifications/documentation be required to complete the investigation.

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D. Recipient Audit Reporting

The RAU has two prevention efforts for reporting fraud and abuse of Medicaid Services by individuals within the community. Both referral methods should be given to the individual by the LDSS. The individual may remain anonymous.

- The individual may send an e-mail to recipientfraud@dmas.virginia.gov.
- The individual can call the Recipient Audit fraud and abuse hotline. Both a local and a toll free number are available 24 hours daily for reporting suspected fraud and abuse: local (804) 786-1066; and toll free (866) 486-1971.

E. Statute of Limitations

There is no "statute of limitations" for Medicaid fraud; cases that are referred for fraud shall be flagged to ensure that the information is not purged.

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NOTICE OF MEDICAID RECIPIENT FRAUD/NON-FRAUD

Date: / /

To: **Recipient Audit Unit (RAU)**
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
Fax Number: (804) 452-5472
Email: RecipientFraud@dmas.virginia.gov

Case Name: _____

Case Name SSN: ___ - ___ - ____ **Medicaid Case Number:** ___ - ____ - ___ - ___

Case Address: _____

_____

_____

Is this a Criminal case being presented to your Commonwealth Attorney? ☐ **Yes** ☐ **No**
Has the Case Head been informed a referral is being sent to RAU? ☐ **Yes** ☐ **No**

Check the appropriate box below and give an explanation in the summary section.

☐ **Fraud** ☐ **Agency Error** ☐ **Other**
☐ **Uncompensated Transfer** ☐ **Non-Entitled Receipt of Medicaid**
☐ **Ineligible for Medicaid** **Dates:** ____

Ineligible person(s): _____

_____

_____

_____

Explanation summary of referral and any corrective action taken by the agency:

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MEDICAID FRAUD AND NON-FRAUD RECOVERY	**Appendix 1**		**2**

NOTICE OF MEDICAID RECIPIENT FRAUD/NON-FRAUD

ATTACH THE FOLLOWING INFORMATION IF AVAILABLE:

- **Reason for and estimated period of ineligibility for Medicaid.**
- **Applicable Medicaid applications or review forms for the referral/ineligibility.**
- **Any record of communication between the agency and the recipient or recipient's representative, such as case narratives, letters, and notices.**
- **Information obtained for the agency's fraud investigation, including names and addresses of knowledgeable individuals for testimony and/or interviews.**
- **Relevant covered group, income, resource, and/or asset transfer documentation.**
- **A copy of any Regional Specialist's decision regarding trust that affects eligibility.**
- **Address and telephone number of any attorney-in fact, authorized representative, or other individual who assisted in the application process;**
- **Confirmation that ongoing eligibility has been reviewed in relation to the allegation and the results. This can be addressed in the summary of the referral.**

Name of Eligibility Worker: _____ **Telephone Number:** (___) ___-____

Agency Name: _____ **FIPS Code:** _____

Address: _____ **Name of Supervisor:** _____

RAU will send acknowledgment of receipt to the referring agency. RAU will contact the agency if any further action is required.

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Appendix removed with Transmittal #DMAS-29

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Appendix removed with Transmittal #DMAS-29

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MEDICAID FRAUD AND NON-FRAUD RECOVERY	***Appendix 3***		***1***

NOTICE to DMAS of ESTATE RECOVERY/TPL/TRUSTS

DATE: __/__/____

TO:

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
TPL UNIT
600 EAST BROAD STREET, SUITE 1300
RICHMOND, VA 23219
FAX NUMBER: (804) 786-0729

Case Name: _____

Case Address: _____
_____
_____

Case Name's Social Security Number: ___-__-____

Medicaid Case Number: ___-_____-__-

☐ ***Estate Recovery*** ***Refer when deceased member is over 55 and has no surviving spouse, child under 21 or a disabled or blind child of any age.***

☐ ***TPL Recovery*** ***Member has received funds from a settlement. DSS has received information concerning member being in an accident. DSS has information where member has other third party payers.***

☐ ***Trust*** ***Refer all: Irrevocable, Discretionary, Pooled, and Special Needs Trusts***

Explanation Summary of referral:

_____
_____
_____
_____

Describe any corrective action taken by the agency:

_____
_____
_____
_____

_____

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NOTICE to DMAS of ESTATE RECOVERY/TPL/TRUSTS

ATTACH THE FOLLOWING INFORMATION IN THE ORDER LISTED BELOW:

- ***Confirmation that ongoing eligibility has been reviewed in relation to allegation and results:***
- ***Please attach the required decision from your Regional Specialist on all trust referrals;***
- ***Member's Social Security number;***
- ***Applicable Medicaid applications or review forms for the referral/ineligibility***
- ***Address and telephone number of any attorney-in fact, authorized representative, or other individual who assisted in the application process;***
- ***When reporting health insurance information please include a copy of the insurance card or write in the "Explanation Summary of referral" as much information you can obtain. The policy number, insurance carrier name is most important.***
- ***When reporting accident information concerning a Medicaid member, please include date of accident, the name of the attorney representing the member or the liable insurance carrier's name and address.***
- ***For Estate recovery please include the address of any property owned by the Medicaid member.***
- ***Relevant covered group, income, resource, and/or asset transfer documentation;***
- ***Any record of communication between the agency and the client or representative, such as case narratives, letters, and notices; and***
- ***Information obtained from the agency's investigation, including names and addresses of knowledgeable individuals for testimony and/or interviews.***

Name of Eligibility Worker/Medicaid Technician: _____

Telephone Number: (____) ____-____

Agency Name: _____

FIPS Code: ___

Address: _____

_____

Name of Supervisor: _____

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MEDICAID FRAUD AND NON-FRAUD RECOVERY	**Appendix 4**	**1**

PUBLIC ASSISTANCE REPORTING INFORMATION SYSTEM (PARIS) NOTICE OF MEDICAID RECIPIENT FRAUD/NON-FRAUD

Date:

To: **Department of Medical Assistance Services**
Recipient Audit Unit (RAU)
Fax Number: (804) 452-5472
Email: RecipientFraud@dmas.virginia.gov
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If you fax or email, you do not need to mail a copy of the referral.

Case Name:	
Case Social Security Number:	
VaCMS Number:	
Medicaid Number:	
Case Address:	

☐ **PARIS Interstate** ☐ **PARIS Veterans** ☐ **PARIS Federal**

Match Person(s):		
Date of the PARIS match:		
Date of contact with the other state government agency:		
Individual(s) receiving Medicaid in the other state:		
Individual(s) receiving Veterans or federal benefits:		
Start date and end date of Medicaid from other state:		
Veterans or Federal benefit information:		
Did you verify individual (s) met Virginia residency for ongoing Medicaid coverage?	**Yes they met VA residency.** ☐ **If yes date of confirmation from individual (s) verfying they are residing in VA:**	**No they did not meet VA residency.** ☐ **If no date VA coverage will be cancelled:**
Documentation on file:		

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Name of Eligibility Worker:	**Telephone Number:**
Agency Name:	**FIPS Code:**
Address:	**Name of Supervisor:**

RAU will send acknowledgment of receipt to the referring agency and will be in contact if any further action is required

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CHAPTER M18

MEDICAL SERVICES

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M18 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-26	1/1/23	Pages 6a, 7 and 8
TN #DMAS-22	1/1/22	Page 8 Page 7 is a runover page.
TN #DMAS-20	7/1/21	Page 7 Page 8 is a runover page.
TN #DMAS-12	04/01/2019	Page 3, 5
TN #11 DMAS -11	01/01/2019	Page 3
TN #DMAS-10	10/1/18	Pages 3-5
TN #DMAS-6	10/1/17	Table of Contents Pages 3-5 Page 6 is a runover page. Page 6a was added.
TN #100	5/1/15	Table of Contents Pages 1-9 Pages 10-17 were deleted. Appendix 1 was removed.
UP #9	4/1/13	Page 3
UP #7	7/1/12	Page 12
TN #96	10/01/11	Pages 3, 4, 16
TN #95	3/1/11	Page 9
TN #94	9/1/10	Page 12
TN #93	1/1/10	Pages 4, 5
TN #91	5/15/09	Page 2 Pages 5, 6 Page 8

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MEDICAL SERVICES

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M1800 MEDICAL SERVICES

M1810.100 MEDICAID ELIGIBILITY CARD

A. Medicaid Card Issuance

A Medicaid card is issued to an individual who has been found eligible for Medicaid and is enrolled with the Department of Medical Assistance Services (DMAS). The card is plastic with the enrollee's name, gender and birth date on the front, and a strip on the back that providers can "swipe" to ascertain the type of coverage and the begin date of coverage. The card is intended to be permanent. Presentation of the card to the Medicaid-enrolled (certified) provider of medical services authorizes the provider to bill Medicaid for the needed services, if such services are covered by the Medical Assistance Program and DMAS has pre-authorized the service, when pre-authorization is required.

Exception: The following recipients do not receive a Medicaid card:

- individuals eligible for Medicare premium payment only,
- individuals enrolled in a closed period of coverage in the past with no ongoing coverage, and
- *incarcerated individuals eligible for Medicaid payment of inpatient hospitalization services only.*

B. Use of the Medicaid Card

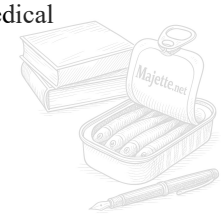
1. General

Local social services departments must provide recipients with information concerning use of the Medicaid card. This includes information that misuse of the card is fraud and can result in prosecution. Examples of misuse include:

- using the card following cancellation of eligibility,
- alteration of names, dates, or other information to secure medical care to which the individual is not entitled, and
- knowingly permitting another person to use an individual's card to secure medical care.

2. Foster Care Children in Institutional Facilities

The local department of social services (LDSS) should use the local department's address when enrolling a foster care child whose custody is held by the local department of social services and who is placed in an institution. Upon receipt of the Medicaid card, it should be sent to the appropriate institution for use on the child's behalf. The local department has the responsibility of advising the child caring institution of the medical and dental services covered by Medicaid.



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3. Nursing Facility Patients

Patients in nursing facilities receive Medicaid cards. The nursing facility also receives a computer-generated list at the first of the month which lists all eligible Medicaid patients in that facility.

This *report* reflects only those Medicaid-eligible patients for whom the nursing facility has submitted an "admission packet."

DMAS staff enters the patient information into the system and assigns a patient control number to the facility for use in billing Medicaid for the patient's care.

When a patient dies or is discharged from the facility, the facility is responsible for notifying DMAS and the LDSS of the date of discharge or death. Long-term care (LTC) providers have been instructed to notify the LDSS of death or discharge via the Medicaid Long-term Care Communication Form (DMAS-225).

M1820.100 SERVICE PROVIDERS

A. Enrollment Requirement

Providers of medical services must be enrolled by DMAS to receive Medicaid payment for their services. Lists of enrolled providers are available to local departments of social services and enrollees from DMAS and are available online at www.dmas.virginia.gov.

B. Out-of-State Providers

1. Covered Services

Medicaid will cover medical services rendered by out-of-state providers when the use of such providers is:

a. the general custom of the eligible individual (e.g., a recipient living near the border of another state),

b. needed by a non IV-E Foster Care child placed outside Virginia,

c. necessitated when an eligible person is temporarily outside Virginia and has a medical emergency, or

d. indicated because of referral to an out-of-state facility when preauthorized by DMAS.

2. Provider Enrollment

In instances where an out-of-state provider is not currently enrolled as a DMAS provider, DMAS will accept the provider's initial billing and will contact the provider to determine the provider's wish to become enrolled so that subsequent services can be paid through the computerized Medicaid claims processing system.

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M1830.100 MANAGED CARE

A. General Information

DMAS provides Medicaid coverage to enrollees primarily through two delivery systems: fee-for-service (FFS) and managed care. FFS benefits are administered by DMAS through participating providers within the traditional Medicaid program rules. Most Virginia Medicaid enrollees *including individuals with other forms of health insurance (TPL)* are required to receive medical care through a managed care organization.

B. *Medallion Programs*

The Medallion 4.0 managed care program is administered through DMAS' contracted managed care organizations (MCO).

Individuals eligible for Medallion *4.0* include non-institutionalized enrollees in both Families & Children (F&C) and Aged, Blind or Disabled (ABD) covered groups. Some enrollees in the groups below are not Medallion *4.0* eligible because they meet exclusionary criteria. The following is a **partial** list of enrollees excluded from managed care enrollment:

- Enrollees who are inpatients in state mental hospitals,
- Enrollees who are in long-stay hospitals, nursing facilities, or intermediate care facilities for the intellectually disabled,
- Enrollees who meet a spenddown and are enrolled for a closed period of coverage,
- Enrollees who are participating in Plan First,
- Enrollees under age 21 in Level C residential facilities,
- Enrollees who have an eligibility period that is less than three months or who have an eligibility period that is only retroactive.

All Medallion 4.0 health plans offer enhanced benefits to members including, but not limited to:

- Adult Dental
- Vision for adults
- Cell phone
- Centering pregnancy program
- GED for Foster Care
- Sports physical at no cost (under age 21)
- Swimming lessons for members six (6) years and younger
- Boys and Girls Club membership (6-18 olds)
- Free meal delivery after inpatient hospital stays

Note: Not all health plans will offer all of the same enhanced benefits

Enrollees excluded from mandatory managed care enrollment shall receive Medicaid services under the current fee-for-service system. When enrollees no longer meet the criteria for exclusion, they shall be required to enroll in the appropriate managed care program.

Enrollees and their families may contact the Medallion 4.0 Helpline at 1-800-643-2273 for information and assistance.

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C. Managed Care HelpLine

Eligible individuals can enroll in an MCO or obtain additional information, as well as assistance with coverage issues, by calling the Managed Care HelpLine at 1-800-643-2273 (TTY/TDD 1-800-817-6608). The Helpline is available Monday through Friday from 8:30 a.m. until 6:00 p.m. Information is available online at www.virginiamanagedcare.com.

D. Family Access to Medical Insurance Security Plan (FAMIS) Managed Care

FAMIS benefits are administered through DMAS contracted MCOs or through FAMIS fee-for-service. The DMAS contracted MCOs for FAMIS are the same as those contracted with DMAS for Medallion 3.0.

In all areas of the Commonwealth, FAMIS enrollees have the choice between 2 or more MCOs. When a child is first enrolled in FAMIS, he or she is able to access health care through the FAMIS fee-for-service program. Within 1 or 2 months after FAMIS enrollment, the child will be enrolled with a FAMIS MCO.

FAMIS benefits are slightly different than the benefits that children enrolled in Medicaid receive. There are benefit limitations and small co-payments similar to those associated with commercial group health insurance. The following is a partial list of services (while covered under Medicaid) are **NOT** covered under FAMIS.

- Early and Period Screening Diagnosis and Treatment (EPSDT) services are not covered for FAMIS MCO members. Many of the services that are covered as EPSDT services by Medicaid are covered under FAMIS MCO's well child and immunization benefits. EPSDT services **are** covered for FAMIS FFS members because they receive the Medicaid benefit package.

- Psychiatric treatment in free standing facilities is not covered under FAMIS. However, psychiatric treatment is covered when provided in a psychiatric unit of an acute hospital.

- Routine transportation to and from medical appointments is not covered for FAMIS MCO enrollees. Children enrolled in FAMIS FFS may receive non-emergency transportation services. Emergency transportation is covered for both FAMIS MCO and FAMIS FFS enrollees.

- Intensive in-home, therapeutic day treatment, mental health crisis intervention, and case management for children at risk of or experiencing a serious emotional disturbance are covered under FAMIS. Other community mental health rehabilitation services are not covered.

Eligible FAMIS individuals can enroll in an MCO or obtain additional information, as well as assistance with coverage issues, by calling Cover Virginia at 1-855-242-8282, Monday through Friday from 8:00 a.m. until 7:00 p.m. and Saturdays from 9:00am – noon. Information is also available online at www.covervirginia.org.

A summary of FAMIS covered services can be found online at: http://coverva.org/mat/FAMIS%20Covered%20Services.pdf.

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E. Commonwealth Coordinated Care (CCC) Plus

Effective August 1, 2017, the CCC Plus Medicaid managed care program was implemented. CCC Plus operates statewide through a network of managed care plans across six regions as a mandatory program serving adults and children with disabilities and complex care needs. Individuals in nursing facilities and the home and community based waivers, as well as dually-eligible individuals (those with both Medicare and Medicaid) receive Medicaid through CCC Plus. Individuals receiving services through the Developmental Disabilities waivers are currently enrolled in CCC Plus only for their non-waiver services.

*The following is a **partial** list of enrollees excluded from enrollment in CCC Plus:*

- *Limited covered groups – Plan First, Qualified Medicare Beneficiaries (QMB) only, Special Low income Medicare Beneficiaries (SLMB), and Qualified Individuals (QI);*
- *Enrollees in specialized settings – intermediate care facilities for individuals with intellectual disability (ICF-ID), Veterans' nursing facilities, psychiatric residential treatment facilities (PRTF), the Virginia Home, and the Piedmont, Catawba and Hancock state facilities;*
- *Enrollees in hospice care (CCC Plus who elect hospice will remain in CCC Plus);*
- *Enrollees in other programs – Medicaid or FAMIS Medallion 4.0 managed care, and the Program for All-inclusive Care for the Elderly (PACE).*

Medicaid Expansion enrollees receive the same amount, duration and scope of services as other CCC Plus Program Members, with the following four (4) additional federally-required essential health benefits.

- *Annual adult wellness exams;*
- *Individual and group smoking cessation counseling;*
- *Nutritional counseling for individuals with obesity or chronic medical diseases;*
- *Recommended adult vaccines or immunizations.*

Enrollees and their families may contact the CCC Plus Helpline at 1-844-374-9159 for information and assistance.

G. Enrollment Corrections/ Changes

DMAS pays a capitation rate for every month an individual is enrolled in managed care regardless of whether the individual receives medical services during the month. If an individual is incorrectly enrolled in a Medicaid managed care program, the eligibility worker must refer the case to DMAS at the following address for possible recovery of expenditures (see chapter M1700):

Recipient Audit Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

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M1840.100 UTILIZATION REVIEW AND CLIENT MEDICAL MANAGEMENT

A. Utilization Review

Federal regulations require the Department of Medical Assistance Services (DMAS) to regularly review recipients' use and need for the covered medical services they receive. Regulations require that Medicaid pay only for medically necessary covered medical services. Medicaid cannot pay for duplicate services since they are not necessary.

DMAS staff in the Program Integrity Division reviews provider claims and recipient utilization histories for medical necessity. If it is determined that services were not medically necessary, providers are obligated to reimburse DMAS for any Medicaid payment they have received.

B. Client Medical Management (CMM) Program

An enrollee's utilization of Medicaid cards for physicians' services and pharmaceutical services is monitored regularly by DMAS. Whenever the utilization of one or both of these services is unusually high, the services will be reviewed for medical necessity. If some services are considered not medically necessary, recipients who are not enrolled in a managed care program will be placed in the CMM Program and required to select a primary physician and/or pharmacy or both.

Individuals identified as high utilizers will receive a letter of notification with instructions about selecting primary providers and identifying those providers to DMAS. Individuals who do not respond to the letter within the specified time will have their primary physician and pharmacy designated by DMAS.

For recipients who have been placed in the CMM Program, Medicaid payment for physicians' services will be limited to those services rendered by the primary physician (including a physician providing services to the patients of the primary physician when the primary physician is not available), physicians seen on referral from the primary physician, and emergency medical services.

Prescriptions may be filled by a non-designated pharmacy only in emergency situations when the designated pharmacy is closed or cannot readily obtain the drug.

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M1850.100 COVERED SERVICES

A. General Information

Information on Medicaid covered services is provided to assist the eligibility worker in responding to general inquiries from applicants/recipients. Individuals who have problems with bills or services from providers of care should be referred as follows:

- Refer FFS Medicaid enrollees to the DMAS Recipient Helpline at 804-786-6145. Refer individuals who need assistance with transportation to the DMAS transportation broker at 1-866-386-8331.

- Refer individuals enrolled in managed care to the Managed Care HelpLine at 1-800-643-2273 or directly to their MCO. Individuals in managed care who need assistance with transportation must contact their MCO directly.

B. Copayments

a. Medicaid Enrollees without Medicare

Medicaid covered services *no longer* have a "copayment," which is the portion of the cost of the service for which the recipient is responsible.

b. Medicare Beneficiaries

Medicaid covers the Medicare copayment for individuals with Medicare and full-benefit Medicaid (dual eligibles) and Qualified Medicare Beneficiaries (QMB). However, a provider is allowed to collect the Medicare copayment at the time of service. If the provider requires the individual to pay the Medicare copayment, the individual must be reimbursed or credited the difference between the Medicare and Medicaid copayments once the provider receives payment of the Medicaid claim.

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C. Covered Services The services listed below are covered:

- case management services;
- certified pediatric nurse and family nurse practitioner services;
- clinical psychologist services;
- community-based services for individuals with intellectual disabilities, including day health rehabilitation services and case management;
- dental services for children enrolled in Medicaid and FAMIS, pregnant women enrolled in Medicaid, FAMIS MOMS, and FAMIS Prenatal Coverage, and effective July 1, 2021, all other adults with **full** Medicaid benefits.
- *dialysis services;*
- emergency hospital services;
- Early Periodic Screening, Diagnostic and Treatment (EPSDT) services;
- family planning services;
- Federally Qualified Health Center clinic services;
- home and community-based care waiver services (see subchapter M1440);
- home health services: nurse, aide, supplies, treatment, physical therapy, occupational therapy, and speech therapy services;
- hospice services;
- inpatient hospital services;
- Intensive Behavioral Dietary Counseling, for individuals in MEDICAID WORKS;
- intermediate care facility services for the intellectually disabled (ICF-ID);
- laboratory and x-ray services;
- Medicare premiums: Hospital Insurance (Part A); Supplemental Medical Insurance (Part B) for the Categorically Needy (CN) and Medically Needy (MN);

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- behavioral health services, including clinic services, outpatient psychiatric services, mental health case management, psychosocial rehabilitation, mental health skill building, therapeutic day treatment for children and adolescents, intensive in-home services for children and adolescents, mental health partial hospitalization, mental health intensive outpatient, assertive community treatment, applied behavior analysis, multisystemic therapy, functional family therapy, mobile crisis response, community stabilization, 23-hour crisis stabilization, residential crisis stabilization unit services, therapeutic group homes and psychiatric residential treatment services.

- nurse-midwife services;

- nursing facility care;

- other clinic services: services provided by rehabilitation agencies, ambulatory surgical centers, renal dialysis clinics, and local health departments;

- outpatient hospital services;

- personal assistance services, for individuals in MEDICAID WORKS;

- physical therapy and related services;

- physician services;

- podiatrist services;

- *pregnancy related services;*

- prescribed drugs;

- prosthetic devices;

- Rural Health Clinic services;

- skilled nursing facility services for individuals under age 21 years;

- substance abuse services;

- transplant services;

- transportation to receive medical services; and

- vision services.

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M1860.100 SERVICES RECEIVED OUTSIDE VIRGINIA

A. General

Medicaid must pay for covered medical services received by any eligible person who is temporarily absent from Virginia if the medical service provider agrees to accept Medicaid payment.

B. Out-of-State Institutional Placements

Virginia Medicaid will cover an *enrollee* who is placed in *an LTC* facility in another state only if the placement is preauthorized by the DMAS Long Term Care Section.

A child in IV-E Foster Care who is placed in an institution outside Virginia is eligible for Medicaid through the state in which he resides. A child in non-IV-E Foster Care is eligible for Virginia Medicaid when the child is in an institution outside Virginia, since the child is considered to be a resident of the locality which holds custody.

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CHAPTER M21

FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS)

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TN #DMAS-34	1/1/25	Appendix 1
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TN #DMAS-28	7/1/23	Appendix 1
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TN #DMAS-2	10/1/16	Page 3
TN #DMAS-1	6/1/16	Appendix 1, page 1
TN #100	5/1/15	Table of Contents; Pages 1-7 Appendices 1 Pages 8-10 and Appendices 2 and 3 were deleted.
UP #10	5/1/14	Pages 1-3 Appendix 1
TN #99	1/1/14	Pages 1-3 Appendix 1
TN # 98	10/1/13	Table of Contents Pages 1-10 Pages 10a and 11-16 were deleted.
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TN #97	9/1/12	Pages 3, 4
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UP #6	4/1/12	Appendix 1
TN #96	10/1/11	Pages 3, 8
TN #95	3/1/11	Table of Contents Pages 5, 6, 14, 15, Page 16 added Appendix 1
TN #94	9/1/10	Page3 Appendix 3, pages 1 and 2
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M2100.000 FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS)

M2110.100 FAMIS GENERAL INFORMATION

A. Introduction

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program, enacted as Title XXI of the Social Security Act, to provide funds to States to enable them to initiate the provision of child health insurance to **uninsured low-income children**.

FAMIS is not an entitlement program, which means that if funds for this program are exhausted, no additional individuals will receive benefits under the program. The Department of Medical Assistance Services (DMAS) will notify the Department of Social Services (DSS) Central Office if funds for this program run out.

Children found eligible for FAMIS receive benefits described in the State's Title XXI Child Health Insurance Program. Eligible children are enrolled for benefits effective the first day of the child's application month if all eligibility requirements are met in that month, but no earlier than the date of the child's birth.

Retroactive coverage is only available to an eligible child who was born within the 3 months prior to the FAMIS application month. Eligibility for FAMIS coverage will be effective retroactive to the child's date of birth if the child would have met all eligibility criteria during that time.

Eligibility for FAMIS is determined by either the local DSS, including a DSS out stationed site, or the Cover Virginia Central Processing Unit (CPU). Approved applications processed by the Cover Virginia CPU will be transferred to the appropriate local DSS for case maintenance.

B. Legal Basis

The 1998 Acts of Assembly, Chapter 464, authorized Virginia's Children's Health Insurance Program by creating the Children's Medical Security Insurance Plan for uninsured children under 19 years of age. In August 2001, the program was revised and renamed the Family Access to Medical Insurance Security Plan (FAMIS).

C. Policy

FAMIS covers uninsured low-income children under age 19 who are not eligible for Medicaid (children's Medicaid) and whose gross family income is less than or equal to 200% of the federal poverty level (FPL) for the individual's household size (see M2130.100 for the definition of the FAMIS household and Appendix 1 for the income limits).

Federal mandate requires that children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased. A FAMIS enrolled child who becomes eligible for Medicaid can be moved to a Medicaid Aid Category and given a new 12-month continuous eligibility period.*

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M2120.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

The child must meet, with certain exceptions, the Medicaid Nonfinancial Eligibility Requirements in chapter M02 and the nonfinancial eligibility requirements imposed by FAMIS.

B. M02 Requirements

The nonfinancial eligibility requirements in chapter M02 that must be met for FAMIS eligibility are:

- the citizenship and alienage requirements, with the exception noted in M2120.100 C below;
- Virginia residency requirements;
- Provision of a Social Security Number (SSN) or proof of application for an SSN.
- Assignment of rights to payment for medical care from any liable third party is a condition of eligibility for the child;
- institutional status requirements regarding inmates of a public institution.

C. FAMIS Alien Status Requirements

Lawfully residing children under age 19 meet the FAMIS alien requirements without regard to their date of arrival or length of time in the U.S. The lawfully residing alien groups are contained in section M0220.314.

Exception to M02:

FAMIS does **not** provide emergency services only coverage for non-citizens who are not lawfully residing in the U.S., such as illegal aliens or those whose lawful admission status has expired. These aliens are not eligible for FAMIS.

If the child meets the definition of a pregnant woman in M0310.124 and does not meet the definition of a lawfully residing child under 19 in M0220.314, use Chapter M23 to evaluate the child for eligibility under FAMIS Prenatal Coverage.

D. FAMIS Nonfinancial Requirements

The child must meet the following FAMIS nonfinancial requirements:

1. Age Requirement

The child must be under age 19 for at least one day during the month. No verification is required.

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

2. Uninsured Child

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

3. IMD Prohibition

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



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M2120.200 HEALTH INSURANCE COVERAGE

A. Introduction

The intent of FAMIS is to provide health coverage to low-income uninsured children. Eligibility for this program is prohibited when a child has creditable health insurance coverage, with two exceptions:

1. A child who was enrolled in the Health Insurance Premium Payment (HIPP) Program while covered by Medicaid and who subsequently becomes income eligible for FAMIS *can remain enrolled in FAMIS.*
2. *A child who is found eligible for Medicaid and given a 12 month continuous eligibility period may be enrolled in other health insurance without penalty. Eligibility will be re-determined after 12 months.*

B. Definitions

1. Creditable Coverage

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

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

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

2. Health Benefit Plan

"Health benefit plan" is defined in the Virginia Bureau of Insurance Regulations (14VAC5-234-30) and means:

- "any accident and health insurance policy or certificate,
- health services plan contract,
- health maintenance organization subscriber contract,
- plan provided by a Multiple Employer Welfare Arrangement (MEWA)".

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Health benefit plan does not mean:

- Medicaid, FAMIS Plus, or State/Local Hospitalization;
- accident only;
- credit or disability insurance;
- long-term care insurance;
- dental only or vision only insurance;
- specified disease insurance;
- hospital confinement indemnity coverage;
- limited benefit health coverage;
- coverage issued as a supplement to liability insurance;
- insurance arising out of workers' compensation or similar law;
- automobile medical payment insurance; or
- insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

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

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

C. Policy

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

- have creditable health insurance coverage;
- have coverage under a group health plan (TRICARE, federal employee benefit plan, private group insurance such as Anthem, etc.) or Medicare;

If the child's health insurance is terminated on a day other than the last day of the month, FAMIS coverage begins effective the day after the insurance ended if all other eligibility requirements are met.

M2130.100 FINANCIAL ELIGIBILITY

A. Financial Eligibility

1. Asset Transfer Asset transfer rules do not apply to FAMIS.

2. Resources Resources are not evaluated for FAMIS.

3. Income

a. Countable Income

FAMIS uses the MAGI methodology for counting income contained in chapter M04.

To the maximum extent possible, *attested* income must be verified by information obtained from electronic data sources, such as the federal hub or another reliable data source, prior to requesting paystubs or employer statements.

FAMIS uses MAGI methodology for estimating income (see chapter M04).

b. Household Size

FAMIS uses MAGI methodology for determining household size (see Chapter M04).

c. Available Gross Income

Retroactive period (for newborns only) – available income is the gross income actually received in each month in the retroactive period.

Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months.

d. Income Limits

The FAMIS income limit is 200% of the FPL (see Appendix 1 to this subchapter) for the number of individuals in the FAMIS assistance unit. Per MAGI policy in chapter M04, a 5% FPL income disregard is applicable.

5. Spenddown

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

M2140.100 APPLICATION and CASE PROCEDURES

A. Application Requirements

The policies in subchapters M0120 and M0130 apply.

B. Eligibility Determination

When an application is received and the child is not eligible for Medicaid due to excess income, determine eligibility for FAMIS. In order to complete an eligibility determination, both the FAMIS nonfinancial requirements in M2120.100 and the financial requirements in M2130.100 must be met

The applicant/enrollee must be notified in writing of the required information and the deadline by which the information must be received. Applications must be acted on as soon as possible, but no later than 45 days from the date the signed application was received.

C. Entitlement and Enrollment

1. Begin Date

Children determined eligible for FAMIS are enrolled for benefits effective the first day of the child's application month if all eligibility requirements are met in that month, **but no earlier than the date of the child's birth.**

If the child's health insurance is terminated on a day other than the last day of the month, FAMIS coverage begins effective the day after the insurance ended if all other eligibility requirements are met.

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2. Retroactive Coverage For Newborns Only

Retroactive coverage is available ONLY to an eligible child who was born within the 3 months prior to the FAMIS application month. Eligibility for FAMIS coverage will be effective retroactive to the child's date of birth if the child was born within the retroactive period and would have met all eligibility criteria during the retroactive period.

The following eligibility requirements must be met in order for a newborn child to be enrolled in FAMIS for retroactive FAMIS coverage:

a. Retroactive coverage must be requested on the application form or in a later contact.

b. The child's date of birth must be within the three months immediately preceding the application month (month in which the agency receives the signed application form for the child).

c. The child must meet all the FAMIS eligibility requirements during the retroactive period.

3. FAMIS Aid Categories

The aid categories (ACs) for FAMIS are:

AC	Meaning
006	child under age 6 with income > 150% FPL and < 200% FPL
007	child 6 – 19 with income > 150% FPL and < 200% FPL
008	child under age 6 with income > 143% FPL and < 150% FPL
009	child 6 – 19 with income > 143% FPL and < 150% FPL
010	FAMIS deemed newborn <1 year old
014	FAMIS deemed newborn above 150% FPL

D. Notification Requirements

The eligibility worker must send a Notice of Action on Medicaid and FAMIS to the family informing them of the action taken the application. The notice must include the eligibility determination for both Medicaid and FAMIS.

If the child is ineligible for both Medicaid and FAMIS, the family must be sent a notice that the child is not eligible for either program. A referral to the Health Insurance Marketplace must be made, and the child must be given the opportunity to have a Medicaid medically needy evaluation if he is under 18 years. Along with the notice, request verification of resources using Appendix E, which can be found at: http://www.coverva.org/mat/APPENDIX%20E%20Medically%20Needy%20application.pdf (Application for Health Insurance and Help Paying Costs (Medical Needy Spenddown). Advise the family that if the signed application is returned within 10 calendar days, the original application date will be honored.

E. Transitions Between Medicaid And FAMIS (Changes and Renewals)

When excess income for Medicaid causes the child's eligibility to change from Medicaid to FAMIS, the new income must be verified or determined reasonably compatible using an electronic data source such as the federal Hub or another reliable data source prior to requesting paystubs or employer statements. For all case actions effective *August 26, 2022*, if the income attested to by the applicant is within 20% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required. If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return.

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F. FAMIS Select

Under the FAMIS program, a family, whose child(ren) are determined eligible for FAMIS and who has access to health insurance through an employer or wishes to purchase a private policy, has the option of enrolling the family in that health plan. "FAMIS Select" allows the choice of the private or employer's insurance instead of FAMIS. Children enrolled in FAMIS whose families have access to private or employer sponsored health insurance coverage may qualify to have the State pay part of the family's share of the health insurance premium.

If a child is enrolled in FAMIS and the family is interested in more information about FAMIS Select (and has access to health insurance), they may contact DMAS about the benefits of enrolling in the FAMIS Select component of FAMIS and information about how to participate in the program. Participation in the FAMIS Select component is voluntary.

G. 12-Month Continuous Coverage

Children under age 19 who are enrolled in FAMIS are entitled to 12 months of continuous coverage ***unless*** *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased. Income changes or enrolling in other health insurance do not affect the child's eligibility during the 12 month period.*

If an individual enrolled in FAMIS becomes pregnant, reinstate her coverage in FAMIS MOMS. Her FAMIS MOMS coverage continues through the last day of the 12th month following the month in which the pregnancy ends. When her pregnancy ends, she will be redetermined for coverage in other covered groups.

Children enrolled in FAMIS who *are* subsequently *found eligible* for Medicaid *(because of a change or a new application)* must have their FAMIS coverage cancelled so they can be reinstated in Medicaid. *A new 12 month period of eligibility will begin.*

H. Renewal Period Extension For Declared Disaster Areas

Effective January 1, 2017, if the Governor or the Federal Emergency Management Agency (FEMA) declares Virginia or any area in Virginia to be a disaster area, children enrolled in FAMIS who reside in the declared disaster area may be granted a 90-day extension of the continuous coverage period before their next renewal is due.

The extension of the renewal period applies only to children in a declared disaster area (1) for whom an ex parte renewal cannot be completed and (2) who do not return a renewal form or complete an online or telephonic renewal prior to the renewal due date.

The next 12-month continuous eligibility period begins the month after the renewal completion date.

M2150.100 REVIEW OF ADVERSE ACTION

A. Case Reviews

An applicant for FAMIS may request a review of an adverse determination regarding eligibility for FAMIS. FAMIS reviews follow the procedures established by Medicaid for client appeals (see chapter M16).

The payment of medical services on the part of any child or any right to participate in the program is not subject to review if funds for FAMIS are exhausted.

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FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS)
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/15/25*

# of Persons in FAMIS House-hold	**FAMIS 150% FPL**		**FAMIS 200% FPL**		
	Annual Limit	Monthly Limit	Annual Limit	Monthly Limit	205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)
1	*$23,475*	*$1,957*	*$31,300*	*$2,609*	*$2,674*
2	*$31,725*	*$2,644*	*$42,300*	*$3,525*	*$3,614*
3	*$39,975*	*$3,332*	*$53,300*	*$4,442*	*$4,553*
4	*$48,225*	*$4,019*	*$64,300*	*$5,359*	*$5,493*
5	*$56,475*	*$4,707*	*$75,300*	*$6,275*	*$6,432*
6	*$64,725*	*$5,394*	*$86,300*	*$7,192*	*$7,372*
7	*$72,975*	*$6,082*	*$97,300*	*$8,109*	*$8,312*
8	*$81,225*	*$6,769*	*$108,300*	*$9,025*	*$9,251*
Each add'l, add	*$8,250*	*$688*	*$11,000*	*$917*	*$940*

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FAMIS MOMS

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TN #98	10/1/13	Table of Contents Pages 1-7 Appendix 1 Pages 8-10 were deleted.
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UP #8	10/1/12	Pages 2, 3 Page 3a deleted
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M2200.000 FAMIS MOMS

M2210.100 FAMIS MOMS GENERAL INFORMATION

A. Introduction

The 2005 Appropriations Act directed the Department of Medical Assistance Services (DMAS) to expand medical coverage to uninsured pregnant women who are ineligible for Medicaid and have income in excess of the Medicaid limits, but whose family income is less than or equal to 200% of the federal poverty level (FPL). The Family Access to Medical Insurance Security (FAMIS) MOMS program was subsequently established. FAMIS MOMS was closed to new applications from January 1, 2014 until November 30, 2014. Enrollment in the program resumed on December 1, 2014.

Eligibility for FAMIS MOMS is determined by either the local DSS, including a DSS outstationed site, or the Cover Virginia Central Processing Unit (CPU). Applications processed by the Cover Virginia CPU will be transferred to the appropriate local DSS for case maintenance.

Eligible women are enrolled for benefits effective the first day of the application month if all eligibility requirements are met in that month. There is no retroactive coverage in FAMIS MOMS. Pregnant women found eligible for FAMIS MOMS receive the same benefits as Medicaid pregnant women, including comprehensive dental services. An eligible woman will receive coverage through her pregnancy and *for 12 months following the end of the month in which her pregnancy ends, regardless of income changes.*

B. Policy Principles

FAMIS MOMS covers uninsured low-income pregnant women who are not eligible for Medicaid due to excess income, and whose countable income is less than or equal to 200% of the FPL.

A pregnant woman is eligible for FAMIS MOMS if all of the following are met:

- she is not eligible for Medicaid and has income in excess of the Medicaid limits;
- she is a resident of Virginia;
- she is uninsured;
- she is not an inmate of a public institution;
- she is **not** an inpatient in an institution for mental diseases *at the time of application/reevaluation*; and
- she has countable family income less than or equal to 200% FPL.

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M2220.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

A. Policy

The pregnant woman must meet, with certain exceptions, the Medicaid nonfinancial eligibility requirements in Chapter M02 and the nonfinancial eligibility requirements imposed by FAMIS.

B. M02 Applicable Requirements

The Medicaid nonfinancial eligibility requirements in Chapter M02 that must be met are:

- citizenship or alien status, with the exception noted in M2220.100 C below;
- Virginia residency requirements;
- Provision of a Social Security Number (SSN) or proof of application for an SSN;
- assignment of rights;
- application for other benefits;
- institutional status requirements regarding inmates of a public institution.

C. FAMIS MOMS Alien Status Requirements

Lawfully residing pregnant women meet the FAMIS alien requirements without regard to their date of arrival or length of time in the U.S. The lawfully residing alien groups are contained in section M0220.314.

Exception to M02:

FAMIS MOMS does **not** provide emergency services only coverage for non-citizens who are not lawfully residing in the U.S., such as illegal aliens or those whose lawful admission status has expired. These aliens are not eligible for FAMIS MOMS but may be eligible for FAMIS Prenatal Coverage if they apply for coverage no later than the month their child is born. **Use Chapter M23 to evaluate the pregnant woman for eligibility under FAMIS Prenatal Coverage.**

D. FAMIS MOMS Covered Group Requirements

1. Declaration of Pregnancy

The woman's pregnancy is declared on the application and requires no further verification unless the agency has received conflicting information. See M0310.124 for the definition of a pregnant woman.

2. Must be Uninsured

The pregnant woman must be uninsured; that is, she must not be covered under any creditable health insurance plan offering hospital and medical benefits. If a pregnant woman has creditable health insurance that does not cover pregnancy, labor and/or delivery services, the pregnant woman is ineligible for FAMIS MOMS because she is insured. *If the pregnant woman obtains health insurance coverage after enrollment, she remains eligible for FAMIS MOMS coverage*.

3. IMD Prohibition

The pregnant woman cannot be in inpatient in an institution for the treatment of mental diseases (IMD) *at the time of application/reevaluation.*

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M2220.200 HEALTH INSURANCE COVERAGE

A. Introduction

The intent of FAMIS MOMS is to provide health coverage to low-income uninsured pregnant women. A pregnant woman who has creditable health insurance coverage is not eligible for FAMIS MOMS.

B. Definitions

1. Creditable Coverage

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

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

2. Employer-Sponsored Dependent Health Insurance

Employer-sponsored dependent health insurance means the employer pays a portion of the premium payment. COBRA coverage in which the employer makes no contribution to the payment of the premium is not employer-sponsored insurance.

***3*. Health Benefit Plan**

"Health benefit plan" is defined in the Virginia Bureau of Insurance Regulations (14VAC5-234-30) and means:

- any accident and health insurance policy or certificate,
- health services plan contract,
- health maintenance organization subscriber contract,
- plan provided by a Multiple Employer Welfare Arrangement (MEWA)".

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Health benefit plan does NOT mean:

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

4. Insured means having creditable health insurance coverage or coverage under a health benefit plan. A woman is considered to be insured if she is covered by a creditable health insurance plan, even if the policy or plan does not cover pregnancy-related services.

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

C. Policy

1. Must be Uninsured A nonfinancial requirement of FAMIS MOMS is that the pregnant woman be uninsured. A pregnant woman **cannot:**

- have creditable health insurance coverage; or
- have coverage under a group health plan (TRICARE, federal employee benefit plan, private group insurance such as Anthem, etc.) or Medicare.

2. Prior Insurance Prior insurance coverage is not a factor as long as the pregnant woman is uninsured during the month for which FAMIS MOMS eligibility is being determined.

M2220.300 NO CHILD SUPPORT COOPERATION REQUIREMENTS

A. Policy There are no requirements for FAMIS MOMS applicants or recipients to cooperate in pursuing support from an absent parent.

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M2230.100 FINANCIAL ELIGIBILITY

A. Financial Eligibility

1. Income

Modified Adjusted Gross Income (MAGI) methodology contained in Chapter M04 is used for the FAMIS MOMS income evaluation. To the maximum extent possible, attested income must be verified by information obtained from electronic data sources, such as the federal hub or another reliable data source, prior to requesting paystubs or employer statements. For all case actions effective October 26, 2019, if the income attested to by the applicant is within 10% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required. If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return.

The FAMIS MOMS income limit is 200% of the FPL (see Appendix 1 to this chapter) for the number of individuals in the pregnant woman's MAGI household composition as defined in M04. The pregnant woman is counted as herself plus the number of children she is expected to deliver. Per MAGI policy in chapter M04, a 5% FPL income disregard is applicable.

2. Resources

Resources are not evaluated for FAMIS MOMS.

3. No Spenddown

Spenddown does not apply to FAMIS MOMS. If countable income exceeds the FAMIS MOMS income limit, the pregnant woman is not eligible for the FAMIS MOMS program. She must be referred to the Health Insurance Marketplace and be given the opportunity to have a MN Medicaid evaluation.

M2240.100 APPLICATION and CASE PROCEDURES

A. Application Requirements

The policies in subchapters M0120 and M0130 apply.

B. Eligibility Determination

1. Pregnant *Individual* Under Age 19

Process an application by a pregnant *individual* under age 19 in the following order:

.Determine eligibility for Medicaid as a pregnant woman; if not eligible because of excess income, go to item *b*.

. Determine eligibility for FAMIS MOMS; if not eligible because of excess income, go to item c .

a. If she is not eligible for FAMIS MOMS because of excess income, she must be referred to the Health Insurance Marketplace and given the opportunity to have a Medically Needy evaluation completed.

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2. 7 Calendar Day Processing

Applications for pregnant women must be processed as soon as possible, but no later than seven (7) calendar days from the date the signed application was filed. If all necessary verifications are not received, the application continues to pend until the 45 day processing time limit is met.

3. Notice Requirements

The applicant/recipient must be notified in writing of the required information and the deadline by which the information must be received.

The agency must have all necessary verifications within 7 calendar days in order to determine eligibility. If the agency does not receive the verifications within the 7 calendar days, the worker must send the applicant written notice on the 7th day. The notice must state why action on the application could not be taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 calendar days to submit the verification.

Once all necessary verifications for the pregnant woman are received, an eligibility determination must be made immediately and the applicant must be notified of the decision.

C. Case Setup Procedures for Approved Cases

A woman enrolled as FAMIS MOMS may have the same base case number in the Medicaid Enterprise System (MES—formerly the Virginia Medicaid Management Information System [MMIS]) as Medicaid enrollees.

D. Entitlement and Enrollment

1. *Dates* of Coverage

Pregnant women determined eligible for FAMIS MOMS are enrolled for benefits effective the first day of the application month, if all eligibility requirements are met in that month. *FAMIS MOMS coverage ends the last day of the 12th month after the end of the month in which the pregnancy ends.*

2. No Retroactive Coverage

There is no retroactive coverage in the FAMIS MOMS program.

3. Aid Category

The FAMIS MOMS aid category (AC) is "005."

E. Notification Requirements

Written notice must be sent to the pregnant woman informing her of the action taken on the application. The notice must include the eligibility determination results for both Medicaid and FAMIS MOMS, as well as a referral to the Health Insurance Marketplace, if applicable.

If the pregnant woman is ineligible for both Medicaid and FAMIS MOMS due to excess income, she must be sent a written notice that she is not eligible for either program and that her case has been referred to the Health Insurance Marketplace. She must also be given the opportunity to have a Medicaid medically needy evaluation completed. Send the notice and a request for information about her resources to the pregnant woman and advise her that if the resource information is returned within 10 days the original application date will be honored.

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F. **Application Not Required for Newborn**

The newborn child born to a FAMIS MOMS enrollee is deemed eligible for FAMIS coverage until his first birthday. Follow the procedures for enrolling a newborn in M0330.802, using the appropriate AC as follows:

AC 010 = mother's income > 143% FPL but ≤ 150% FPL

AC 014 = mother's income > 150% FPL but ≤ 200% FPL.

Act on the enrollment of a deemed newborn as soon as feasible when the birth is reported to the local DSS office or to DMAS.

M2250.100 REVIEW OF ADVERSE ACTIONS

An applicant for FAMIS MOMS may request a review of an adverse determination regarding eligibility for FAMIS MOMS. FAMIS MOMS follows the procedures established by Medicaid for client appeals (see Chapter M16).

The payment of medical services on the part of any pregnant woman or any right to participate in the program is not subject to review if the reason for denial or cancellation is that funds for the FAMIS MOMS program are exhausted.

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FAMIS MOMS
200% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/15/25*

Household Size	200% FPL Yearly Amount	200% FPL Monthly Amount	205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)
2	*$42,300*	*$3,525*	*$3,614*
3	*$53,300*	*$4,442*	*$4,553*
4	*$64,300*	*$5,359*	*$5,493*
5	*$75,300*	*$6,275*	*$6,432*
6	*$86,300*	*$7,192*	*$7,372*
7	*$97,300*	*$8,109*	*$8,312*
8	*$108,300*	*$9,025*	*$9,251*
Each additional, add	*$11,000*	*$917*	*$940*

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CHAPTER M23

FAMIS PRENATAL COVERAGE

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M23 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-34	1/1/25	Pages 6 & 7 Page 7a is added
TN #DMAS-33	10/1/24	Page 7
TN #DMAS-31	4/1/24	Appendix 1
TN #DMAS-30	1/1/24	Pages 1, 6, 7, 8
TN #DMAS-28	7/1/23	Appendix 1
TN #DMAS-25	10/1/22	Pages 5 & 6. Adjust pages 7-8
TN #DMAS-24	7/1/22	Page 6
TN #DMAS-23	4/1/22	Page 6 Appendix 1, page 1
TN #DMAS-21	10/1/21	Pages 6, 7

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FAMIS Prenatal Coverage Income Limits .....Appendix 1.....1

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M2300.000 FAMIS PRENATAL COVERAGE

M2310.100 FAMIS PRENATAL COVERAGE GENERAL INFORMATION

A. Introduction

The 2021 Special Sessions I Appropriations Act directed the Department of Medical Assistance Services (DMAS) to amend the Family Access to Medical Insurance Security Plan (FAMIS) and expand medical coverage to uninsured pregnant women and their unborn children

- who are ineligible for full-benefit Medicaid or FAMIS Moms due to the woman's immigration status and
- whose Modified Adjusted Gross Income (MAGI) household income is less than or equal to 200% of the federal poverty level (FPL).

FAMIS Prenatal Coverage is effective beginning July 1, 2021.

Eligibility for FAMIS Prenatal Coverage is determined by either the local DSS, including a DSS out stationed site, or the Cover Virginia Central Processing Unit (CPU). Applications processed by the Cover Virginia CPU will be transferred to the appropriate local DSS for case maintenance.

Eligible women are enrolled for benefits effective the first day of the application month if all eligibility requirements are met in that month. There is no retroactive coverage in FAMIS Prenatal Coverage. If the woman applies for coverage after the month in which the child is born but within the application's retroactive period, she may be eligible for Medicaid coverage of the labor and delivery as emergency services if the woman's countable MAGI household income is within the Medicaid limit. See M0220.400.

Pregnant women found eligible for FAMIS Prenatal Coverage receive the same benefits as Medicaid and FAMIS MOMS pregnant women, including comprehensive dental services.

An eligible woman will receive coverage through her pregnancy and the end of the month in which the 60th day following the end of the pregnancy occurs. An infant born to a woman enrolled in FAMIS Prenatal Coverage will receive ongoing coverage beginning on the date of the infant's birth *and ending 12 months after the child's birth month*. The infant's coverage will be in Medicaid or FAMIS, based on the mother's MAGI household unit income at the time of application. The infant's birth is evaluated as a case change; an application does not need to be submitted for the infant.

B. Policy Principles

FAMIS Prenatal Coverage covers uninsured low-income pregnant women who are not eligible for Medicaid or FAMIS MOMS due to the woman's immigration status and whose countable income is less than or equal to 200% of the FPL.

A pregnant woman **of any age** is eligible for FAMIS Prenatal Coverage if all of the following are met:

- she applies for coverage while pregnant or in the month of the birth of her infant child;

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- she does not meet the definition of a **lawfully residing non-citizen pregnant woman in M0220.314**.
- she is a resident of Virginia;
- she is uninsured;
- she is not an inmate of a public institution;
- she is not an inpatient in an institution for mental diseases; and
- she has countable MAGI household income less than or equal to 205% FP (200% FPL plus 5% FPL disregard)..

M2320.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

A. Policy

The pregnant woman must meet, with certain exceptions, the Medicaid nonfinancial eligibility requirements in Chapter M02 and must be uninsured.

B. M02 Applicable Requirements

The Medicaid nonfinancial eligibility requirements in Chapter M02 that must be met are:

- Virginia residency requirements (M0230)
- assignment of rights (M0250)
- application for other benefits (M0270)
- institutional status requirements regarding inmates of a public institution (M0280).

The Social Security Number (SSN) requirement does not apply to the pregnant woman.

C. Alien Status and FAMIS Prenatal Coverage

FAMIS Prenatal Coverage is limited to a pregnant woman of any age who **does not** meet the lawfully residing alien status requirement for pregnant women for full-benefit coverage in M0220.314 and who applies for coverage while pregnant or no later than the month in which the infant is born.

A pregnant woman who does not meet the lawfully residing alien status requirement and who applies for coverage after the month in which the child is born but within the application's retroactive period may be eligible for Medicaid coverage of the labor and delivery as emergency services if the woman's countable MAGI household income is within the Medicaid or limit or she is eligible as Medically Needy. See M0220.400.

D. FAMIS Prenatal Coverage Covered Group Requirements

1. Declaration of Pregnancy

The woman's pregnancy and the number of unborn children are declared on the application and require no further verification unless the agency has received conflicting information. See M0310.124 for the definition of a pregnant woman.

2. Must be Uninsured

The pregnant woman must be uninsured; that is, she must not be covered under any creditable health insurance plan offering hospital and medical benefits. If a pregnant woman has creditable health insurance that does not cover pregnancy, labor and/or delivery services, the pregnant woman is ineligible for FAMIS Prenatal Coverage because she is insured.

3. IMD Prohibition

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

M2320.200 HEALTH INSURANCE COVERAGE

A. Introduction

A pregnant woman who has creditable health insurance coverage is not eligible for FAMIS Prenatal Coverage.

FAMIS Prenatal coverage provides the same coverage as FAMIS MOMS, including coverage of prenatal care, other medical care, dental care, and transportation to received covered services. Pregnant women enrolled in FAMIS Prenatal Coverage will receive care through a managed care organization (see M1830.100)

B. Definitions

1. Creditable Coverage

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

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

2. Employer-Sponsored Dependent Health Insurance

Employer-sponsored dependent health insurance means the employer pays a portion of the premium payment. COBRA coverage in which the employer makes no contribution to the payment of the premium is not employer-sponsored insurance.

3. Health Benefit Plan

"Health benefit plan" is defined in the Virginia Bureau of Insurance Regulations (14VAC5-234-30) and means:

- any accident and health insurance policy or certificate,
- health services plan contract,
- health maintenance organization subscriber contract,
- plan provided by a Multiple Employer Welfare Arrangement (MEWA)".

Health benefit plan does NOT mean:

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

4. Insured means having creditable health insurance coverage or coverage under a health benefit plan. A woman is considered to be insured if she is covered by a creditable health insurance plan, even if the policy or plan does not cover pregnancy-related services.

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

C. Policy

1. Must be Uninsured A nonfinancial requirement of FAMIS Prenatal Coverage is that the pregnant woman be uninsured. A pregnant woman **cannot:**

- have creditable health insurance coverage; or
- have coverage under a group health plan (TRICARE, federal employee benefit plan, private group insurance such as Anthem, etc.) or Medicare.

2. Prior Insurance Prior insurance coverage is not a factor as long as the pregnant woman is uninsured during the month for which FAMIS Prenatal Coverage eligibility is being determined.

M2320.300 NO CHILD SUPPORT COOPERATION REQUIREMENTS

A. Policy There are no requirements for FAMIS Prenatal Coverage applicants or members to cooperate in pursuing support from an absent parent.

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M2330.100 FINANCIAL ELIGIBILITY

A. Financial Eligibility

1. Income

MAGI methodology contained in Chapter M04 is used for the FAMIS Prenatal Coverage income evaluation. To the maximum extent possible, attested income must be verified by information obtained from electronic data sources, such as the federal hub or another reliable data source, prior to requesting paystubs or employer statements. If the income attested to by the applicant is within 20% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required. If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return. If the documentation is delayed in the mail due to no fault of the applicant, accept delayed documentation and complete application processing.

The FAMIS Prenatal Coverage income limit is 200% of the FPL (see Appendix 1 to this chapter) for the number of individuals in the pregnant woman's MAGI household composition as defined in M04. The pregnant woman is counted as herself plus the number of children she is expected to deliver. Per MAGI policy in chapter M04, a 5% FPL income disregard is applicable.

2. Resources

Resources are not evaluated for FAMIS Prenatal Coverage.

3. No Spenddown

Spenddown does not apply to FAMIS Prenatal Coverage. If countable income exceeds the FAMIS Prenatal Coverage income limit, the pregnant woman is not eligible for the FAMIS Prenatal Coverage program. If the woman has no documentation of immigration status, DO NOT make a referral to the Health Insurance Marketplace

M2340.100 APPLICATION and CASE PROCEDURES

A. Application Requirements

The policies in subchapters M0120 and M0130 apply.

B. Eligibility Determination

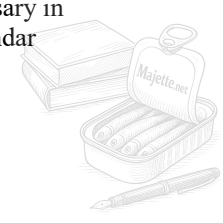
1. 7 Calendar Day Processing

Applications for pregnant women must be processed as soon as possible, but no later than seven (7) calendar days from the date the signed application was filed. If all necessary verifications are not received, the application continues to pend until the 45 day processing time limit is met.

2. Notice Requirements

The applicant/recipient must be notified in writing of the required information and the deadline by which the information must be received.

The agency must have all necessary verifications within 7 calendar days in order to determine eligibility. If the agency does not receive the verifications within the 7 calendar days, the worker must send the applicant written notice on the 7th day. The notice must state why action on the application could not be taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 calendar days to submit the verification.



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Once all necessary verifications for the pregnant woman are received, an eligibility determination must be made immediately and the applicant must be notified of the decision.

C. Case Setup Procedures for Approved Cases

A woman enrolled as FAMIS Prenatal Coverage may have the same base case number in the Medicaid Enterprise System (MES—formerly the Virginia Medicaid Management Information System [MMIS]) as Medicaid enrollees.

D. Entitlement & Enrollment

1. Begin Date of Coverage

Pregnant women determined eligible for FAMIS Prenatal Coverage are enrolled for benefits effective the first day of the application month, if all eligibility requirements are met in that month.

2. No Retroactive Coverage

There is no retroactive coverage in the FAMIS Prenatal Coverage program.

3. Aid Categories

The FAMIS Prenatal Coverage aid categories (AC)* are:

- 110 for pregnant women with income ≤143% FPL
- 111 for pregnant women with income >143% FPL but ≤ 200% FPL.

Note: A change in the MMIS enrollment system was effective July 1, 2022 to display the FAMIS Prenatal aid categories AC110 / AC111. Anyone enrolled prior to July 1, 2022 will remain in aid category AC005 *until renewal* if eligibility is not run and updated to the new AC.

4. Coverage Period

After her eligibility is established as a pregnant woman, the woman's FAMIS Prenatal Coverage entitlement continues through her pregnancy and the 60-day period following the end of her pregnancy regardless of income changes. Her coverage ends the last day of the month in which the 60th postpartum day occurs. The 12-month coverage period for pregnant women in Medicaid and FAMIS MOMS is not applicable to FAMIS Prenatal Coverage.

E. Notification Requirements

Written notice must be sent to the pregnant woman informing her of the action taken on the application. The notice must include the eligibility determination results for FAMIS Prenatal Coverage.

If the woman is not eligible for FAMIS Prenatal Coverage and has no documentation of immigration status, DO NOT make a referral to the Health Insurance Marketplace.

F. Enrolling Infant Born to a Woman in FAMIS Prenatal Coverage

For women assigned to AC 110 under a fee for service (FFS) arrangement, her labor and delivery services are paid as emergency services, and the newborn is considered a deemed-eligible newborn. When the birth of the child born to a women enrolled in FAMIS Prenatal Coverage is reported, review the available systems to determine if the mother is assigned to AC110 under FFS. If so, the child is enrolled as a deemed newborn in AC 093 and is eligible for 12 months of continuous coverage. An infant born to a woman in FAMIS Prenatal Coverage who is assigned to AC 111 and/or enrolled in managed care must be evaluated for ongoing coverage. The infant is not considered a deemed-eligible newborn but has rather been enrolled prenatally through the mother's enrollment in FAMIS Prenatal

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Coverage, and the *enrollment is treated as a change in circumstances. If the newborn's eligibility can be verified with information known to the agency, enroll the child effective the date of the birth with a 12-month certification period. If the child's eligibility can't be verified,* the infant's birth is treated as an "add a person" case change in the enrollment system and given a 12-month certification period starting with the mother's first month of enrollment.

To enroll the infant, the worker must have the information below. Use existing case data if possible. If additional information is needed, send a request for verification. *The newborn is protected by continuous eligibility until the end of their certification period. If a verification request is sent and returned, process it as a change in circumstances. If the child remains eligible, give them a new 12-month certification period. If the verification request is not returned or the information provided indicates that the child is ineligible, do not disenroll them. Eligibility will be reviewed through the annual redetermination process at the end of their current certification period.*

1. Required Information

- Name, date of birth, sex (gender)
- Information about the infant's MAGI household and income, if not available in the case record

Unless the agency has information about the infant's father living in the home (i.e. for another program), use only the mother's reported income to enroll the infant. Do not request information about the father or the father's income unless the agency has *current* information about the father living in the home and his income. *Information on file can be used if less than six months old.*

Note: The infant is not required to provide an SSN or proof of application for an SSN in order to be enrolled. Follow the procedures in M0240.200 B.3 90 days following the infant's enrollment to determine if an SSN has been assigned. If the SSN number has not yet been issued at 90 days, obtain the SSN or proof of application for an SSN at the first renewal of the infant's coverage.

2. Enrollment and Aid Category

Update the case with the new infant's information, enrolling the child as a Medicaid child under 19 or in FAMIS, as appropriate based on the mother's countable income at the time of application. Use the appropriate AC below to enroll the infant:

- Medicaid AC 090 for income > 109% FPL ≤ 143% FPL
- Medicaid AC 091 for income ≤ 109% FPL
- FAMIS AC 006 for income > 150% FPL and ≤ 200% FPL
- FAMIS AC 008 for income > 143% FPL and ≤ 150% FPL

3. Renewal

The infant's first renewal is due 12 months from the month of the child's enrollment.

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G. Examples

Example 1: Rose is pregnant and is carrying one unborn child. She was born outside the U.S. She applies for Medicaid on October 27, 2021. She reported on the application that she visited the emergency room in August 2021. The retroactive period for her application is July – September 2021.

Rose is unable to verify that she is lawfully residing in the U.S.; therefore, she cannot be eligible for full-benefit Medicaid or FAMIS Moms and is evaluated for FAMIS Prenatal Coverage. Her verified countable monthly income is $1,756 per month, which is under the income limit for FAMIS Prenatal Coverage for her MAGI household size of two. She is approved for FAMIS Prenatal coverage and enrolled effective October 1, 2021, in AC 110, based on her countable income of under 143% FPL (see M23, Appendix 1). She is enrolled in Managed Care, so her infant will not be considered a deemed-eligible newborn.

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Because she received an emergency service during the retroactive period and her income is under the Medicaid limit for a pregnant woman, she is evaluated for Emergency Services coverage.

Rose's son, AJ, is born on February 25, 2022, and is enrolled in AC 090 beginning February 25, 2022. His Medicaid renewal is due *in February 2023.* Rose's FAMIS Prenatal Coverage ends on April 30, 2022.

Example 2

Jo lives with her husband Al and daughter Em, who was born on October 31, 2021. Jo was born outside the U.S. She applies for Medical Assistance on November 25, 2021 and requests retroactive coverage for her pregnancy. She does not request coverage for her husband.

Jo is unable to verify that she is lawfully residing in the U.S.; therefore, she cannot be eligible for full-benefit Medicaid or FAMIS Moms. Because Jo applied for coverage the month after her infant's birth, she cannot be eligible for FAMIS Prenatal Coverage

Jo's MAGI household consists of three people—Jo, her infant, and her husband. The verified countable monthly income for the household is $3,473.

Jo's countable income is over the limit of 143% FPL for Medicaid and has excess resources for Medically Needy eligibility; therefore, she cannot be approved for Medicaid coverage of emergency services for the labor and delivery.

Em is determined to be eligible for FAMIS, which covers an eligible child who was born within the 3 months prior to the application month. Em is enrolled effective October 31, 2021, in AC 006. Her renewal is due in *October* 2022.

The eligibility worker sends a Notice of Action indicating Jo is not eligible for Medicaid or FAMIS Prenatal Coverage and Em has been enrolled in FAMIS.

M2350.100 REVIEW OF ADVERSE ACTIONS

An applicant for FAMIS Prenatal Coverage may request a review of an adverse determination regarding eligibility for FAMIS Prenatal Coverage. FAMIS Prenatal Coverage follows the procedures established by Medicaid for client appeals (see Chapter M16).

The payment of medical services on the part of any pregnant woman or any right to participate in the program is not subject to review if the reason for denial or cancellation is that funds for the FAMIS Prenatal Coverage program are exhausted.

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FAMIS PRENATAL COVERAGE
200% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/15/25*

	Enroll Using Aid Category 110			**Enroll Using Aid Category 111**		
Household Size	**143% FPL Yearly Amount**	**143% FPL Monthly Amount**	**148% FPL (143% FPL + 5% FPL Disregard)**	**200% FPL Yearly Amount**	**200% FPL Monthly Amount**	**205% FPL (200% FPL + 5% FPL Disregard)**
2	*$30,245*	*$2,521*	*$2,609*	*$42,300*	*$3,525*	*$3,614*
3	*$38,110*	*$3,176*	*$3,287*	*$53,300*	*$4,442*	*$4,553*
4	*$45,975*	*$3,832*	*$3,966*	*$64,300*	*$5,359*	*$5,493*
5	*$53,840*	*$4,487*	*$4,644*	*$75,300*	*$6,275*	*$6,432*
6	*$61,705*	*$5,143*	*$5,322*	*$86,300*	*$7,192*	*$7,372*
7	*$69,570*	*$5,798*	*$6,001*	*$97,300*	*$8,109*	*$8,312*
8	*$77,435*	*$6,453*	*$6,679*	*$108,300*	*$9,025*	*$9,251*
Each additional, add	*$7,865*	*$656*	*$679*	*$11,000*	*$917*	*$940*

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CHAPTER M16

APPEALS PROCESS

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M16 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-28	7/1/23	Table of Contents Pages 1-9, 11 Page 13 was added
TN #DMAS-20	7/1/21	Table of Contents Pages 1-10 Pages 11 and 12 were added.
N/A	10/15/20	Pages 3, 8 Page 8a was added as a runover page.
TN DMAS-12	4/1/19	Page 7
TN #DMAS-8	4/1/18	Page 7
TN #DMAS-4	4/1/17	Page 7 Pages 8-10 are runover pages.
TN #DMAS-2	10/1/16	Page 3
TN #DMAS-1	6/1/16	Page 1
TN #100	5/1/15	Page 3
Update #9	4/1/13	Page 8

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M1600.00 APPEALS PROCESS

M1610.100 PURPOSE AND SCOPE

A. Legal Base

The Social Security Act requires that the State Plan for Medical Assistance provide individuals affected by the administration of the Medical Assistance Program an opportunity for a fair hearing. The act establishes the right of any individual to appeal and receive a fair hearing before the administering agency, the Department of Medical Assistance Services (DMAS), when DMAS or any of its designated agents:

- takes an action to terminate, deny, suspend, or reduce benefits,
- fails to take an application for medical assistance,
- fails to act on an application for medical assistance with reasonable promptness, or
- takes any other action that adversely affects receipt of medical assistance.

This chapter applies to client appeals resulting from eligibility determinations made by the Virginia Department of Social Services, its local offices, the Department of Medical Assistance Services, Cover Virginia, and agents *or contractor(s)*.

Many Medicaid members are enrolled with a Managed Care Organization (MCO). The MCO appeals process differs from the Eligibility appeals process and the procedures contained within this chapter do not apply to MCO appeals.

B. Participants

The DMAS Appeals Division provides the Hearing Officer who makes arrangements for the fair hearing. The Appeals Division is separate and apart from operational divisions and units within and outside of DMAS. The Division provides a neutral forum for appeals. The Hearing Officer is an impartial decision-maker who will conduct hearings, decide on questions of evidence, procedure and law, and render a written final decision. The Hearing Officer is one who has not been directly involved in the initial adverse action which is the issue of the appeal.

The Agency or Contractor taking the action being appealed and the appellant (the individual appealing some aspect of entitlement to medical assistance or its scope of services) or their representative must participate in the hearing. Most hearings will be conducted by telephone.

Appeals that result from a self-directed application in the eligibility and enrollment system are handled by the local department of social services (LDSS) that houses *the* processed application.

C. Ex Parte Communication

Ex parte communication with the Hearing Officer is strictly prohibited. Ex parte communication is any off-the-record communication (oral or written) between the Hearing Officer and an interested party outside the presence of the other parties to the proceeding during the life of the appeal proceeding.

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The Hearing Officer cannot discuss the substantive issues of an appeal with anyone outside of the hearing. Therefore, it is not appropriate to contact the Hearing Officer to discuss the Agency's action prior to or after the hearing.

Any information provided to the Hearing Officer must be provided to all parties of the proceeding. However, as noted in M1620.100, it is appropriate to notify all parties to the appeal when an action is taken by an Agency to resolve the issue of the appeal. Communication is also allowed for administrative reasons such as scheduling hearings, canceling hearings, and indicating a desire to withdraw an appeal.

D. Notification and Rights

At the time of application or redetermination, and at the time of any action or proposed action affecting eligibility for medical assistance, medical services or patient pay, every applicant for and enrollee of medical assistance shall be informed in writing of the right to a hearing. Appellants shall also be notified of the method by which they may obtain a hearing, and of their right to represent themselves at the hearing or to be represented by an authorized representative such as an attorney, relative, friend, or other spokesperson.

M1620.100 LOCAL AGENCY CONFERENCE

A. Definition and Scope

The Local Agency Conference *(also known as the 'pre-hearing conference")* is an informal process outside of the standard appeal process and does not involve the DMAS Appeals Division. At the conference, the Agency must:

- *explain at the outset that the Local Agency Conference is an informal discussion between the local agency representative and the applicant/enrollee that does not involve the DMAS Appeals Division;*
- *state that the purpose is to describe the reason for the action, give the individual the opportunity to discuss their position/ask questions, and allow the individual to submit documents if they choose;*
- allow the applicant/enrollee to represent themselves or be represented by an authorized representative such as a legal counsel, a friend, or a relative.
- give the applicant/enrollee an explanation of the action;
- allow the applicant/enrollee to present any information to support their disagreement with the action;
- *make clear at the conclusion of the Local Agency Conference that if the applicant/enrollee disagrees with the results of the Local Agency Conference, the standard appeal process remains available;*
- *tell applicants/enrollees who have not yet filed an appeal that the appeal filing timeframes are applicable (30 days from the date of the notice with an additional allowance of five days for mailing – 35 days total from the date of the originating written notice of action) and inform them of the methods to request an appeal; and*



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- *tell applicants/enrollees who have already requested an appeal that they may continue the standard appeal process, can submit additional documents directly to DMAS, and should monitor their correspondence for notification of a hearing date.*

B. Time Limits

A dissatisfied applicant or enrollee must be given the opportunity to request a Local Agency Conference. If a conference is requested, it must be scheduled within 10 business days of receiving the request. *The Agency may proactively offer a Local Agency Conference at any point prior to a scheduled hearing, but the applicant/enrollee is not required to participate.*

C. The Conference and Right to Appeal

The Local Agency Conference must not be used as a barrier to the *applicant/enrollee's* right to a fair hearing. Participation in a conference does not extend the *35*-day time limit for requesting an appeal.

D. Failure to Request a Conference

The applicant's or enrollee's failure to request a conference does not affect the right to appeal within 30 days of the Notice of Action on Benefits and does not affect the right to continued *coverage* if the appeal is *submitted* to the DMAS Appeals Division prior to the effective date of the action.

E. Agency Case Review

An Agency representative should review the case before contacting the applicant/enrollee for a Local Agency Conference:

- *If errors are identified, the Agency representative should correct the case, re-determine eligibility, send a new notice of action to the applicant/enrollee, and upload the notice of action to the Appeals Information Management System portal.*
- *If no errors are identified the Agency representative should be prepared to provide an explanation for the adverse action during the Local Agency Conference.*

F. Decision Notification

The Local Agency Conference may or may not result in a change in the Agency's decision to take the action in question; however, an Agency may reverse its decision at any time between making the original decision and when a decision is rendered by the Hearing Officer.

If the Agency decides not to take the adverse action indicated on the notice, the Agency must inform the *applicant/enrollee* in writing. The Agency must send a new notice of action regarding the changed action *to the appellant/enrollee. The Agency must upload the new notice of action to the Appeals Information Management System portal.*

If the Agency's decision is to stand by its action, the applicant/enrollee must be informed, but written notice of this decision is not required.

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M1630.100 APPEAL REQUEST PROCEDURES

A. Appeal Definition

An appeal is a request for a fair hearing. The request must be a clear expression by an applicant or enrollee, their legal representative (such as a guardian, conservator, or person having power of attorney), or authorized representative acting at their request, of a desire to present their case to a higher authority.

B. Appeal Request

Applicant/enrollees are encouraged to file and appeal request through the DMAS appeals portal at **https://www.dmas.virginia.gov/appeals/**. *It is also acceptable to file an appeal by other means,* using the "Virginia Medicaid/FAMIS Appeal Request Form," which is available from DMAS at **https://www.dmas.virginia.gov/appeals/**.

The appeal request should identify the action under appeal, the reason for the appeal, and include a copy of the notice of action. The submission should also include acceptable proof of authorization to act on behalf of an applicant or enrollee if an authorized representative is filing on their behalf. Appeals filed more than 35 days after the date on the notice of action should include a good cause statement explaining the reason for filing an untimely appeal. Finally, appellants and their representatives may include any other documentation that they wish the hearing officer to consider.

***C.* How to File an Appeal Request**

1. **Electronically. Via the Appeals Information Management System (AIMS) portal at https://www.dmas.virginia.gov/appeals/ or** email an appeal request to appeals@dmas.virginia.gov
2. **By fax**. Fax an appeal request to DMAS at **(804) 452-5454**
3. **By mail** or **in person.** Send or bring an appeal request to:
   Department of Medical Assistance Services
   Appeals Division
   600 East Broad Street
   Richmond, Virginia 23219
4. **By phone.** Call the Appeals Division at (**804) 371-8488** (**TTY: 1-800-828-1120**).

C. Assuring the Right to Appeal

The right to appeal must not be limited or interfered with in any way. When requested to do so, the Agency must assist the applicant/enrollee in preparing and submitting a request for a fair hearing. The Agency may not discourage an applicant/enrollee from requesting an appeal and may not pressure an appellant to withdraw an appeal that they have already filed.

D. Appeal Time Standards

A request for an appeal must be made within *35* days of the *notice of action (thirty days from the date of the notice with an additional allowance of five day for the mailing – 35 days total from the date of the originating written notice of action).* that Medicaid coverage or medical services has been denied, terminated, reduced, adversely affected, *or that an application or request for coverage* has not been acted upon with reasonable promptness.

Notification is presumed received by the applicant/enrollee within five days of the date the notice was mailed, unless the applicant/enrollee demonstrates that the notice was not received in the five-day period through no fault of *their* own.



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An appeal request shall be deemed to be filed timely if it is mailed, faxed, electronically transmitted, or otherwise delivered to the DMAS Appeals Division before the end of last day of filing (30 days plus five mailing days after the date the Agency mailed the notice of adverse action). The date of filing will be determined by:

- the postmark date,
- the date of an internal DMAS receipt date-stamp, or the date the request was faxed or hand-delivered.

In computing the time period, the day of the act or event from which the period of time begins to run shall be excluded, and the last day included. If the time limit would expire on a weekend or state or federal holiday, it shall be extended until the next regular business day.

The DMAS Appeals Division will, at its discretion, grant an extension of the time limit for requesting an appeal if failure to comply with the time limit is due to a good cause such as illness of the appellant or their representative, failure to have been notified of the right to appeal, delay due to the postal service or to an incorrect address, *filing the appeal with another government agency in good faith,* or other unusual or unavoidable circumstances.

M1640.100 CONTINUED COVERAGE PENDING APPEAL DECISION

A. Appeal Validation

Following receipt of a written request for a hearing, the DMAS Appeals Division will determine whether the request is valid. A valid appeal is one that involves an action over which the DMAS Appeals Division has hearing authority, and that is received within the required time limit or extended time limit. During the process of validating an appeal request, a representative of the DMAS Appeals Division may contact the Agency to request a copy of the notice of the adverse action. Upon receipt of such a request, the Agency must immediately send a copy of the notice to the DMAS Appeals Division.

When an appeal is determined to be valid, the DMAS Appeals Division will send official notification to the Agency and identify the issue and Hearing Officer.

B. Coverage May Continue

When an appeal is received and validated, the DMAS Appeals Division decides if Medicaid coverage must continue and notifies the Agency. The Agency should not continue coverage due to the appeal until it has been contacted by the Appeals Division. Upon being informed, by telephone or correspondence, that the enrollee is eligible to receive continued coverage, the Agency must reinstate coverage immediately.

An enrollee's Medicaid coverage must continue until a final appeal decision is made when an appeal hearing is requested prior to the effective date of the action stated on the *Notice of Action*, or when the appeal is requested after the effective date but within 10 days of the *Notice of Action.*

In the case of a patient pay adjustment, the patient pay obligation must return to the amount that was effective prior to the change shown on the Notice of Obligation for Long Term Care Costs that is the subject of the appeal.



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C. When Continued Coverage Does Not Apply

Coverage **will not** continue through the date of the appeal decision when:

- an appeal hearing is requested after the effective date of action, or more than 10 days after the Notice of Action if the appellant is given less than 10 days of advanced notice; or the sole issue under appeal is one of Federal or State law or policy, and the Agency promptly informs the appellant that services will be terminated or reduced pending the appeal hearing decision.

D. Recovery of Continued Coverage Costs

When the Hearing Officer determines the appellant is not eligible for coverage, the cost of medical care received during the period of continued coverage may be recovered by DMAS, to the extent they were furnished solely by reason of this section. (See M1670.100)

M1650.100 PRE-HEARING ACTIONS

A. Invalidation

A request for an appeal may be invalidated if it was not filed within the time limit imposed or if it was not filed by the applicant/enrollee or an authorized representative. The Hearing Officer shall issue *the appropriate* final decision.

1. Appeal Not Filed Timely

If DMAS determines that the appellant has failed to file a timely appeal, DMAS shall notify the appellant or the appellant's representative of the opportunity to show good cause for the late appeal.

If there is no response, or if after evaluating the response, the Hearing Officer determines that the reason for failing to file a timely appeal does not meet good cause criteria, the appeal request will be considered invalid and the Hearing Officer will issue the appropriate final decision.

2. Factual Dispute of Timeliness

If a factual dispute exists about the timeliness of the request for an appeal, the Hearing Officer shall receive testimony and evidence at the hearing prior to receiving testimony and evidence about the substantive issue of the appeal. A decision on the timeliness issue will be made prior to a determination of whether to make a decision about the substantive issue of the appeal.

3. When Individual Filing Appeal Is Not the Appellant

If the individual filing the appeal is not the appellant or an authorized representative of the appellant, DMAS will request that the appellant and/or representative provide proof of authorization to represent the appellant. If proof is not provided, the appeal request will be considered invalid and the Hearing Officer will issue the appropriate final decision.

B. Administrative Dismissal

A request for an appeal may be administratively dismissed without a hearing if the appellant has no right to a hearing. The Hearing Officer shall issue a final decision.

1. No Adverse Action Taken

If DMAS learns that no adverse action was taken prior to the date of the appeal request, the Hearing Officer will issue a final decision dismissing the appeal.

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2. Disability Decision Rescinded By DDS

If the appellant's Medicaid application is returned to a pending status because the Disability Determination Services analyst rescinds the denial of disability, the Hearing Officer will issue a final decision dismissing the appeal.

C. Withdrawal

If the appellant requests that the appeal be withdrawn, the Hearing Officer will send the appellant a letter acknowledging the withdrawal and no further action will be taken on the appeal. A copy of the letter will be sent to the Agency.

- The appellant must provide the Appeals Division with a statement clearly indicating that they wish to withdraw their appeal. *Appellants or authorized representatives who have established access to the Appeals Information Management System portal may withdraw their appeal electronically within the portal. Otherwise,* the statement or form must be mailed, e-mailed, or faxed to the DMAS Appeals Division.

- In lieu of a written statement, the appellant may make a recorded verbal statement clearly indicating that they wish to withdraw their appeal by calling the Appeals Division at **(804) 371-8488.** Verbal notification to the LDSS by the appellant to withdraw an appeal is **not** sufficient.

D. Failure to Appear

If the appellant or their representative fails to appear at the scheduled hearing, and does not reply within 10 days to the Hearing Officer's request for an explanation that meets good cause criteria, or if the appellant does reply and the Hearing Officer decides that the reply does not meet good cause criteria, the appeal will be closed as "abandoned," and the Hearing Officer will issue a final decision.

E. Administrative Resolution

If, upon reevaluation by the LDSS, the appellant's coverage is reinstated to the full amount of coverage that was in effect prior to closure or reduction of benefits, the appeal will be closed as administratively resolved, and the Hearing Officer will issue a final decision.

NOTE: The Agency should not assume that any new Notice of Action automatically ends the appeal. The Agency must send any new Notices to the Appeals Division, and the Appeals Division will decide whether the appeal is administratively resolved. The Agency will receive a copy of final letters for administrative closures.

F. Judgment on the Record

If the Hearing Officer determines from the record that the Agency's action was clearly in error and that the case should be resolved in the appellant's favor, he shall issue a judgment on the record instead of holding a hearing. The Hearing Officer will provide the Agency with a clear explanation of the reason(s) for issuing a judgment on the record and which actions must be taken by the Agency to correct the case. The decision to issue a judgment on the record is at the Hearing Officer's discretion

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G. Remand to the Agency Prior to the Hearing

If the Hearing Officer determines from the record that the case might be resolved in the appellant's favor if the Agency obtains and develops additional information, documentation, or verification, they may remand the case to the Agency for action consistent with the Hearing Officer's written instructions. The Agency must complete the remand evaluation within 30 days or 45 days as applicable.

H. Defective Notices

If the appealed Notice of Action is defective on its face, the Hearing Officer may remand the appeal to the Agency for the issuance of a legally compliant Notice.

For Notices reducing or terminating existing coverage or services, the Hearing Officer will issue a decision that finds in favor of the appellant by ordering the Agency/contractor to reinstate the existing level of coverage or services at issue for a period of at least 30 calendar days; and
Requires the Agency/contractor to issue a new compliant notice prior to the end of the 30 calendar day period by reviewing the same application or service authorization request. If the Agency/contractor requires additional information to process the application or service authorization request, they must ensure that the information is requested and obtained in order to timely issue the new compliant notice.

For Notices concerning new applications for eligibility or requests for new services, the Hearing Officer may issue a decision remanding the Notice to the entity that issued it and order that, within a reasonable period determined by the Hearing Officer, a new compliant Notice be issued to the member on the same eligibility application or service authorization request. If the Agency/contractor requires additional information to process the application or service authorization request, they must ensure that the information is requested and obtained in order to timely issue the new compliant notice. Alternatively, the appellant will be given the option to waive the deficient notice and continue with the State Fair Hearing process.

M1660.100 SCHEDULING THE HEARING

A. Scheduling and Location

The Hearing Officer will select a date and time for the hearing. Typically, hearings are scheduled at least three weeks in advance.

Hearings will be *conducted by telephone* unless the appellant requests a face-to-face hearing. Appellants may request to participate in their hearing at the local Agency rather than appearing telephonically.

Hearings regarding actions taken *by other agents* or contractors will be conducted telephonically.

B. Confirmation Letter

The schedule letter is mailed to the appellant and representative, and a copy is *provided* to the Agency *via the Appeals Information Management System Portal.*

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The schedule letter contains information about summary due dates and other pertinent information.

If the Agency representative cannot be available on the date and time selected by the Hearing Officer, he/she must notify the DMAS Appeals Division as soon as possible and request an alternate date and time for the hearing.

M1670.100 AGENCY APPEAL SUMMARY

A. Agency Appeal Summary Form

Upon notification that a fair hearing has been requested, the Agency must complete an Agency Appeal Summary. There is a form for the Agency Appeal Summary (form #032-03-805) available on Fusion.

When preparing the Agency Appeal Summary, the Agency must consider all documents submitted up until that point, even if the information/documents were submitted for the first time during the appeal process, as discussed below at M1680.100 (A)(5). The Agency Appeal Summary must thoroughly explain the facts, policy, and other relevant information that support the Agency's position on the appeal. The Agency must submit all documents relevant to the Agency's determination with the Agency Appeal Summary.

If new documentation submitted by the appellant during the appeals process would not result in a finding of *medical assistance* eligibility, then the Agency or Contractor must produce an appeal summary explaining why the new documentation did not result in a finding of eligibility and should attend the hearing prepared to explain why the Agency or Contractor maintains its position on the appeal.

B. Send to Appeals Division and Appellant

The Agency must *transmit* one copy of the Agency Appeal Summary and all relevant documentation to the following parties by the due date specified by the Appeals Division at the time of the notification *and in the following manner:*

- Department of Medical Assistance Services, Appeals Division - Electronically via the *Appeals Information Management System* at portal at www.dmas.virginia.gov/appeals. Use of the *Appeals Information Management System* portal is the *required* method for filing the appeal summary with DMAS.

- The appellant or their authorized representative, if the appellant has designated a representative for the appeal, *via U.S. Mail.*

The Agency must keep a copy of the Agency Appeal Summary and all relevant documentation, including applications, notices, and DMAS appeal decisions for its records.

C. Deadline for Submission

In most cases, the Agency Appeal Summary must be submitted to the DMAS Appeals Division and the appellant or their authorized representative within 21 days after the Agency or Contractor is notified of the appeal. The only exception is when the Appeals Division certifies an expedited appeal.

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Manual Title	Chapter	Page Revision Date	
Virginia Medical Assistance Eligibility	**M16**	**July 2023**	
Subchapter Subject	Page ending with		Page
M16 APPEALS PROCESS	**M1680.100**		**10**

C. Deadline for Submission

In most cases, the Agency Appeal Summary must be submitted to the DMAS Appeals Division and the appellant or their authorized representative within 21 days after the Agency or Contractor is notified of the appeal. The only exception is when the Appeals Division certifies an expedited appeal.

M1680.100 THE HEARING PROCEDURE

A. Hearing Procedure

The hearing will be conducted in an informal manner. Formal rules of evidence do not apply in these proceedings. The appellant is entitled to guarantees of fair hearings established in Goldberg v. Kelly, 397 US 245 (1970). The proceedings will be governed by the following rules:

1. Record

The Hearing Officer will swear-in all hearing participants who will be presenting evidence or facts and will record the hearing proceedings.

2. Appellant

The appellant will present their own case or have it presented by an authorized representative. They will be allowed to bring witnesses, establish all pertinent facts and circumstances, advance any testimony or evidence, and question witnesses called on their own behalf and by the Agency.

3. Agency Representatives

The worker at the Agency who took the action being appealed and/or the worker's supervisor should be present at the hearing, and must be prepared to explain the Agency's action. The Agency may be represented by its county or city attorney. The Agency has the authority to ask its county or city attorney to attend the hearing.

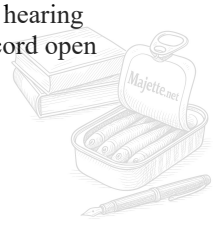
When the action being appealed is a disability decision made by the DDS, a representative from DDS must be present at the hearing. When the action being appealed is a denial of a medical or dental covered service, a representative from DMAS or its contractor who made the decision must be present at the hearing.

4. Opportunity to Examine Documents

The appellant or their representative must be given the opportunity to examine all documents and records to be used at the hearing, at a time before the hearing or during the hearing. Copies of case record information must be made available free of charge to the appellant at their request.

5. De Novo Hearing

The DMAS state fair hearing is a de novo hearing in front of a DMAS Hearing Officer. That means that the DMAS Hearing Officer will issue an entirely new determination based upon all relevant evidence that the appellant offers during the appeal process. This includes evidence that may not have been available to the Agency or Contractor at the time the appealed eligibility determination was made. The DMAS Hearing Officer will review all information that was submitted for the initial eligibility determination, as well as any additional documentation and testimony that is submitted during the appeal process. Appellants who wish for additional documentation to be reviewed may submit it with their appeal request, prior to the scheduled hearing, during the hearing itself, or after the hearing if the Hearing Officer agrees to hold the record open for submission of additional documentation.



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Further, a de novo hearing is a hearing that starts over from the beginning. This means the Hearing Officer must allow the appellant to develop the record fully. The record will consist of any relevant evidence, documentation, and testimony, regardless of whether it was available at the time of the adverse determination. The Hearing Officer's decision will be based solely on the record developed during the de novo hearing process, and it will include an explanation of how the facts apply to the relevant laws, regulations, and policies.

Agencies and Contractors will receive a copy of any new documentation that has been submitted to the DMAS Appeals Division during the appeal process to determine whether it is possible to approve MA coverage. If the Agency or Contractor receives new documentation from the appellant independently during the appeal process, copies of such documentation must be sent to the DMAS Appeals Division. The Agency or Contractor can use new documentation to determine that the appellant is eligible for coverage. If the Agency or Contractor determines that the appellant is eligible, then they shall issue a new *Notice of Action* and provide it to all parties to the appeal. The Hearing Officer must then decide whether it is appropriate to resolve the appeal based upon the new *Notice of Action.*

If the new documentation submitted by the appellant would not result in a finding of MA eligibility, then the Agency or Contractor must produce an appeal summary explaining why the new documentation did not result in a finding of eligibility and must attend the hearing prepared to explain why the Agency or Contractor maintains its position on the appeal.

After the hearing, the DMAS Hearing Officer will issue a decision as to whether or not the appellant is approved for coverage based upon all of the documentation, evidence, and testimony provided by the appellant and the Agency or Contractor.

B. Hearing Officer Evaluation and Decision

1. Evaluation

Following the hearing, the Hearing Officer will prepare a decision taking into account the Agency Appeal Summary, evidence provided by the appellant or their representative, testimony, and additional information provided by the parties. The Hearing Officer will evaluate all evidence, research laws, regulations and policy, and will decide if the applicant or recipient is approved for coverage.

2. Hearing Officer Decision

Examples of the Hearing Officer's decisions include:

a. Sustain

When the Hearing Officer's decision is consistent with the Agency's action, the decision is "sustained."



b. Reverse

When the Hearing Officer's decision overturns the Agency's action, including when the Hearing Officer finds the appellant eligible for Medical Assistance under the de novo hearing process, the decision is "reversed."

c. Remand

When The Hearing Officer sends the case back to the Agency for additional evaluation, the decision is "remanded." The Hearing Officer's decision will include instructions that must be followed when completing the remand evaluation.

3. Failure to Provide Requested Information

If the Agency denies an application or terminates coverage because of failure to provide requested information, the Hearing Officer can hold the hearing record open for a period of time to allow the appellant to submit additional information to receive a de novo eligibility determination. The Hearing Officer may decide to reconvene the hearing if appropriate.

C. Local Agency Action

The decision of the Hearing Officer is the final administrative action taken on the appeal. The local Agency or Contractor must comply with the Hearing Officer's decision.

1. Agency Action - Sustained Cases

If the Hearing Officer's decision is to sustain the Agency's action, and coverage was continued during the appeal process, the case must be closed without an additional notice to the enrollee from the Agency. The Hearing Officer's decision letter to the appellant is the appropriate official notice of cancellation.

2. Agency Action - Remanded Cases

The Agency must take action to close the case in the Medicaid system using cancel reason "015" effective the date the Agency receives the decision.

a. Do Not Send Documents to Hearing Officer

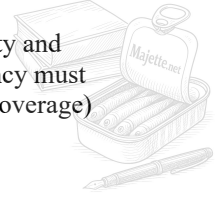
If the Hearing Officer's decision is to remand the case to the local Agency, the local Agency must not send documentation of the evaluation or a copy of the remand notice to the Hearing Officer.

b. Enrollment Actions

If the Hearing Officer's decision is to remand the case for further evaluation and coverage was continued during the appeal process, coverage must be continued until the local Agency completes the evaluation and makes a new decision.

If the remand evaluation results in the appellant's continuous eligibility, the Agency must notify the appellant in writing of their continuing eligibility for coverage.

If the remand evaluation results in the appellant's continuous eligibility and coverage was not continued during the appeal process, the local Agency must reinstate coverage back to the original termination date (no break in coverage) and notify the appellant of their continued eligibility.



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If the remand evaluation results in the appellant's ineligibility and coverage was continued during the appeal process, the enrollee's coverage must be canceled at the completion of the evaluation, and the appellant must be notified in writing.

c. **Take Action in 30 or 45 Days**

The Agency must complete the remand evaluation within 30 days or 45 days according to the Hearing Officer's instructions in the decision.

Agency Action-Reversed Cases

Following a Hearing Officer's decision to reverse an Agency's action to deny, reduce, or terminate coverage, the Agency must reinstate coverage retroactive to the date of closure or month of application (including retroactive coverage months, if applicable) according to the Hearing Officer's instructions in the decision.

M1690.100 RECOVERY OF BENEFITS PAID DURING APPEAL

A. Applicable Circumstances

The Medicaid Program may recover expenses paid on behalf of appellants whose Medicaid coverage was continued during the appeal process, when the Agency's proposed action is upheld by the Hearing Officer.

DMAS will be responsible for recovering these expenses from the appellant, not the service provider. The appellant will be notified, after the hearing decision is made, of how much money if any is owed to the Medicaid Program.

B. Recovery Period

Medicaid expenditures for services received from the original effective date of the proposed adverse action (as stated on the notice) until the actual cancellation of Medicaid coverage or payment will be recovered.

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CHAPTER M20

EXTRA HELP - MEDICARE PART D LOW-INCOME SUBSIDY

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M20 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-31	4/1/24	Page 1
TN #96	10/1/11	Table of Contents pages 1, 2 Pages 3-18 and Appendices 1-9 were removed.
Update (UP) #3	3/01/10	Table of Contents, page ii Appendix 3, page 1
TN #93	1/1/10	Table of Contents, page ii pages 3, 5, 6, 7, 10, 11, 15 Appendix 1, page 1 Appendix 2, page 1 Appendix 3, page 1 Appendix 4, page 1

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Manual Title	Chapter	Page Revision Date	
Virginia Medical Assistance Eligibility	**M20**	**October 2011**	
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	Section	Page
Extra Help General Information	**M2010.100**	**1**

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Manual Title	Chapter	Page Revision Date	
Virginia Medical Assistance Eligibility	**M20**	**April 2024**	
Subchapter Subject	Page ending with		Page
M20 – EXTRA HELP	**M2010.100**		**1**

M2000.000 EXTRA HELP - MEDICARE PART D LOW-INCOME SUBSIDY

M2010.100 EXTRA HELP GENERAL INFORMATION

A. Introduction

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173) amended Title XVIII of the Social Security Act by establishing Medicare Part D, the Voluntary Prescription Drug Benefit Program for individuals who are entitled to Medicare Part A and/or enrolled in Medicare Part B.

B. Medicaid and Medicare Part D Prescription Drug Coverage

For the purposes of Medicare Part D, individuals who are eligible for both Medicare and Medicaid benefits are considered dually eligible. Effective January 1, 2006, Medicaid does not provide prescription drug coverage for dually eligible individuals. These individuals receive their prescription drug coverage through Medicare Part D. Medicaid will only cover prescription medication that cannot be covered by Medicare under the MMA, including some controlled medications.

Medicare beneficiaries who are not eligible for Medicaid and who choose to participate in Medicare Part D are subject to cost-sharing obligations, including monthly premiums, deductibles, and copayments.

C Extra Help Low Income Subsidy

Extra Help is the subsidy provided under Medicare Part D that reduces out-of-pocket expenses for Medicare Part D enrollees who, based on their income and resources, are determined to be low-income. Extra Help is the public name for the subsidy program; the Social Security Administration (SSA) generally refers to the subsidy as Low-Income Subsidy (LIS) in its contacts with state Medicaid programs. *As of January 1, 2024, there is only one level of the LIS* - the full subsidy. The individual's income and resources determine *eligibility for* the subsidy.

1. Dually Eligible Individuals Have Full LIS – No Premiums, Deductibles or Copays

Dually eligible individuals are automatically eligible for the full LIS and are enrolled using data matches from the Department of Medical Assistance Services (DMAS) and the Centers for Medicare and Medicaid Services (CMS). Under the full LIS, dually eligible individuals have no Medicare Part D premiums, deductibles, or threshold costs. All dually eligible individuals except those in nursing facilities have copayments ranging from $1 to $5 per prescription.

2. Non Dually Eligible Individuals

Medicare beneficiaries who are not eligible for Medicaid must apply for the subsidy and be determined eligible in order to receive assistance with their Medicare Part D cost-sharing obligations. More information about the benefits available under the LIS for non-dually eligible individuals is available on-line at *Apply for Medicare Part D Extra Help program | SSA*.

D. LIS Medicaid Applications

Effective January 1, 2011, all applications for the Extra Help LIS made to SSA are also considered applications for Medicaid. The SSA transmits data on all LIS applicants residing in Virginia to the Virginia Department of Social Services. A pre-populated Application for Adult Medical Assistance is generated by the Medicaid LIS system for individuals who are not currently enrolled in Medicaid and transmitted to the appropriate local agency. See M0120.300 B.10 for additional information about LIS Medicaid applications.

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Manual Title	Chapter	Page Revision Date
Virginia Medical Assistance Eligibility	**M20**	**October 2011**
Subchapter Subject	Page ending with	Page
M20 – EXTRA HELP	**M2010.100**	**2**

E. Extra Help LIS Eligibility for Non Dual Eligibles

Individuals who are not dually eligible and *not* automatically eligible for the LIS may be eligible for the LIS if all of the following are met:

- he is a resident of the United States,
- he is entitled to Medicare Part A and/or enrolled in Medicare Part B,
- he and his spouse, if married and living together, have countable income less than 150% of the federal poverty level (FPL) for his assistance unit size,
- he, and his spouse if married, has countable resources within the limits *for the LIS,* and
- he resides in the service area of a Part D prescription drug plan (service area does not include facilities in which individuals are incarcerated but otherwise covers the 50 States, District of Columbia, and U.S. Territories).

F. *LDSS Responsibilities*

The MMA mandates that eligibility for the Extra Help LIS can be determined by both the Social Security Administration (SSA) and the states. The local department of social services (LDSS) may also assist an individual with applying for Extra Help from the SSA in several ways, such as helping complete and/or submit the subsidy application directly to SSA, referrals to the SSA toll-free helpline, and helping to complete the on-line SSA application form. When the LDSS assists the individual with the application but does not determine eligibility, the LDSS does not have responsibility for the case.

1. Individual Requests LDSS Determine LIS Eligibility

If an individual requests that the LDSS determine his eligibility for Extra Help, inform the individual that, when the Social Security Administration determines eligibility for Extra Help, the SSA is able to verify most income and resources ***without*** *requesting documentation from the individual. Indicate that assistance with completing the application for the Extra Help LIS can also be provided by the SSA.*

2. LDSS Responsibility for LIS Applications

LDSS must determine eligibility for the LIS only in situations where an individual specifically requests that the agency do so. If such a request is made, the LDSS must comply with the request and must:

- determine eligibility,
- enroll the recipient if eligible,
- provide notice,
- participate in appeals,
- comply with reporting requirements, and
- provide ongoing case maintenance, including notices, appeals, and redeterminations, unless the applicant is later found to be deemed eligible for Extra Help or has been found eligible by SSA.

If the LDSS is required to determine an individual's eligibility for the LIS, contact a regional Medical Assistance Program Consultant for additional instructions.



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Cheryl Roberts
DIRECTOR

Department of Medical Assistance Services

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800/343-0634 (TDD)
www.dmas.virginia.gov

December 1, 2025

Virginia Medical Assistance Eligibility Manual Transmittal
DMAS-37

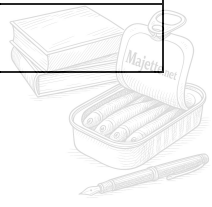
The following acronyms are contained in this letter:

- COLA – Cost of Living Increase
- DMAS – Department of Medical Assistance Services
- LIFC – Low Income Families & Children
- MA – Medical Assistance
- MSP – Medicare Savings Plan
- NBD – Non-Blind/Disabled
- PMA – Personal Maintenance Allowance
- SSI – Supplemental Security Income
- TN – Transmittal

TN #DMAS-37 includes policy clarifications, updates and revisions. Unless otherwise noted in the Cover Letter and/or policy, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after January 1, 2026.

The following changes are contained in TN #DMAS-37:

Changed Sections	Changes
M0120.500 C. 2.	Updates procedure to make a coverage correction request and removes the enrollment email address.
M0130.300 D.3.	Updates procedure to make a coverage correction request and removes the enrollment email address.
M0320	Update COLA and Medicare changes for 2026
M0410.100 M0430.400 M0450.300	Correct examples to reflect that LIFC pregnant individuals count as a household of two (including the unborn child).
M0530	Update the NBD allocation, parental living allowance and deeming standard for 2026
M0810	Update SSI amounts for 2026.



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Subchapter M0820	Update Student Earned Income Exclusion for 2026.
Subchapter M1110	Update the MSP resource limits for 2026.
Subchapter M1460	Update the home equity limit and Student Earned Income Exclusion for 2026.
Subchapter M1470	Update the PMA and the Special Earnings Allowance for 2026
Subchapter M1480	Update the home equity limit, the spousal resource standards, the maximum monthly maintenance needs allowance, the personal maintenance allowance, and the special earnings allowance for 2026.
M1510.107	Updates procedure to make a coverage correction request and removes the enrollment email address.

Please retain this TN letter for future reference. Should you have questions about information contained in this transmittal, please contact Sara Cariano, Director, DMAS Eligibility Policy & Outreach Division, at sara.cariano@dmas.virginia.gov or (804) 229-1306.

Sincerely,

Sarah Hatton

Sarah Hatton, M.H.S.A.
Deputy of Administration and
Coverage

Attachment

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M0120 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Page 17
TN #DMAS-36	10/1/25	M0120.100
TN #DMAS-35	7/1/25	Pages 2 and 5
TN #DMAS-30	1/1/24	Page 17
TN #DMAS-25	10/1/22	Page 7
TN #DMAS-23	4/1/22	Pages 9, 10, 16, 17, 19
TN #DMAS-18	1/1/21	Pages 11, 17 Page 12 is a runover page. Page 12a was added as a runover page.
TN #DMAS-17	7/1/20	Pages 2, 2a, 5, 7, 8, 13, 16 Page 6 is a runover page. Page 14 was removed. Pages 15-20 were renumbered.
TN #DMAS-14	10/1/2019	Pages 7, 10, 11, 18 Page 20a was deleted.
TN #DMAS-12	4/1/19	Pages 2, 12-13,15, 20a
TN #DMAS-10	10/1/18	Pages 2, 4, 15, 17-20 Page 20a was added as a runover page.
TN #DMAS-8	4/1/18	Page 12
TN #DMAS-6	10/1/17	Page 1
TN #DMAS-5	7/1/17	Page 2a
TN #DMAS-4	4/1/17	Pages 2a, 7, 10, 13
TN #DMAS-3	1/1/17	Page 15
TN #DMAS-2	9/1/16	Pages 2, 15 Page 2a is a runover page.
TN #DMAS-1	6/1/16	Pages 7, 10, 11, 16-20
TN #100	5/1/15	Table of Contents Pages 1, 2, 15, 20 Page 2a and 16 are runover pages.
UP #10	5/1/14	Table of Contents Pages 11, 16-18 Pages 11a and 11b were deleted. Pages 19 and 20 were added.
TN #99	1/1/14	Page 11 Pages 11a and b were added.
TN #98	10/1/13	Table of Contents Pages 1-17
UP #9	4/1/13	Page 13, 15, 16
UP #7	7/1/12	Pages 1, 10-12
TN #96	10/1/11	Table of Contents Pages 6-18
TN #95	3/1/11	Pages 1, 8, 8a, 14
TN #94	9/1/10	Pages 8, 8a
TN #93	1/1/10	Pages 1, 7, 9-16
Update (UP) #1	7/1/09	Page 8
TN #91	5/15/09	Page 10

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(AC 035) is limited to outpatient prenatal services; labor and delivery are not covered under HPE for AC 035. HPE coverage for Plan First enrollees AC084 is limited to family planning services only. Transportation to receive covered medical services is covered for all HPE enrollees.

Enrollment as HPE is limited to one HPE period per calendar year for all individuals other than pregnant women. For pregnant women, enrollment is limited to one HPE eligibility period per pregnancy. Children's 12 month continuous eligibility does not apply to children enrolled as HPE.

There are no appeal rights for an HPE determination.

1. Eligibility Procedures – Post HPE Enrollment

a) MA Application Not Submitted

If the person does not submit an MA application prior to the end of the HPE coverage period, no further worker action or additional notice not required because the enrollment was for a closed period of coverage.

b) MA Application Submitted

For MA coverage to continue beyond the initial HPE coverage period, the individual must submit a full MA application. MA applications submitted by HPE enrollees are subject to the standard eligibility and entitlement policies. The 7-calendar day processing standard applies to MA applications submitted by pregnant women. The 10-work day requirement applies to applications submitted by BCCPTA individuals enrolled in HPE.

While the LDSS does not determine eligibility for HPE, if an MA application is received and pended in VaCMS, the individual's coverage in the HPE AC may need to be extended or reinstated (if HPE coverage will end during the application processing period) while the application is processed. If HPE coverage needs to be extended/reinstated, alert a VDSS Regional Consultant or *submit a* Coverage Correction Request *through the Coverage Correction Portal (CCP) on the MES website.*, *Home | MES*. *To access the CCP and User Guides, LDSS, VDSS, CoverVA, and DMAS staff must sign into the MES using their current credentials and then sign into the MMIS with their eCode. The enrollment mailbox has been disabled.*

Example 1: Mary Smith is enrolled in HPE coverage in AC 065 (LIFC) for the period of 3-5-18 through 4-30-18. On 4-20-18, she submits an MA application; however, the 45th processing day will fall after the HPE end date of 4-30-18. Therefore, the worker must have the HPE coverage reinstated in *MES* under the same aid category (AC 065), using the MA application date. The effective date of the reinstatement is 5-1-18, the day after the HPE coverage ends. Once the application has been processed. the worker must act to cancel the HPE coverage, and if the individual remains eligible reinstate coverage in the appropriate AC.

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M0130 Changes
Page 2 of 2

Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Page 12
TN #DMAS-36	10/1/25	M0130.500
TN #DMAS-35	7/1/25	Pages 1, 9, 10 and 15
TN #DMAS-34	1/1/25	Page 9
TN #DMAS-33	10/1/24	TOC, Pages 1, 6, 6a, 12-14 Page 15 is added.
TN #DMAS-32	7/1/24	Pages 9 and 10
TN #DMAS-29	10/1/23	Page 12
TN #DMAS-27	4/1/23	Page 6a
TN #DMAS-25	10/1/22	Pages 9,10
TN #DMAS-23	4/1/22	Pages 5, 12
TN #DMAS-21	10/1/21	Page 14
TN #DMAS-20	7/1/21	Page 2 Page 2a is a runover page.
TN #DMAS-18	1/1/21	Pages 4, 8, 13

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Manual Title	Chapter	Page Revision Date	
Virginia Medical Assistance Eligibility	**M01**	**January 2026**	
Subchapter Subject	Page ending with		Page
M0130 APPLICATION PROCESSING	**M0130.300**		**12**

D. Application Disposition

1. General Principle

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

If an applicant dies during the application process, his eligibility can only be established for the period during which he was alive.

If an applicant (other than a Medicare beneficiary, HPE, or deceased individual) is ineligible for MA for any reason other than the inability to determine eligibility, a referral to the VIM must be made so that his eligibility for the APTC in conjunction with a Qualified Health Plan (QHP) can be determined. Individuals who have Medicare, who are incarcerated, who are enrolled as HPE, and deceased individuals and are not referred to the VIM.

2. Entitlement and Enrollment

a. Entitlement

Entitlement to medical assistance is based on the application month. However, entitlement cannot begin prior to an individual's date of birth, and cannot continue after an individual's date of death. See section M1510.100 for detailed entitlement policy and examples.

If applicants indicate that they have been receiving MA (Medicaid or Children's Health Insurance Program) coverage in another state prior to moving to Virginia, instruct them to contact the eligibility worker there and request that the coverage be cancelled, if they have not already done so. Individuals are no longer considered residents of the other state once they have moved to and intend to reside in Virginia and are not entitled to receive services paid for by the other state's MA program. Enrollment may begin with the month of application or the earliest month in the application's retroactive period that they met the residency requirement per M0230.

b. Enrollment

MA enrollees must be enrolled in the MES, either through the system interface with the eligibility determination system or by submitting a coverage correction *request through the Coverage Correction Portal (CCP) on the MES website., Home | MES*.

Note: The MES was implemented in April 2022. Prior to April 2022, the Medicaid Management Information System (MMIS) was used for enrollment and claims processing. References to MMIS in the Medical Assistance Eligibility Manual will be updated as other policy revisions are made.

When an individual who does not have Medicare is eligible for only limited MA benefits, such as Plan First, a referral to the VIM must be made so that eligibility for the APTC in conjunction with a QHP can be determined.

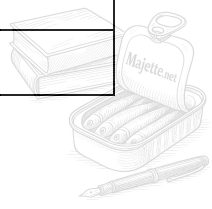
3. Notification to Applicant

Either a Notice of Action generated by the eligibility determination system or the equivalent form #032-03-006 (available at the DSS Fusion website) must be used to notify the applicant of the specific action taken on the application. The notice must be sent to the authorized representative, if one has been designated.



M0320 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Page 11
TN #DMAS-35	7/1/25	Sections .400 and .500
TN #DMAS-34	1/1/25	Pages 11, 27, 32, 34 Pages 32a and 34a are added
TN #DMAS-33	10/1/24	Pages 1, 5, 27, 37
TN #DMAS-32	7/1/24	Pages 24-26a, 29
TN #DMAS-29	10/1/23	Pages 1, 25, 26, 26a, 27, 28
TN #DMAS-27	4/1/23	Pages 11, 24, 25, 27
TN #DMAS-26	1/1/23	Page 11
TN #DMAS-24	7/1/22	Pages 2, 30, 31, 33
TN #DMAS-23	4/1/22	Page 27
TN #DMAS-22	1/1/22	Pages 11, 26a, 27
TN #DMAS-20	7/1/21	Pages 24, 26-29
TN #DMAS-19	4/1/21	Pages 26a, 29
TN #DMAS-18	1/1/21	Pages 11, 22, 26, 27
TN #DMAS-17	7/1/20	Pages 24. 25. 26, 27 Page 26a was added as a runover page.
TN #DMAS-15	1/1/20	Pages 11, 26, 27, 29
TN #DMAS-14	10/1/19	Page 40
TN #DMAS-13	7/1/19	Pages 1, 24-27
TN #DMAS-11	1/1/19	Pages 2a, 11, 35, 37
TN #DMAS-10	10/1/18	Page 1; 1a added as a runover page
TN #DMAS-9	7/1/18	Page 2, 17
TN #DMAS-7	1/1/18	Page 2, 3, 4, 11, 26-27.
TN #DMAS-4	4/1/17	Page 26
TN #DMAS-3	1/1/17	Pages 11, 27, 29, 40, 41, 44, 45, 52
TN #DMAS-2	10/1/16	Pages 4, 15, 16, 18, 20, 22, 30, 33, Pages 39- 41, 43-45, 48, 51, 52, 55
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 1, 11, 25-27, 46-49;Page 50 is a runover page.
TN #100	5/1/15	Pages 6, 11, 24, 25-27, 29-30
TN #99	1/1/14	Page 11
TN #98	10/1/13	Pages 1, 54, 55.
UP #9	4/1/12	Pages 11, 26, 32, 34-37, 45, 46, 55
TN #97	9/1/12	Table of Contents; Pages 1-56 (all pages)
UP #6	4/1/12	Pages 11, 12, 46a
TN #96	10/1/11	Table of Contents; Pages 46f-50b; Page 50c deleted
TN #95	3/1/10	Pages 11, 12, 42c, 42d, 50, 53, 69 Pages 70, 71; Page 72 added.
TN #94	9/1/10	Pages 49-50b
UP #3	3/1/10	Pages 34, 35, 38, 40, 42a, Pages 42b, 42f
TN #93	1/1/10	Pages 11-12, 18, 34-35, 38 Pages 40, 42a-42d, 42f-44, 49 Pages 50c, 69-71
UP #2	8/24/09	Pages 26, 28, 32, 61, 63, 66
Update (UP) #1	7/1/09	Pages 46f-48
TN #91	5/15/09	Pages 31-34 Pages 65-68



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Note: There was no COLA in 2010, 2011 or 2016.

The Cost-of-living calculation formula
(The formula is the current Title II Benefit divided by the percentage increase to equal the benefit amount before the COLA change):

a. *Current Title II Benefit = Benefits before 1/25 COLA*
2.8% (1/25 increase)
b. Current Title II Benefit= Benefit Before 1/24 COLA
2.5% (1/24 Increase)
c. Current Title II Benefit= Benefit Before 1/23 COLA
3.2% (1/23 Increase)
d. Current Title II Benefit = Benefit Before 1/22 COLA
1.059 (1/22 Increase)
e. Benefit Before 1/22 COLA = Benefit Before 1/21 COLA
1.013 (1/21 Increase)
f. Benefit Before 1/21/ COLA = Benefit Before 1/20 COLA
1.016 (1/20 Increase)

5. Medicare Premiums

a. Medicare Part B premium amounts:

1-1-26 $202.90
1-1-25 $185.00
1-1-24 $174.70
1-1-23 $164.90
1-1-22 $170.10

Note: These figures are based on the individual becoming entitled to Medicare during the year listed. The individual's actual Medicare Part B premium may differ depending on when he became entitled to Medicare. **Verify the individual's Medicare Part B premium in SVES or SOLQ-I if it is necessary to know the premium amount for Medicaid eligibility or post-eligibility purposes.**

b. Medicare Part A premium amount:

1-1-26 $565.00
1-1-25 $518.00
1-1-24 $505.00
1-1-23 $506.00
1-1-22 $499.00

Contact a Medical Assistance Program Consultant for amounts for years prior to *2022.*

6. Evaluation

Individuals who are eligible when a cost-of-living increase is excluded are eligible.

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TN #DMAS-37	1/1/26	Pages 2, 13, 30, 31
TN #DMAS-35	7/1/25	Page 4, 14, 15, 20, 33; Appendices 3, 5, 8
TN #DMAS-34	1/1/25	Pages 16a and 16b, Appendix 1,2,6,7
TN #DMAS-33	10/1/24	Appendix 2
TN #DMAS-32	7/1/24	Pages 2, 4, 5, 8, 16, 16b2, 21, 33, 34, 34a Appendices 3, 5 and 8
TN #DMAS-31	4/1/24	Pages 15 and 16a; Appendices 1, 2, 6 and 7
TN #DMAS-30	1/1/24	Pages 1, 34 Page 34a is a runover page
TN #DMAS-28	7/1/23	Page 37 Appendices 1,2,3,5,6 and 7

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- has no resource test (Exception: MAGI Adults requesting coverage of Long-Term Care services are subject to certain asset/resource requirements)

2. MAGI Rules

- MAGI has an income disregard equal to 5% of the federal poverty level (FPL) for the Medicaid or FAMIS individual's household size. The disregard is only given if the individual is not eligible for coverage due to excess income. It is applicable to individuals in both full-benefit and limited-benefit covered groups.
- If the individual meets multiple Medicaid covered groups (and/or FAMIS) his gross income is compared first to the income limit of the group with the highest income limit under which the individual could be eligible.
- If the income exceeds the limit, the 5% FPL disregard can be allowed, and the income again is compared to the income limit.
- When considering tax dependents in the tax filer's household, the tax dependent may not necessarily live in the tax filer's home.
- Under MAGI counting rules, an individual may be counted in more than one household but is only evaluated for eligibility in his household.
- Use non-filer rules when the household does not file taxes.
- Use non-filer rules when the applicant is claimed as a tax dependent by someone outside the applicant's household.
- Non-filer rules may be used in multi-generational household.

3. Eligibility Based on MAGI

MAGI methodology is used for eligibility determinations for insurance affordability programs including Medicaid, FAMIS, the Advance Premium Tax Credit (APTC) and cost sharing reductions through the Health Insurance Marketplace for the following individuals:

a. Children under 19

b. Parent/caretaker relatives of children under the age of 18 - Low Income Families With Children (LIFC)

c. Pregnant individuals, including *LIFC,* FAMIS MOMS and FAMIS Prenatal Coverage

d. Individuals Under Age 21

e. Adults between the ages of 19 and 64 not eligible or enrolled in Medicare (effective January 1,2019)

f. Individuals in Plan First.

4. Eligibility NOT Based on MAGI

MAGI methodology is NOT used for eligibility determinations for: individuals for whom the eligibility worker is not required to make an income determination:

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A. Two Parents Not Married To Each Other, Both File Taxes; 1 Child-In-Common, One Child Not In Common; Mom Is Pregnant

Jill and Max are both tax filers. Also in the home are Max's son, Mark and their child-in-common, May. Jill is pregnant, expecting 1 baby. Max claims both children on his taxes. All applied for MA.

Jill is a tax filer who claims no additional dependents. Her MAGI household is the same as her tax household for Medicaid coverage in the LIFC covered group and includes her unborn child when determining her eligibility as a pregnant woman. Max is a tax filer with two dependent children; his MAGI household is the same as his tax household. Mark is a tax dependent living with his tax filer parent and no exceptions exist; his MAGI household is the same as the tax household. May is a tax dependent, but her parents are not filing jointly so an exception exists and non-filer rules are used for her MAGI household.

The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Jill	2 – Jill and 1 unborn	Tax-filer pregnant woman; no other dependents
Max	3 – Max, Mark and May	Tax filer and two dependent children
Mark	3 – Mark, Max and May	Tax filer rules, tax household rules for person filing for him
May	4 – May, Max, Jill and Mark	Non-filer rules child with parents not filing jointly, non-married parents and half sibling.

B. Tax Filer, Spouse, Their Child, His Child Not Living In the Home

Gerry and Bree are married and file their taxes jointly. Also in the home is their son, Tad age 7, whom they claim as their dependent. They also claim Gerry's daughter, Tansy age 10, who does not live with them. Gerry, Bree and Tad applied for MA.

Gerry and Bree are tax filers who are married, filing jointly claiming two dependent children. Their MAGI household is the same as their tax household.

Tad is a tax dependent child and no tax dependent exceptions exist; Tad's MAGI household is the same as the tax household. The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Gerry	4 – Gerry, Bree, Tad and Tansy	Tax filers and dependent children
Bree	4 – Gerry, Bree, Tad and Tansy	Tax filers and dependent children
Tad	4 – Gerry, Bree, Tad, Tansy	Tax filer and dependents

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A. Example #2 Non Tax Filer Three Generation Household (Using Jan. 18, 2018 figures)

Sally Green is age 64, a grandmother who does not expect to file taxes this year. She is neither blind or disabled. She lives with her daughter Jane, age 20 and a full-time student, and her granddaughter Dee (Jane's daughter), age 2. Sally takes care of Dee while Jane is attending school and working at her part-time job. Jane is pregnant with 1 unborn. They live in Hanover, a Group I locality. Sally doesn't have Medicare.

Income:
Sally receives SSA widow's benefits of $1,000 per month.

Jane earns $300 per month or $3,600 annually and is not required to file taxes.

The MAGI non-filer households are:

Person	# - Household Composition	Reason
Sally	1 – Sally	Non-filer grandmother
Jane (PG)	3 – Jane, Jane's unborn child & Dee	Non-filer, her unborn child & non-filer's child < 19
Dee	2 – Dee, Jane	Non-filer child < 19 & non-filer child's parent

Sally's eligibility determination:
Potential covered groups: Plan
First
MAGI Adult
Monthly Income limits:

MAGI Adult income limit for HH of 1=$1,346
Plan First 200% FPL income limit for HH of 1 = $2,024
5% FPL for 1 = $51

HH gross monthly income = $1,000 Sally's SSA benefits
Her gross income of $1,000 is less than the MAGI Adult limit of $1,346 for 1. Sally is eligible for full coverage in the MAGI Adult coverage group.

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Jane's eligibility determination:

Potential covered groups: LIFC
MAGI Adult
Medicaid Pregnant Women

Monthly Income limits:
LIFC, Group I for HH of 3 = $381
Pregnant Women 143% FPL for a HH of 3 = $2,477 MAGI Adult income limit for HH of 3=$2,391
5% FPL for 3 = $86

HH monthly income = $300 Jane's income.

Jane is over age 19, not a child and not counted as a dependent for anyone else. Jane's earnings must be counted even though she is not required to file taxes. As her mother (Sally) is not in Jane's tax filing HH, Sally's income is not counted when determining Jane's eligibility. The HH would consist of Jane, *her unborn child* and her daughter Dee.

$300 is less than the LIFC limit for 3 ($381) so the 5% disregard is not applied (it is not necessary). Jane is eligible for Medicaid in the LIFC covered group.

If Jane had been over income for the LIFC covered group, the step to apply the 5% disregard would have been used. If she was found over the LIFC income limit, a review as a Medicaid Pregnant Woman 143% income limit would have been used.

Dee's eligibility determination:

Potential covered groups: Child
< Age 19
FAMIS

Monthly Income limits:
Child < Age 19 143% FPL for a HH of 2 = $1,962 FAMIS, 200% FPL for HH of 2 = $2,585
5% FPL for 2 = $65

HH monthly income:
$300 (Jane's gross earnings)

As HH income $300 is less than the Medicaid Child < Age 19 143% FPL income limit for 2 ($1,962), Dee is eligible for Medicaid. The 5% disregard is not necessary since she qualified in this aid category.

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M0530 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Appendix 1, page 1
TN #DMAS-34	1/1/25	Appendix 1, page 1
TN #DMAS-31	4/1/24	Appendix 1, page 1
TN #DMAS-26	1/1/23	Appendix 1, page 1
TN #DMAS-22	1/1/22	Appendix 1, page 1
TN #DMAS-18	1/1/21	Appendix 1, page 1
TN #DMAS-15	1/1/20	Appendix 1, page 1
TN #DMAS-11	1/1/19	Appendix 1, page 1
TN #DMAS-8	4/1/18	Appendix 1, page 1
TN #DMAS-6	10/1/17	Pages 2, 24, 30
TN #DMAS-3	1/1/17	Appendix 1, page 1
TN #DMAS-2	10/1/16	Pages 23, 24
TN #DMAS-1	6/1/16	Appendix 1, page 1
TN #100	5/1/15	Pages 14, 16, 29, 30 Appendix 1, page 1
TN #99	1/1/14	Appendix 1, page 1
UP #9	4/1/13	Appendix 1, page 1
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TN #95	3/1/11	Page 1 Appendix 1, page 1
TN #93	1/1/10	Pages 11, 19 Appendix 1, page 1

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Virginia Medical Assistance Eligibility	**M05**	**January 2026**	
Subchapter Subject	Page ending with		Page
M0530.000 ABD ASSISTANCE UNIT	**Appendix 1**		**1**

Deeming Allocations

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

NBD (Non-blind/disabled) Child Allocation

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

SSI payment for couple - SSI payment for one person = NBD child allocation

2026: $1,491- $994 = $497
2025: $1,450 - $967 = $483
2024: $1,415 - $943 = $472
2023: $1,371 - $914 = $457
2022: $1,261 - $841 = $420

Parental Living Allowance

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

SSI payment for one person = *$994 for 2026;* $967 for 2025; $943 for 2024; $914 for 2023; $841 for 2022.

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

SSI payment for both parents = *$1,491 for 2026;* $1,450 for 2025; $1,415 for 2024; $1,371 for 2023; $1,261 for 2022.

Deeming Standard

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

SSI payment for couple - SSI payment for one person = deeming standard

2026: $1,491 - $994 = $497
2025: $1,450 - $967 = $483
2024: $1,415 - $943 = $472
2023: $1,371 - $914 = $457
2022: $1,261 - $841 = $420
2021: $1,191 - $794 = $397

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M0810 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Pages 1, 2
TN #DMAS-35	7/1/25	Pages 1, 2 and 25
TN #DMAS-34	1/1/25	Pages 1 and 2
TN #DMAS-32	7/1/24	Page 2
TN #DMAS-31	4/1/24	Pages TOC i, 1, 2
TN #DMAS-29	10/1/23	Pages 6, 9
TN #DMAS-28	7/1/23	Pages 2, 6
TN #DMAS-27	4/1/23	Page 2, 25, 27, 28 Page 25a is a runover page
TN #DMAS-25	1/1/23	Pages 1, 2
TN #DMAS-24	7/1/22	Page 2
TN #DMAS-23	4/1/22	Page 2
TN #DMAS-22	1/1/22	Pages 1, 2, 3
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TN #DMAS-19	4/1/21	Page 2
TN #DMAS-18	1/1/21	Pages 1, 2
TN #DMAS-17	7/1/20	Page 2
TN #DMAS-16	4/1/20	Page 2
TN #DMAS-15	1/1/20	Pages 1, 2
TN #DMAS-14	10/1/19	Pages 20, 25, 27 Page 28 is a runover page.
TN #DMAS-12	4/1/19	Page 2
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UP #9	4/1/13	Pages 1, 2
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UP #6	4/1/12	Pages 1, 2
TN #95	3/1/11	Pages 1, 2
TN #93	1/1/10	Pages 1, 2
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Virginia Medical Assistance Eligibility	**M08**	**January 2026**
Subchapter Subject	Page ending with	Page
M0810 GENERAL - ABD INCOME RULES	**M0810.002**	**1**

GENERAL

M0810.001 INCOME AND ELIGIBILITY

A. Introduction

The following sections explain how to treat income to determine eligibility in the Aged, Blind and Disabled covered groups in the Medicaid program. Virginia Medicaid follows Social Security Administration rules from the SSI section of the Program Operations Manual System (POMS) SSA's Policy Information Site - POMS. Some of the rules are adapted due to state laws and regulations. We have noted in each section if the section follows SSA policy without deviation by adding "per POMS'. This chapter explains how we count income.

B. Policy Principles

1. Who is Eligible

An individual is eligible for Medicaid if the person:

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

2. General Income Rules

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

M0810.002 INCOME LIMITS

A. Income Limits

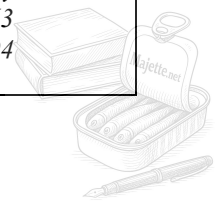
The Medicaid covered group determines which income limit to use to determine eligibility.

1. Categorically Needy

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

2. Categorically Needy Protected Cases Only

Categorically-Needy Protected Covered Groups Which Use SSI Income Limits		
Family Unit Size	*2025 Monthly Amount*	*2026 Monthly Amount*
1	*$967*	*$994*
2	*1,450*	*$1,491*
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size	*2025 Monthly Amount*	*2026 Monthly Amount*
1	*$645*	*$663*
2	*$967*	*$994*



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M0810 GENERAL - ABD INCOME RULES	**M0810.002**	**2**

3. Categorically Needy 300% of SSI

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

Family Size Unit	*2025 Monthly Amount*	*2026 Monthly Amount*
1	*$2,901*	*$2,982*

4. ABD Medically Needy

a. Group I	7/1/24-6/30/25		7/1/25	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,391.01	$398.50	$2,460.34	$410.05
2	3,043.80	507.30	3,132.06	522.01

b. Group II	7/1/24-6/30/25		7/1/25	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$ 2,758.87	$ 459.81	$ 2,838.87	$ 473.14
2	3,396.83	566.14	3,495.33	582.55

c. Group III	7/1/24-6/30/25		7/1/25	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$3,586.53	$597.76	$3,690.53	$615.08
2	4,323.80	720.63	4,449.18	741.53

5. ABD Categorically Needy

For:

ABD 80% FPL, QMB, SLMB, & QI <u>without</u> Social Security income; all QDWI; effective 1/15/25

ABD 80% FPL, QMB, SLMB, & QI <u>with</u> Social Security income; effective 3/1/25

All Localities	2024		2025	
ABD 80% FPL	Annual	Monthly	Annual	Monthly
1	$12,048	$1,004	$12,520	$1,044
2	16,352	1,363	16,920	1,410
QMB 100% FPL	Annual	Monthly	Annual	Monthly
1	$15,060	$1,255	$15,650	$1,305
2	20,440	1,704	21,150	1,763
SLMB 120% of FPL	Annual	Monthly	Annual	Monthly
1	$18,072	$1,506	$18,780	$1,565
2	24,528	2,044	25,380	2,115
QI 135% FPL	Annual	Monthly	Annual	Monthly
1	$20,331	$1,695	$21,128	$1,761
2	27,594	2,300	28,553	2,380
QDWI 200% of FPL	Annual	Monthly	Annual	Monthly
1	$30,120	$2,510	$31,300	$2,609
2	40,880	3,407	42,300	3,525

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M0820 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Pages 30, 31
TN #DMAS-34	1/1/25	Pages 30, 31
TN #DMAS-31	4/1/24	TOC i, Pages 15a, 31
TN #DMAS-29	10/1/23	Pages 3, 4, 11, add 15a, 17, 28, 29
TN #DMAS-28	7/1/23	Pages 4, 11, 17, 29. Page 12 is a runover page.
TN #DMAS-23	1/1/23	Pages 30, 31
TN #DMAS-22	1/1/22	Pages 30, 31
TN #DMAS-18	1/1/21	Pages 30, 31
TN #DMAS-12	4/1/20	Page 29
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TN #DMAS-14	10/1/19	Pages 10, 11, 13, 22, 24
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TN #DMAS-11	1/1/19	Pages 30, 31
TN #DMAS-7	1/1/18	Page 11, 30-32
TN #DMAS-5	7/1/17	Pages 11, 13, 29, 30 Page 12 is a runover page.
TN #DMAS-3	1/1/17	Pages 30, 31
TN #DMAS-1	6/1/16	Pages 30, 31, 47
TN #100	5/1/15	Pages 30, 31, 47 Page 48 is a runover page.
TN #99	1/1/14	Pages 30, 31
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TN #95	3/1/11	Pages 3, 30, 31
TN #93	1/1/10	Pages 30, 31
TN #91	5/15/09	Table of Contents Pages 29, 30

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M0820 EARNED INCOME	**M0820.500**	**30**

3. Other Earned Income

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

a. Federal earned income tax credit payments.

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

c. *For 2026, up to $2,410 per month, but not more than $9,730 in a calendar year, of the earned income of a blind or disabled child.*

For 2025, up to $2,350 per month, but not more than $9,460 in a calendar year, of the earned income of a blind or disabled student child.

For 2024, up to $2,290 per month, but not more than $9,230 in a calendar year, of the earned income of a blind or disabled child.

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

e. $65 of earned income in a month.

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

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

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

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

4. Unused Exclusion

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

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

5. Couples

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

B. References

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

- S0810.410 for infrequent/irregular income
- S0810.420 $20 general exclusion
- M0810.430 amount to fulfill a plan for achieving self-support

For exclusions applicable only to earned income, see S0820.510 - S0820.570.



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M0820 EARNED INCOME	**M0820.510**	**31**

M0820.510 STUDENT CHILD EARNED INCOME EXCLUSION

A. Policy

1. General

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

For Months	Up to per month	But not more than in a calendar year
In calendar year 2026	*$2,410*	*$9,730*
In calendar year 2025	$2,350	$9,460
In calendar year 2024	$2,290	$9,230
In calendar year 2023	$2,220	$8,950

2. Qualifying for the Exclusion

The individual must be:

- a child under age 22; and
- a student regularly attending school.

3. Earnings Received Prior to Month of Eligibility

Earnings received prior to the month of eligibility do not count toward the yearly limit.

4. Future Increases

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

B. Procedure

1. Application of the Exclusion

Apply the exclusion:

- consecutively to months in which there is earned income until the exclusion is exhausted or the individual is no longer a child; and
- only to a student child's own income.

2. School Attendance and Earnings

Develop the following factors and record them:

- whether the child was regularly attending school in at least 1 month of the current calendar quarter, or expects to attend school for at least 1 month in the next calendar quarter, and
- the amount of the child's earned income (including payments from Neighborhood Youth corps, Work-Study, and similar programs).

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



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M1110 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Page 2
TN #DMAS-34	1/1/25	Page 2, 10a
TN #DMAS-32	7/1/24	Pages 1 and 18
TN #DMAS-31	4/1/24	TOC, Pages 1, 6, 7
TN #DMAS-30	1/1/24	Page 2
TN #DMAS-27	4/1/23	Pages 6, 7
TN #DMAS-26	1/1/23	Page 2
TN #DMAS-22	1/1/22	Pages 1, 2
TN #DMAS-20	7/1/21	Page 16
TN #DMAS-19	4/1/21	Page 16
TN #DMAS-18	1/1/21	Page 2
TN #DMAS-17	7/1/20	Page 1
TN #DMAS-15	1/1/20	Page 2
TN #DMAS-12	4/1/19	Pages 10-10a
TN #DMAS-11	1/1/19	Page 2
TN #DMAS-3	1/1/18	Page 2
TN #DMAS-4	4/1/17	Pages 10, 10a
TN #DMAS-3	1/1/17	Pages 2, 7, 10, 11 Page 10a was added as a runover page.
TN #100	5/1/15	Page 2
TN #99	1/1/14	Page 2
UP #9	4/1/13	Page 2
UP #6	4/1/12	Page 2
TN #96	10/1/11	Page 2
TN #95	3/1/11	Page 2
Update (UP) #3	3/2/10	Table of Contents page 2
TN #93	1/1/10	Page 2
TN #91	5/15/09	Pages 14-16

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ABD RESOURCES - GENERAL	**M1110.003**	**2**

M1110.003 RESOURCE LIMITS

A. Introduction

The resource limit is the maximum dollar amount of countable assets an individual, couple, or family may own and still meet the established criteria for Medical Assistance in an ABD category. These amounts are established by law.

B. Policy Principles

1. Resource Ineligibility

An individual (or couple) with countable resources in excess of the applicable limit is not eligible for Medicaid.

2. Resource Limits

ABD Eligible Group	One Person	Two People
Categorically Needy Medically Needy	$2,000	$3,000
ABD with Income ≤ 80% FPL	$2,000	$3,000
QDWI	$4,000	$6,000
QMB SLMB QI	**Calendar Year** **2024** $9,430 **2025** $9,660 ***2026*** *$9,950*	**Calendar Year** **2024** $14,130 **2025** $14,470 ***2026*** *$14,910*

3. Change in Marital Status

A change in marital status can result in a change to the applicable resource limit. The resource limit change is effective with the month that we begin treating both members of a couple as individuals. For example, separation from an ineligible spouse can change the limit from $3,000 to $2,000. See M1110.530 B.

4. Reduction of Excess Resources

Month of Application

Excess resources throughout the month of application causes ineligibility for the application month. Reduction of excess resources within the application month can cause resource eligibility for that month.

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M1460 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Pages 3, 35
TN #DMAS-36	10/1/25	Pages 2, 17, 41, 42, 44, 46
TN #DMAS-34	1/1/25	Pages 3, 29, 35 Page 26a is added
TN #DMAS-33	10/1/24	Pages 4, 23, 24
TN #DMAS-32	7/1/24	Page 4a
TN #DMAS-31	4/1/24	Page 3, 35
TN #DMAS-30	1/1/24	Pages 11 and 19
TN #DMAS-26	1/1/23	Pages 3, 35
TN #DMAS-24	7/1/22	Pages 11, 47, 48
TN #DMAS-23	4/1/22	Pages 12, 23
TN #DMAS-22	1/1/22	Pages 3, 35
TN #DMAS-18	1/1/21	Pages 3, 35
TN #DMAS-15	1/1/20	Pages 3, 35
TN #DMAS-14	10/1/19	Pages 4, 29
TN #DMAS-13	7/1/19	Page 42
TN #DMAS-11	1/1/19	Pages 3-5, 10, 26, 31
TN #DMAS-10	10/1/18	Table of Contents, page i Pages 1-3, 4b, 5, 6, 9, 10, 13, 15, 17a, 18, 18a, 26, 27, 30a, 37, 38 Pages 8a, 11, 19, 30, 39 and 40 are runover pages.
TN #DMAS-8	4/1/18	Pages 18a, 32, 35
TN #DMAS-7	1/1/18	Pages 3, 7
TN #DMAS-3	1/1/17	Pages 3, 4, 4b, 24, 25, 29
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TN #DMAS-1	6/1/16	Table of Contents, page i Pages 3, 8a, 17, 32
TN #100	5/1/15	Table of Contents, page i Pages 1, 2, 5, 6, 10, 15, 16-17a, 25,41-51
TN #99	1/1/14	Pages 3, 35
UP #9	4/1/13	Table of Contents Pages 3, 35, 38, 41, 42, 50, 51
TN #97	9/1/12	Table of Contents Pages 1, 4-7, 9-17 Page 8a was deleted. Pages 18a-20, 23-27, 29-31 Pages 37-40, 43-51 Pages 52 and 53 were deleted
UP #6	4/1/12	Pages 3, 35
TN #96	10/1/11	Pages 3, 20, 21
TN #95	3/1/11	Pages 3, 4, 35
TN #94	9/1/10	Page 4a
TN #93	1/1/10	Pages 28, 35
TN #91	5/15/09	Pages 23, 24

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11. Old Bills

Old bills are unpaid medical, dental, or remedial care expenses which:

- were incurred prior to the Medicaid application month and the application's retroactive period,
- were not fully deducted from (counted in) any previous sp3enddown budget period where the spenddown was met, and
- remain a liability to the individual.

EXCEPTION: Bills paid by a state or local program and which meet the definition of "old bills" are treated as old bills even though they are not the individual's liability.

12. Projected Expenses

Expenses for services that have not yet been incurred but are reasonably expected to be incurred are projected expenses.

13. Spenddown Liability

The spenddown liability is the amount by which the individual's countable income exceeds the MNIL for the budget period.

M1460.150 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LTSS

A. Applicability

The policy in this section applies to nursing facility and CBC/PACE patients, including MAGI Adults effective January 1, 2019, who meet the requirements for LTC services, now called long term services and supports (LTSS), on or after January 1, 2006. This includes individuals who filed reapplications after a break in Medicaid eligibility. It does **not apply** to Medicaid recipients who were approved for LTSS prior to January 1, 2006, and who maintain continuous Medicaid eligibility.

For Medicaid applicants or enrollees approved for LTSS on or after July 1, 2006, the amount of equity in the home at the time of the initial LTSS determination and at each renewal must be evaluated.

B. Policy

Individuals with equity value (tax assessed value minus encumbrances) in home property that exceeds the limit are NOT eligible for Medicaid payment of LTSS unless the home is occupied by

- a spouse,
- a dependent child under age 21 years, or
- a blind or disabled child of any age.

If substantial home equity exists, the individual is not evaluated for or eligible for the Medicaid payment of LTSS. Do not evaluate asset transfers.

An individual with excess home equity is not eligible in the 300% of SSI covered group, but may be eligible for Medicaid payment of covered services other than LTSS if he is eligible in another covered group. Evaluate eligibility for an individual with substantial home equity in other covered groups.

***1.* Home Equity Limit**

The applicable home equity limit is based on the date of the application or request for LTC coverage. The home equity limit is:

- Effective January 1, 2024: $713,000
- Effective January 1, 2025: $730,000
- *Effective January 1, 2026: $752,000*

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M1460.000 LTC FINANCIAL ELIGIBILITY	**M1460.611**	**35**

6. Domestic Travel Tickets Gifts of domestic travel tickets [1612(b)(15)].

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

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

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

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

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

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

a. *For 2026, up to $2,410 per month, but not more than $9,730 in a calendar year, of the earned income of a blind or disabled Student child.*
For 2025, up to $2,350 per month, but no more than $9,460 in a calendar year, of the earned income of a blind or disabled child.

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

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

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

e. One-half of remaining earned income in a month [1612(b) (4)(C)].

f. BWE - Earned income of blind individuals used to meet work expenses [1612(b) (4)(A)].

g. Earned income used to fulfill an SSI approved plan to achieve self-support (PASS) [1612(b) (4)(A) & (B)].

12. Child Support Child support payments received from an absent parent for a blind or Disabled child [1612(b) (9)].

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TN #DMAS-37	1/1/26	Page 19
TN #DMAS-36	10/1/25	Pages 26, 32, 54
TN #DMAS-35	7/1/25	Pages 1 and 48
TN #DMAS-34	1/1/25	Pages 1, 2, 10, 11, 19, 20, 24
TN #DMAS-33	10/1/24	Pages 1, 2, 2a
TN #DMAS-32	7/1/24	Pages 1, 2, 5, 12, 15, 18-20, 28-30, 44, 54, and 55
TN #DMAS-31	4/1/24	Page 10, 12a, 14 and 14a
TN #DMAS-30	1/1/24	Page 20
TN #DMAS-29	10/1/23	Pages 46-48
TN #DMAS-28	7/1/23	Page 19, Appendix 1
TN #DMAS-27	4/1/23	Page 15
TN #DMAS-26	1/1/23	Pages 19, 20
TN #DMAS-25	10/1/22	Page 20
TN #DMAS-24	7/1/22	Pages 1, 15, 28a, 44, 48-50 Page 14a is a runover page.
TN #DMAS-22	1/1/22	Pages 19, 20
TN #DMAS-21	10/1/21	Page 17
TN #DMAS-20	7/1/21	Pages 11, 20, 26
TN #DMAS-19	4/1/21	Pages 7, 8, 22, 23
TN #DMAS-18	1/1/21	Pages 19, 20
TN #DMAS-17	7/1/20	Table of Contents, page ii Pages 1, 14, 28a, 47, 48, 50, 55 Appendix 1, page 1
TN #DMAS-15	1/1/20	Pages 19, 20

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M1470 PATIENT PAY	**M1470.410**	**19**

M1470.410 MEDICAID CBC – PERSONAL MAINTENANCE ALLOWANCE

A. Individuals

For the month of entry and subsequent months, deduct from the patient's gross monthly countable income a personal maintenance allowance (PMA). The amount of the allowance depends upon under which Medicaid CBC waiver the patient receives LTC services.

The total amount of the PMA cannot exceed 300% SSI.

1. Basic Maintenance Allowance

Patients receiving Medicaid CBC under the following waivers are allowed a monthly basic PMA:

- Commonwealth Coordinated Care Plus (CCC Plus) Waiver (formerly the Elderly or Disabled with Consumer-Direction Waiver and the Technology-Assisted Individuals Waiver),
- Community Living (CL) Waiver (formerly Intellectual Disabilities Waiver),
- Family and Individual Supports (IS) Waiver (formerly Individual and Family Developmental Disabilities Support Waiver), and
- Building Independence (BI) Waiver (formerly Day Support Waiver).

Individuals enrolled in the Program for All Inclusive Care for the Elderly (PACE) are also allowed the basic PMA.

The PMA is:

- January 1, 2022 through December 31, 2022: $1,388
- January 1, 2023 through December 31, 2023: $1,509
- January 1, 2024 through December 31, 2024: $1,556
- January 1, 2025 through December 31, 2025: $1,596
- *January 1, 2026 through December 31, 2026: $1,641*

Contact a Medical Assistance Program Consultant for the PMA in effect for years prior to 202*3*.

2. Guardianship Fee

Deduct an amount up to 5% of the patient's gross monthly income (including amounts not counted as income and excluded income) for guardianship fees, if the patient has a legally appointed guardian or conservator AND the guardian or conservator charges a fee. The guardianship **filing** fees CANNOT be deducted from the individual's income. Document how it was determined that the guardian/conservator charges a fee and the amount of the fee.

No deduction is allowed if the patient's guardian receives a payment for providing guardianship services from a public agency or organization that receives funding for guardianship services.

No deduction is allowed for representative payee or "power of attorney" fees or expenses.

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TN #DMAS-37	1/1/26	Pages 7, 18c, 66, 69, 70
TN #DMAS-36	10/1/25	Page 66
TN #DMAS-35	7/1/25	Pages 1 and 66
TN #DMAS-34	1/1/25	Pages 7, 18c, 66, 69, 70
TN #DMAS-33	10/1/24	Pages 16, 66
TN #DMAS-32	7/1/24	Pages 6, 8a, 8b, 15, 17, 18, 18a, 18c, 21, 30, 31, 47, 52, 52a, 55, 56, 60, 65, 66, 68, 73, 74, 77, 78, 82, 86, 87, 91
TN #DMAS-31	4/1/24	Page 8a, 17
TN #DMAS-30	1/1/24	Pages 3, 7, 18c, 66, 69, 70
TN #DMAS-29	10/1/23	Page 66
TN #DMAS-26	1/1/23	Pages 7, 18c, 66, 69, 70
TN #DMAS-25	10/1/22	Page 66
TN #DMAS-24	7/1/22	Pages 8a, 8b, 13, 50b, 51, 55, 57, 66, 87, 89, 91
TN #DMAS-22	1/1/22	Pages 7, 18c, 66, 69, 70
TN #DMAS-21	10/1/21	Page 66
TN #DMAS-20	7/1/21	Pages 66, 70
TN #DMAS-18	1/1/21	Page 7, 18c, 66, 69, 70, 92
TN #DMAS-17	7/1/20	Pages 8b, 9, 14, 66, 77, 92
TN #DMAS-15	1/1/20	Pages 1, 7, 18c, 66, 69, 70

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M1480 MARRIED INSTITUTIONALIZED INDIVIDUALS	**M1480.015**	**7**

27. Spousal Share means ½ of the couple's combined countable resources at the beginning of the **first** continuous period of institutionalization, as determined by a resource assessment.

28. Spouse means a person who is legally married to another person under Virginia law.

29. Waiver Services means Medicaid-reimbursed home or community-based services covered under a 1915© waiver approved by the Secretary of the United States Department of Health and Human Services.

M1480.015 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LONG-TERM CARE

A. Applicability

The policy in this section applies to nursing facility and CBC/PACE patients, who meet the requirements for LTC services, now called long term services and supports (LTSS), on or after January 1, 2006. This includes individuals who filed reapplications after a break in Medicaid eligibility. It does **not apply** to Medicaid recipients who were approved for LTSS prior to January 1, 2006, and who maintain continuous Medicaid eligibility.

For Medicaid applicants or enrollees approved for LTSS on or after July 1, 2006, the amount of equity in the home at the time of the initial LTC determination and at each renewal must be evaluated. For the purposes of the home equity evaluation, the definition of the home in M1130.100 A.2 is used; the home means the house and lot used as the principal residence and all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000.

B. Policy

Individuals with equity value (tax assessed value minus encumbrances) in home property that exceeds the limit are NOT eligible for Medicaid payment of long-term care services unless the home is occupied by:

- a spouse,
- a dependent child under age 21 years, or
- a blind or disabled child of any age.

If substantial home equity exists, the individual is not evaluated for or eligible for the Medicaid payment of LTSS. Do not evaluate asset transfers.

An individual with excess home equity is not eligible in the 300% of SSI covered group, but may be eligible for Medicaid payment of covered services other than LTSS if he is eligible in another covered group. Evaluate eligibility for an individual with substantial home equity in other covered groups.

***1.* Home Equity Limit**

The applicable home equity limit is based on the date of the application or request for LTSS coverage. Effective January 1, 2011, the home equity limit is subject to change annually. The home equity limit is:

- Effective January 1, 2023: $688,000
- Effective January 1, 2024: $713,000
- Effective January 1, 2025: $730,000
- *Effective January 1, 2026: $752,000*

***2.* Reverse Mortgages**

Reverse mortgages **do not** reduce equity value until the individual begins receiving the reverse mortgage payments from the lender.

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2. After Eligibility is Established

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

If an institutionalized spouse's Medicaid coverage was cancelled and reapplies as an institutionalized individual, use only the resources of the institutionalized spouse for *the applicant's* eligibility determination.

M1480.231 SPOUSAL RESOURCE STANDARDS

A. Introduction

This section provides the amounts and the effective dates of the standards used to determine an institutionalized spouse's initial and ongoing resource eligibility. Use the standard in effect on the date of the institutionalized spouse's Medicaid application. Definitions of the terms are found in section M1480.010.

B. Spousal Resource Standard

$32,532	*1-1-26*
$31,584	1-1-25
$30,828	1-1-24
$29,724	1-1-23

C. Maximum Spousal Resource Standard

$162,660	*1-1-26*
$157,920	1-1-25
$154,140	1-1-24
$148,620	1-1-23

M1480.232 INITIAL ELIGIBILITY DETERMINATION PERIOD

A. Policy

The initial eligibility determination period begins with the month of application. If the institutionalized spouse is eligible for the month of application, the initial eligibility determination period will both begin and end with that month.

After eligibility is established, the usual reporting and notification processes apply. Send written notice for the month(s) during which the individual establishes Medicaid eligibility. VaCMS will generate the "Notice of Patient Pay Responsibility" and it will be sent to the individual or his authorized representative.

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M1480 MARRIED INSTITUTIONALIZED INDIVIDUALS	**M1480.420**	**66**

M1480.400 PATIENT PAY

A. Introduction This section contains the policy and procedures for determining an institutionalized spouse's (as defined in section M1480.010 above) patient pay in all covered groups.

B. Married With Institutionalized Spouse in a Facility For a married long-term services and support (LTSS) patient with an institutionalized spouse in a facility, **NO** amount of the patient's income is deducted for the spouse's needs in the patient pay calculation.

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

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

B. Monthly Maintenance Needs Allowance	$2,288.75	7-1-22
	$2,465	7-1-23
	$2,555	7-1-24
	$2,643.75	7-1-25
C. Maximum Monthly Maintenance Needs Allowance	$3,435.00	1-1-22
	$3,715.50	1-1-23
	$3,853.50	1-1-24
	$3,948.00	1-1-25
	$4,066.50	*1-1-26*
D. Excess Shelter Standard	$686.63	7-1-22
	$739.50	7-1-23
	$766.50	7-1-24
	$793.13	7-1-25

E. Utility Standard Deduction (SNAP)	$369.00	1 - 3 household members	10-1-24
	$467.00	4 or more household members	10-1-24
	$375.00	1 - 3 household members	10-1-25
	$476.00	4 or more household members	10-1-25

M1480.420 PATIENT PAY FOR ABD 80% FPL AND 300% SSI INSTITUTIONALIZED SPOUSE

A. Policy After a 300% SSI or ABD 80% FPL institutionalized spouse has been found eligible for Medicaid, determine patient pay (post-eligibility treatment of income).

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$875 gross earned income
- 75 first $75 per month
800 remainder
÷ 2
400 ½ remainder
+ 75 first $75 per month
$475 which is > $190

His personal needs allowance is calculated as follows:

$ 40.00 basic personal needs allowance
+190.00 special earnings allowance
+ 17.50 guardianship fee (2% of $875)
$247.50 personal needs allowance

2. Medicaid CBC Waiver Services and PACE

a. Basic Maintenance Allowance

For the Commonwealth Coordinated Care Plus (CC Plus) Waiver (formerly the Elderly or Disabled with Consumer Direction Waiver and the Technology-Assisted Individuals Waiver), Community Living (CL) Waiver (formerly Intellectual Disabilities Waiver), Family and Individual Supports (IS) Waiver (formerly Individual and Family Developmental Disabilities Support Waiver), Building Independence (BI) Waiver (formerly Day Support Waiver), or PACE, deduct the appropriate maintenance allowance for one person as follows:

- January 1, 2023 through December 31, 2023: $1,509
- January 1, 2024 through December 31, 2024: $1,556
- January 1, 2025 through December 31, 2025: $1,596
- *January 1, 2026 through December 21, 2026: $1,641*

Contact a Medical Assistance Program Consultant for the amount in effect for years prior to 20*23*.

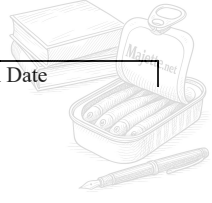
b. Guardian Fee

Deduct the actual fee a guardian or conservator charges, up to a maximum of 5% of the patient's actual gross income (including amounts not counted as income and excluded amounts) for guardianship fees, IF:

* the patient has a legally appointed guardian or conservator AND
* the guardian or conservator charges a fee.

Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

NOTES: No deduction is allowed for representative payee or "power of attorney" fees or expenses. No deduction is allowed if the patient's guardian receives a payment for providing guardianship services from a public agency or organization that receives funding for guardianship services. The guardianship filing fees CANNOT be deducted from the individual's income.



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c. Special Earnings Allowance For CCC Plus, CL, IS, and BI Waivers

[EXAMPLE #19 was deleted]

For the CCC Plus, CL, IS, and BI waivers, deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

- for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (*$2,982 in 2026*) per month.

- for individuals employed at least 4 but less than 20 hours per week, all earned income up to 200% of SSI (*$1,988 in 2026*) per month.

The total of the basic maintenance allowance, the guardianship fee and the special earnings allowance cannot exceed 300% SSI.

EXAMPLE #20: (Using January 2000 figures)

A working patient in the CL Waiver is employed 18 hours per week. He has gross earnings of $928.80 per month and SS of $300 monthly. His special earnings allowance is calculated first:

$	928.80	gross earned income
-	1,024.00	200% SSI maximum
$	0	remainder

$928.80 = special earnings allowance

His personal maintenance allowance is calculated as follows:

$	512.00	maintenance allowance
+	928.80	special earnings allowance
	$1,440.80	personal maintenance allowance

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TN #DMAS-37	1/1/26	Page 9a
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TN #DMAS-31	4/1/24	Pages 7 and 8
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TN #DMAS-24	7/1/22	Pages 8, 9a, 12-14
TN #DMAS-22	1/1/22	Page 8a Page 8 is a runover page.
TN #DMAS-21	10/1/21	Page 9a
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TN #DMAS-16	4/1/20	Pages 5, 6, 12, 13 Pages 14 and 15 are runover pages.
TN #DMAS-14	10/1/19	Pages 2b, 4, 5-7
TN #DMAS-12	4/1/19	Pages 7, 9a. Page 7a is a runover page.
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Manual Title	Chapter	Page Revision Date
Virginia Medical Assistance Eligibility	**M15**	**January 2026**
Subchapter Subject	Page ending with	Page
M1510 MEDICAID ENTITLEMENT	**M1510.107**	**9a**

M1510.107 Enrollment Changes

~~D~~. Enrollment Changes

VaCMS is the MA eligibility system of record, however some enrollment functions can only be handled by the DMAS Eligibility and Enrollment Unit. The VaCMS and MES [Medicaid Enterprise System (formerly MMIS)] systems **must** reflect correct coverage. Appropriate change requests include (but are not limited to):

- Coverage corrections unable to be handled through VaCMS
- Duplicate linking
- Erroneous death cancellations
- Same day void.

There may be instances when VaCMS should be able to successfully update the enrollment system but does not. When this occurs, the eligibility worker must follow the steps as listed below:

- First attempt to make the correction in VaCMS with the help of supervisors or other agency resources. If not successful;
    - Contact the VDSS Regional Practice Consultant (RC) for assistance. The RC will help the local worker make the correction in VaCMS.
- If either the agency resources or RC is unable to correct the enrollment in VaCMS, they can instruct the worker to submit a coverage correction to DMAS *by submitting a coverage correction request through the Coverage Correction Portal (CCP) on the MES website., Home | MES.*

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Cheryl Roberts
DIRECTOR

Department of Medical Assistance Services

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April 1, 2026

Virginia Medical Assistance Eligibility Manual Transmittal
DMAS-38

The following acronyms are contained in this letter:

- CBC – Community Based Care
- CCC+ - Medicaid managed care program serving adults and children with disabilities and complex care needs.
- DDS – Disability Determination Services
- DMAS – Department of Medical Assistance Services
- MCO – Managed Care Organization
- PRTF – Psychiatric Residential Treatment Facility
- TN – Transmittal

TN #DMAS-38 includes policy clarifications, updates and revisions. Unless otherwise noted in the Cover Letter and/or policy, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after April 1, 2026.

The following changes are contained in TN #DMAS-38:

Changed Sections	Changes
Chapter M000	Added Income Limits and Reference section
Subchapter M0310.112 D.2.b.	Although a referral to DDS must still be made before the 18th birthday, Continuous Eligibility protections will apply until the earlier of the month that the child turns 19 or the month that their 12-month protected period ends.
Subchapter M0320.400	Determination date for Medicaid Works is the date the person requests it, in writing or by phone. Signed Medicaid Works Agreement is no longer required.
Subchapter M0320.502	CBC services must start within 180 days of the Notice of Action approving LTSS coverage.
Subchapter M0330.400 D.	Individuals whose pregnancy ends with birth or for any reason are eligible for 12 or 2 month post-pregnancy coverage.
Subchapter M0520.001 B. 4	Replace link to PRTFs Rate Setting
Chapter M18	Remove references to Medallion 4.0 and CCC+ MCO programs. Remove reference to excluding individuals under 21 in PRTF from managed care
Subchapter M2210.100	Individuals whose pregnancy ends with birth or for any reason are eligible for 12 or 2 month post-pregnancy coverage. Publish converted Chapter 22.
Subchapter M2310.100	Individuals whose pregnancy ends with birth or for any reason are eligible for 12 or 2 month post-pregnancy coverage. Publish converted Chapter 23.

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Please retain this TN letter for future reference. Should you have questions about information contained in this transmittal, please contact Sara Cariano, Director, DMAS Eligibility Policy & Outreach Division, at sara.cariano@dmas.virginia.gov or (804) 229-1306.

Sincerely,

Sarah Hatton

Sarah Hatton, M.H.S.A.
Deputy of Administration and
Coverage

Attachment

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Virginia Medical Assistance Eligibility Manual

Chapter M00
Appendix – Income Charts

Created April 2026

Chapter M00 Appendix Changes

Changed With	Effective Date	Subchapters Changed

TN – Transmittal
UP – Update

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REFERENCE INFORMATION – GROUPING OF LOCALITIES

The three locality tables that follow are used in conjunction with the following income charts: MAGI Income Charts, Families & Children Income, and Aged, Blind and Disabled Income Charts.

The information in the tables is associated with Chapters M04, M07 and M08 of the Medical Assistance Eligibility Manual.

Chart Name: Grouping of Localities – Group I
Effective Date: July 1, 2017

Counties – Listed Alphabetically: A - Fra	Counties – Listed Alphabetically: Fre -N	Counties – Listed Alphabetically: O - Y	Cities
Accomack	Frederick	Orange	Bristol
Alleghany	Giles	Page	Buena Vista
Amelia	Gloucester	Patrick	Danville
Amherst	Goochland	Pittsylvania	Emporia
Appomattox	Grayson	Powhatan	Franklin
Bath	Greene	Prince Edward	Galax
Bedford	Greensville	Prince George	Norton
Bland	Halifax	Pulaski	Suffolk
Botetourt	Hanover	Rappahannock	
Brunswick	Henry	Richmond County	
Buchanan	Highland	Rockbridge	
Buckingham	Isle of Wight	Russell	
Campbell	James City	Scott	
Caroline	King George	Shenandoah	
Carroll	King & Queen	Smyth	
Charles City	King William Lancaster	Southampton	
Charlotte	Lee	Spotsylvania	
Clarke	Louisa	Stafford	
Craig	Lunenburg	Surry	
Culpeper	Madison	Sussex	
Cumberland	Mathews	Tazewell	
Dickenson	Mecklenburg	Washington	
Dinwiddie	Middlesex	Westmoreland	
Essex	Nelson	Wise	
Fauquier	New Kent	Wythe	
Floyd	Northampton	York	
Fluvanna	Northumberland		
Franklin	Nottoway		

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Chart Name: Grouping of Localities – Group II
Effective Date: July 1, 2017

Counties	Cities
Albemarle	Chesapeake
Augusta	Covington
Chesterfield	Harrisonburg
Henrico	Hopewell
Loudoun	Lexington
Roanoke	Lynchburg
Rockingham	Martinsville
Warren	Newport News
	Norfolk
	Petersburg
	Portsmouth
	Poquoson
	Radford
	Richmond Roanoke
	Salem
	Staunton
	Virginia Beach
	Williamsburg
	Winchester

Chart Name: Grouping of Localities – Group III
Effective Date: July 1, 2017

Counties	Cities
Arlington	Alexandria
Fairfax	Charlottesville
Montgomery	Colonial Heights
Prince William	Falls Church
	Fredericksburg
	Hampton
	Manassas
	Manassas Park
	Waynesboro

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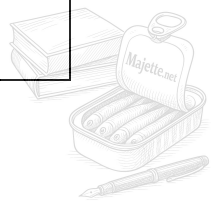
REFERENCE INFORMATION – TREATMENT OF INCOME FOR CHILDREN, FAMILIES & CHILDREN, AND CHILDREN COVERED GROUPS

The table below is used in conjunction the following income charts: MAGI Income Charts, Families & Children Income.

The information in the table is associated with Chapters M04 and M07 of the Medical Assistance Eligibility Manual.

Effective Date: July 2025

INCOME	MAGI COVERED GROUPS	MEDICALLY NEEDY; 300% SSI; F&C COVERED GROUPS
Difficulty of Care Payments	*Not counted*	*Counted with appropriate earned income disregards*
Earnings	Counted with no disregards	Counted with appropriate earned income disregards
Social Security Benefits Adult's MAGI household	Benefits received by a parent or stepparent are counted for his eligibility determination, as well as the eligibility determinations of his spouse and children in the home.	Counted if anyone in the Family Unit/Budget Unit receives
Social Security Benefits Child's MAGI household	If the child lives with a parent, only counted if the child is required to file a federal tax return.	Counted if anyone in the Family Unit/Budget Unit receives
Child Support Received	Not counted	Counted – subject to $50 exclusion
Child Support Paid	Not deducted from income	Not deducted from income
Alimony Received	Counted if divorce agreement was finalized prior to January 1, 2019, and the agreement has not been modified.	Counted – subject to $50 exclusion if comingled with child support
Alimony Paid	Deducted from income if divorce agreement was finalized prior to January 1, 2019	Not deducted from income
Worker's Compensation	Not counted	Counted
Veteran's Benefits	Not counted if they are not taxable in IRS Publication 525	Counted
Scholarships, fellowships, grants and awards used for educational purposes	Not counted	Not counted
Student Loan Debt	Effective January 1, 2019, student loan debt forgiven due to death or disability of student is not counted as income.	Not applicable



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INCOME	MAGI COVERED GROUPS	MEDICALLY NEEDY; 300% SSI; F&C COVERED GROUPS
Foreign Income (whether or not excluded from taxes)	Counted	Counted
Interest	Counted	Counted
Lump Sums	Income in month of receipt	Income in month of receipt
Lottery & Gambling Winnings	Lottery and gambling winnings of $80,000 or greater, received in a single payout, are counted in the month received and over a period of up to 120 months. Income in month of receipt for other HH members.	Income in month of receipt
Gifts, inheritances, life insurance proceeds	Not counted	Counted as lump sum in month of receipt
Parsonage allowance	Not counted	Counted
Pandemic Unemployment Compensation Payments	Not counted (regular Unemployment Compensation is counted.)	Not counted (regular Unemployment Compensation is counted.)
Federal COVID-19 relief payments	Not counted	Not counted

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MAGI INCOME CHARTS

NOTE: The income charts in this section are associated with Chapter M04 – Modified Adjusted Gross Income (MAGI) of the Medical Assistance Eligibility Manual.

Income Chart Name: 5% Federal Poverty Level (FPL) Income Disregard Amounts - All Localities
Effective Date: January 13, 2026

Household Size	Monthly Amount
1	*$67*
2	*$91*
3	*$114*
4	*$138*
5	*$162*
6	*$185*
7	*$209*
8	*$233*
Each additional, add	*$24*

Income Chart Name: Gap-Filling Rule Evaluation 100% Federal Poverty Level (FPL) Income Limits
Effective Date: January 13, 2026

Household size	Annual (Use for Gap-Filling Evaluation)	Monthly
1	*$15,960*	*$1,330*
2	*$21,640*	*$1,804*
3	*$27,320*	*$2,277*
4	*$33,000*	*$2,750*
5	*$38,680*	*$3,224*
6	*$44,360*	*$3,697*
7	*$50,040*	*$4,170*
8	*$55,720*	*$4,644*
Each additional, add	*$5,680*	*$474*

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Income Chart Name: Pregnant Women 143% Federal Poverty Level (FPL) Income Limits – All Localities
Effective Date: January 13, 2026

NOTE: A pregnant woman's household is at least two individuals when evaluated in the Pregnant Women covered group.

Household Size	143% FPL Yearly Amount	143% FPL Monthly Amount	148% FPL (143% FPL + 5% FPL Disregard)
2	*$30,946*	*$2,579*	*$2,669*
3	*$39,068*	*$3,256*	*$3,370*
4	*$47,190*	*$3,933*	*$4,070*
5	*$55,313*	*$4,610*	*$4,771*
6	*$63,435*	*$5,287*	*$5,472*
7	*$71,558*	*$5,964*	*$6,172*
8	*$79,680*	*$6,640*	*$6,873*
Each additional, add	*$8,123*	*$677*	*$701*

Income Chart Name: Child Under Age 19 – 143% Federal Poverty Level (FPL) Income Limits – All Localities
Effective Date: January 13, 2026

# of Persons in Household	109% FPL for Determining Aid Category: Monthly Limit	143% FPL: Annual Limit	143% FPL: Monthly Limit	148% FPL (143% FPL + 5% FPL Disregard): Monthly Limit
1	*$1,450*	*$22,823*	*$1,902*	*$1,969*
2	*$1,966*	*$30,946*	*$2,579*	*$2,669*
3	*$2,482*	*$39,068*	*$3,256*	*$3,370*
4	*$2,998*	*$47,190*	*$3,933*	*$4,070*
5	*$3,514*	*$55,313*	*$4,610*	*$4,771*
6	*$4,030*	*$63,435*	*$5,287*	*$5,472*
7	*$4,546*	*$71,558*	*$5,964*	*$6,172*
8	*$5,062*	*$79,680*	*$6,640*	*$6,873*
Each additional, add	*$516*	*$8,123*	*$677*	*$701*

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Income Chart Name: Low-Income Families with Children (LIFC) Income Limits
Effective Date: July 1, 2025

NOTE: Refer to Section M0010 in this document for a list of Group I, II and III localities and cities.

Group I Income Chart

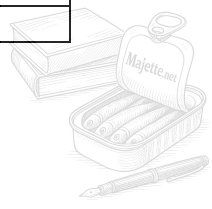
Household Size	Monthly Amount	Annual Amount
1	*$329*	*$3,948*
2	*$495*	*$5,940*
3	*$632*	*$7,584*
4	*$764*	*$9,168*
5	*$896*	*$10,752*
6	*$1010*	*$12,120*
7	*$1142*	*$13,704*
8	*$1276*	*$15,312*
Additional	*$139*	*$1,668*

Group II Income Chart

Household Size	Monthly Amount	Annual Amount
1	*$429*	*$5,148*
2	*$609*	*$7,308*
3	*$767*	*$9,204*
4	*$913*	*$10,956*
5	*$1,075*	*$12,900*
6	*$1,209*	*$14,508*
7	*$1,355*	*$16,260*
8	*$1,510*	*$18,120*
Additional	*$155*	*$1,860*

Group III Income Chart

Household Size	Monthly Amount	Annual Amount
1	*$642*	*$7,704*
2	*$859*	*$10,308*
3	*$1,048*	*$12,576*
4	*$1,226*	*$14,712*
5	*$1,452*	*$17,424*
6	*$1,613*	*$19,356*
7	*$1,793*	*$21,516*
8	*$1,983*	*$23,796*
Additional	*$188*	*$2,256*



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Income Chart Name: Individuals Under 21 Income Limits
Effective Date: July 1, 2025

NOTE: Refer to Section M0010 in this document for a list of Group I, II and III localities and cities.

Group I Income Chart

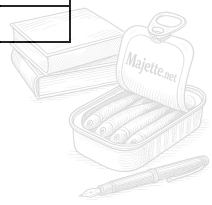
Household Size	Monthly Amount	Annual Amount
1	*$315*	*$3,780*
2	*$481*	*$5,772*
3	*$618*	*$7,416*
4	*$747*	*$8,964*
5	*$880*	*$10,560*
6	*$986*	*$11,832*
7	*$1,114*	*$13,368*
8	*$1,253*	*$15,036*
Additional	*$135*	*$1,620*

Group II Income Chart

Household Size	Monthly Amount	Annual Amount
1	*$424*	*$5,088*
2	*$611*	*$7,332*
3	*$765*	*$9,180*
4	*$914*	*$10,968*
5	*$1,079*	*$12,948*
6	*$1,209*	*$14,508*
7	*$1,355*	*$16,260*
8	*$1,509*	*$18,108*
Additional	*$153*	*$1,836*

Group III Income Chart

Household Size	Monthly Amount	Annual Amount
1	*$560*	*$6,720*
2	*$752*	*$9,024*
3	*$907*	*$10,884*
4	*$1,062*	*$12,744*
5	*$1,256*	*$15,072*
6	*$1,383*	*$16,596*
7	*$1,534*	*$18,408*
8	*$1,689*	*$20,268*
Additional	*$154*	*$1,848*



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Income Chart Name: Plan First 200% Federal Poverty Level (FPL) Income Limits – All Localities
Effective Date: January 13, 2026

Household Size	200% FPL Yearly Amount	200% FPL Monthly Amount	205% FPL (200% FPL + 5% FPL Disregard)
1	*$31,920*	*$2,660*	*$2,727*
2	*$43,280*	*$3,607*	*$3,697*
3	*$54,640*	*$4,554*	*$4,668*
4	*$66,000*	*$5,500*	*$5,638*
5	*$77,360*	*$6,447*	*$6,608*
6	*$88,720*	*$7,394*	*$7,579*
7	*$100,080*	*$8,340*	*$8,549*
8	*$111,440*	*$9,287*	*$9,519*
Each additional, add	*$11,360*	*$947*	*$971*

Income Chart Name: MAGI Adults 133% Federal Poverty Level (FPL) Income Limits – All Localities
Effective Date: January 13, 2026

Household Size	133% FPL Yearly Amount	133% FPL Monthly Amount	138% FPL (133% FPL + 5% FPL Disregard)
1	*$21,227*	*$1,769*	*$22,025*
2	*$28,782*	*$2,399*	*$29,864*
3	*$36,336*	*$3,028*	*$37,702*
4	*$43,890*	*$3,658*	*$45,540*
5	*$51,445*	*$4,288*	*$53,379*
6	*$58,999*	*$4,917*	*$61,217*
7	*$66,554*	*$5,547*	*$69,056*
8	*$74,108*	*$6,176*	*$76,894*
Each additional, add	*$7,555*	*$630*	*$7,839*

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FAMILIES & CHILDREN INCOME

Income Chart Name: Families & Children Medically Needy Income Limits
Effective Date: July 1 2025

NOTE: The income charts in this section are associated with Chapter M07 – Families and Children Income of the Medical Assistance Eligibility Manual. Refer to the Reference Information – Grouping of Localities section in this document for a list of Group I, II and III localities and cities.

Group I Income Chart

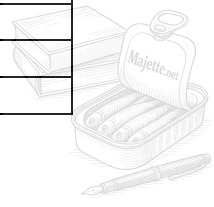
# of Persons in Family/Budget Unit	Semi-Annual Income	Monthly Income
1	*$2,460.34*	*$410.05*
2	*$3,132.06*	*$522.01*
3	*$3,690.53*	*$615.08*
4	*$4,163.71*	*$693.95*
5	*$4,636.86*	*$772.81*
6	*$5,110.01*	*$851.66*
7	*$5,583.16*	*$930.52*
8	*$6,150.95*	*$1,025.15*
Each additional person	*$635.84*	*$105.97*

Group II Income Chart

# of Persons in Family/Budget Unit	Semi-Annual Income	Monthly Income
1	*$2,838.87*	*$473.14*
2	*$3,495.33*	*$582.55*
3	*$4,069.08*	*$678.18*
4	*$4,542.24*	*$757.04*
5	*$5,015.39*	*$835.89*
6	*$5,488.55*	*$914.75*
7	*$5,961.70*	*$ 993.61*
8	*$6,529.48*	*$1,088.24*
Each additional person	*$635.84*	*$105.97*

Group III Income Chart

# of Persons in Family/Budget Unit	Semi-Annual Income	Monthly Income
1	*$3,690.53*	*$615.08*
2	*$4,449.18*	*$741.53*
3	*$5,015.39*	*$835.89*
4	*$5,488.55*	*$914.75*
5	*$5,961.70*	*$993.61*
6	*$6,434.85*	*$1,072.47*
7	*$6,908.00*	*$1,151.33*
8	*$7,381.18*	*$1,230.19*
Each additional person	*$635.84*	*$105.97*



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Income Chart Name: Families & Children 100% Standard of Assistance
Effective Date: July 1 2025

NOTE: Used as the Families and Children Deeming Standard.

Group I Income Chart

Household Size	Income Limit
1	*$324*
2	*$486*
3	*$619*
4	*$752*
5	*$882*
6	*$995*
7	*$1,120*
8	*$1,257*
Each additional person	*$137*

Group II Income Chart

Household Size	Income Limit
1	*$422*
2	*$599*
3	*$755*
4	*$897*
5	*$1,055*
6	*$1,191*
7	*$1,334*
8	*$1,485*
Each additional person	*$153*

Group III Income Chart

Household Size	Income Limit
1	*$632*
2	*$844*
3	*$1,031*
4	*$1,208*
5	*$1,426*
6	*$1,586*
7	*$1,767*
8	*$1,953*
Each additional person	*$185*

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AGED, BLIND & DISABLED (ABD) INCOME LIMITS

Last Section Revision Date: January 2026

NOTE: The income charts in this section are associated with Chapter M08 – Aged, Blind and Disabled (ABD) of the Medical Assistance Eligibility Manual. Refer to the Reference Information – Grouping of Localities section in this document for a list of Group I, II and III localities and cities.

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

A. Categorically Needy Overview

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

B. Categorically Needy Protected Cases Only

Income Chart Name: Categorically Needy Protected Covered Groups Which Use SSI Income Limits
Effective Date: January 2026

Family Unit Size	2025 Monthly Amount	2026 Monthly Amount
1	$967	*$994*
2	$1,450	*$1,490*

Income Chart Name: Individual or Couple Whose Total Food and Shelter Needs are Contributed to the Individual or Couple
Effective Date: January 2026

Family Unit Size	2025 Monthly Amount	*2026 Monthly Amount*
1	$645	*$663*
2	$967	*$994*

C. Categorically Needy 300% of SSI

Income Chart Name: Categorically Needy 300% of SSI
Effective Date: January 2026

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

Family Unit Size	2025Monthly Amount	2026 Monthly Amount
1	$2,901	*$2,982*

D. ABC Medically Needy

Income Chart Name: Aged, Blind, Disabled (ABD) Medically Needy
Effective Date: July 2025

Group I Income Chart

Family Unit Size	*7/1/24-6/30/25 Semi-annual*	*7/1/24-6/30/25 Monthly*	*7/1/25 Semi-annual*	*7/1/25 Monthly*
1	*$2,391.01*	*$398.50*	*$2,460.34*	*$410.05*
2	*$3,043.80*	*$507.30*	*$3,132.06*	*$522.01*

Group II Income Chart

Family Unit Size	*7/1/24-6/30/25 Semi-annual*	*7/1/24-6/30/25 Monthly*	*7/1/25 Semi-annual*	*7/1/25 Monthly*
1	*$ 2,758.87*	*$ 459.81*	*$ 2,838.87*	*$ 473.14*
2	*$3,396.83*	*$566.14*	*$3,495.33*	*$582.55*

Group III Income Chart

Family Unit Size	*7/1/24-6/30/25 Semi-annual*	*7/1/24-6/30/25 Monthly*	*7/1/25 Semi-annual*	*7/1/25 Monthly*
1	*$3,586.53*	*$597.76*	*$3,690.53*	*$615.08*
2	*$4,323.80*	*$720.63*	*$4,449.18*	*$741.53*

E. ABD Categorically Needy

Acronym Definitions Used in the Following Income Charts

- **ABD** – Aged, Blind, Disabled
- **FPL** – Federal Poverty Limit
- **QDWI** – Qualified Disabled Working Individuals
- **QI** – Qualifying Individual
- **QMB** – Qualified Medicare Beneficiary
- **SLMB** – Specified Low-Income Medicare Beneficiary
- **SSI** – Social Security Income

The following income charts are for:

- ABD 80% FPL, QMB, SLMB, and QI without Social Security income; all QDWI
  - Effective *1/15/25*
  - All Localities
- ABD 80% FPL, QMB, SLMB, and QI with Social Security income
  - Effective *3/1/25*
  - All Localities

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Income Chart Name: Aged, Blind, Disabled (ABD) Categorically Needy for 80% FPL
Effective Date: January 13, 2026 for those without SSI; March 1, 2026 for those with SSI

Family Unit Size	2025 Annual	2025 Monthly	2026 Annual	2026 Monthly
1	$12,520	$1,044	*$12,768*	*$1,064*
2	$16,920	$1,410	*$17,312*	*$1,443*

Income Chart Name: Aged, Blind, Disabled (ABD) Categorically Needy for QMB 100% FPL
Effective Date: January 13, 2026 for those without SSI; March 1, 2026 for those with SSI

Family Unit Size	2025 Annual	2025 Monthly	2026 Annual	2026 Monthly
1	$15,650	$1,305	$15,960	$1,330
2	$21,150	$1,763	$21,640	$1,804

Income Chart Name: Aged, Blind, Disabled (ABD) Categorically Needy for SLMB 120% of FPL
Effective Date: January 13, 2026 for those without SSI; March 1, 2026 for those with SSI

Family Unit Size	2025 Annual	2025 Monthly	2026 Annual	2026 Monthly
1	$18,780	$1,565	$19,152	$1,596
2	$25,380	$2,115	$25,968	$2,164

Income Chart Name: Aged, Blind, Disabled (ABD) Categorically Needy for QI 135% of FPL
Effective Date: January 13, 2026 for those without SSI; March 1, 2026 for those with SSI

Family Unit Size	2025 Annual	2025 Monthly	2026 Annual	2026 Monthly
1	$21,128	$1,761	$21,546	$1,796
2	$28,553	$2,380	$29,214	$2,435

Income Chart Name: Aged, Blind, Disabled (ABD) Categorically Needy for QDWI 200% of FPL
Effective Date: January 13, 2026

Family Unit Size	2025 Annual	2025 Monthly	2026 Annual	2026 Monthly
1	$31,300	$2,609	$31,920	$2,660
2	$42,300	$3,525	$43,280	$3,607

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12-MONTH EXTENDED MEDICAID INCOME LIMITS

Last Section Revision Date:

NOTE: The income chart in this section is associated with Chapter M15 – Entitlement Policy & Procedures of the Medical Assistance Eligibility Manual.

Income Chart Name: Twelve Month Extended Medicaid Income Limits – 185% of Federal Poverty Limits: All Localities

Effective *1/17/24*

# of Persons in Family Unit / Budget Unit	185% FPL Monthly Limit
1	*$2,322*
2	*$3,152*
3	*$3,981*
4	*$4,810*
5	*$5,640*
6	*$6,469*
7	*$7,299*
8	*$8,128*
Each additional, add	*$830*

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FAMIS INCOME LIMITS

Last Section Revision Date: January 2026

NOTE: The income charts in this section are associated with Chapter M21 – FAMIS of the Medical Assistance Eligibility Manual.

Income Chart Name: FAMIS Income Limits - All Localities
Effective *1/13/26*

# of Persons in FAMIS Household	150% FPL Annual Limit	150% FPL Monthly Limit
1	*$23,940*	*$1,995*
2	*$32,460*	*$2,705*
3	*$40,980*	*$3,415*
4	*$49,500*	*$4,125*
5	*$58,020*	*$4,835*
6	*$66,540*	*$5,545*
7	*$75,060*	*$6,255*
8	*$83,580*	*$6,965*
Each additional, add	*$8,520*	*$710*

# of Persons in FAMIS Household	200% FPL Annual Limit	200% FPL Monthly Limit
1	*$31,920*	*$2,660*
2	*$43,280*	*$3,607*
3	*$54,640*	*$4,554*
4	*$66,000*	*$5,500*
5	*$77,360*	*$6,447*
6	*$88,720*	*$7,394*
7	*$100,080*	*$8,340*
8	*$111,440*	*$9,287*
Each additional, add	*$11,360*	*$947*

# of Persons in FAMIS Household	205% FPL Annual Limit (200% FPL + 5% Disregard as Displayed in VaCMS)
1	*$2,727*
2	*$3,697*
3	*$4,668*
4	*$5,638*
5	*$6,608*
6	*$7,579*
7	*$8,549*

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# of Persons in FAMIS Household	205% FPL Annual Limit (200% FPL + 5% Disregard as Displayed in VaCMS)
8	*$9,519*
Each additional, add	*$971*

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FAMIS MOMS INCOME LIMITS

NOTE: The income chart in this section is associated with Chapter M22 – FAMIS Moms of the Medical Assistance Eligibility Manual.

Income Chart Name: FAMIS Moms 200% FPL Income Limits - All Localities
Effective: *1/13/26*

Household Size	200% FPL Yearly Amount	200% FPL Monthly Amount	205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)
2	*$43,280*	*$3,607*	*$3,697*
3	*$54,640*	*$4,554*	*$4,668*
4	*$66,000*	*$5,500*	*$5,638*
5	*$77,360*	*$6,447*	*$6,608*
6	*$88,720*	*$7,394*	*$7,579*
7	*$100,080*	*$8,340*	*$8,549*
8	*$111,440*	*$9,287*	*$9,519*
Each additional, add	*$11,360*	*$947*	*$971*

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FAMIS PRENATAL COVERAGE INCOME LIMITS

NOTE: The income charts in this section are associated with Chapter M23 – FAMIS Prenatal Coverage of the Medical Assistance Eligibility Manual.

Income Chart Name: FAMIS Prenatal Coverage 200% FPL Income Limits - All Localities
Effective: *1/13/26*

Enroll Using Aid Category 110

Household Size	143% FPL Yearly Amount	143% FPL Monthly Amount	148% FPL (143% FPL + 5% FPL Disregard)
2	*$30,946*	*$2,579*	*$2,669*
3	*$39,068*	*$3,256*	*$3,370*
4	*$47,190*	*$3,933*	*$4,070*
5	*$55,313*	*$4,610*	*$4,771*
6	*$63,435*	*$5,287*	*$5,472*
7	*$71,558*	*$5,964*	*$6,172*
8	*$79,680*	*$6,640*	*$6,873*
Each additional, add	*$8,123*	*$677*	*$701*

Enroll Using Aid Category 111

Household Size	200% FPL Yearly Amount	200% FPL Monthly Amount	205% FPL (200% FPL + 5% FPL Disregard)
2	*$43,280*	*$3,607*	*$3,697*
3	*$54,640*	*$4,554*	*$4,668*
4	*$66,000*	*$5,500*	*$5,638*
5	*$77,360*	*$6,447*	*$6,608*
6	*$88,720*	*$7,394*	*$7,579*
7	*$100,080*	*$8,340*	*$8,549*
8	*$111,440*	*$9,287*	*$9,519*
Each additional, add	*$11,360*	*$947*	*$971*

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M0310 Changes
Page 2 of 2

Changed With	Effective Date	Pages Changed
TN #DMAS-38	4/1/26	Page 24
TN #DMAS-36	10/1/25	Page 30a ; Appendix 1
TN #DMAS-35	7/1/25	Pages 5 and 28, Appendix 1
TN #DMAS-33	10/1/24	Page 28
TN #DMAS-29	10/1/23	Page 5
TN #DMAS-26	1/1/23	Pages 2, 28b Appendix 1
TN #DMAS-24	7/1/22	Page 36 Page 37 is a runover page.
TN #DMAS-23	4/1/22	Pages 2, 5, 6, 6a
TN #DMAS-22	1/1/22	Page 28
TN #DMAS-20	7/1/21	Page 6 Pages 5 and 5a are runover pages.
TN #DMAS-18	1/1/21	Table of Contents, page ii Pages 26, 27 Appendix 1 was removed. Appendix 2 was renumbered to Appendix 1.
TN #DMAS-17	7/1/20	Page 7 Pages 8 and 9 are runover pages.
TN #DMAS-15	1/1/20	Pages 29, 30
TN #DMAS-14	10/1/19	Pages 24, 26, 27, 40
TN #DMAS-13	7/1/19	Pages 24 Page 24a is a runover page.
TN #DMAS-12	4/1/19	Pages 8, 9, 13
TN #DMAS-10	10/1/18	Table of Contents, page ii Pages 1-4 Page 40 was added.
TN #DMAS-9	7/1/18	Page 35 Appendix 2, Page 1
TN #DMAS-8	4/1/18	Page 9
TN #DMAS-7	1/1/18	Pages 34, Appendix 2, page 1
TN #DMAS-5	7/1/17	Pages 13, 37, 38
TN #DMAS-4	4/1/17	Pages 24, 30a Page 23 is a runover page. Page 24a was added as a runover page.

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1. Individual Under Age 19 and Not Receiving Long-term Care

A child under age 19 who is not receiving LTC services and who is claiming to have a disabling condition must have his disability determined by DDS if:

- he is not eligible for FAMIS Plus or FAMIS, or
- it is 90 calendar days prior to his 19th birthday.

Do **NOT** refer a disabled child under age 19 to DDS for the sole purpose of participation in the Health Insurance Premium Payment (HIPP) program

2. Individual Under 21 in LTC

a. Facility-based Care

An individual under age 21 in a nursing facility or intermediate care facility for the intellectually disabled (ICF-ID) must have his disability determined if

- he is not eligible in the Individuals Under 21 covered group, or
- it is 90 calendar days prior to his **21st** birthday.

b. **Home and Community-based Services (HCBS)**

A child who is receiving HCBS waiver services and has not previously had a disability determination must have his disability determined prior to his **18th** birthday because he will no longer be eligible in the F&C 300% SSI covered group (under which parental income is not counted), once he turns 18. The child must be evaluated for coverage as a blind or disabled individual using the income and resource rules applicable to blind/disabled institutionalized individuals. For a child under 19 who is not disabled, MAGI income counting rules require that parental income be included in the eligibility determination.

Ninety days (90) prior to the child turning age 18, the eligibility worker must contact the parent or responsible party and send a verification checklist to request the required documents to start the DDS referral process. Follow the procedure in M0310.112 G below to make a referral to DDS. *Continuous Enrollment protections will apply until the earlier of: the month that the child turns 19 or the month that their 12-month protected period ends.*

Note: The local DSS is not responsible for initiating a DDS referral for a child turning 18 who receives SSI. The child will have a review of continuing disability and SSI eligibility completed by the SSA. The child remains disabled for Medicaid purposes unless and until his disability status is discontinued by SSA.

E. When an LDSS Referral to DDS is Required

1. Disability Determination Has Not Been Made

The DDS must make a determination of disability when the applicant alleges a disability and a disability determination has not been made by SSA or the RRB. The DDS must make a disability determination within a time frame that will allow the LDSS to process the application within 90 days, provided all medical information has been submitted.



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M0320 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-38	4/1/26	Section M0320.400; Section M0320.500 page 33
TN #DMAS-37	1/1/26	Page 11
TN #DMAS-35	7/1/25	Sections .400 and .500
TN #DMAS-34	1/1/25	Pages 11, 27, 32, 34; Pages 32a and 34a are added
TN #DMAS-33	10/1/24	Pages 1, 5, 27, 37
TN #DMAS-32	7/1/24	Pages 24-26a, 29
TN #DMAS-29	10/1/23	Pages 1, 25, 26, 26a, 27, 28
TN #DMAS-27	4/1/23	Pages 11, 24, 25, 27
TN #DMAS-26	1/1/23	Page 11
TN #DMAS-24	7/1/22	Pages 2, 30, 31, 33
TN #DMAS-23	4/1/22	Page 27
TN #DMAS-22	1/1/22	Pages 11, 26a, 27
TN #DMAS-20	7/1/21	Pages 24, 26-29
TN #DMAS-19	4/1/21	Pages 26a, 29
TN #DMAS-18	1/1/21	Pages 11, 22, 26, 27
TN #DMAS-17	7/1/20	Pages 24. 25. 26, 27; Page 26a is a runover page.
TN #DMAS-15	1/1/20	Pages 11, 26, 27, 29
TN #DMAS-14	10/1/19	Page 40
TN #DMAS-13	7/1/19	Pages 1, 24-27
TN #DMAS-11	1/1/19	Pages 2a, 11, 35, 37
TN #DMAS-10	10/1/18	Page 1; 1a added as a runover page
TN #DMAS-9	7/1/18	Page 2, 17
TN #DMAS-7	1/1/18	Page 2, 3, 4, 11, 26-27.
TN #DMAS-4	4/1/17	Page 26
TN #DMAS-3	1/1/17	Pages 11, 27, 29, 40, 41, 44, 45, 52
TN #DMAS-2	10/1/16	Pages 4, 15, 16, 18, 20, 22, 30, 33, Pages 39- 41, 43-45, 48, 51, 52, 55
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 1, 11, 25-27, 46-49;Page 50 is a runover page.
TN #100	5/1/15	Pages 6, 11, 24, 25-27, 29-30
TN #99	1/1/14	Page 11
TN #98	10/1/13	Pages 1, 54, 55.
UP #9	4/1/12	Pages 11, 26, 32, 34-37, 45, 46, 55
TN #97	9/1/12	Table of Contents; Pages 1-56 (all pages)
UP #6	4/1/12	Pages 11, 12, 46a
TN #96	10/1/11	Table of Contents; Pages 46f-50b; Page 50c deleted
TN #95	3/1/10	Pages 11, 12, 42c, 42d, 50, 53, 69 Pages 70, 71; Page 72 added.
TN #94	9/1/10	Pages 49-50b
UP #3	3/1/10	Pages 34, 35, 38, 40, 42a, Pages 42b, 42f
TN #93	1/1/10	Pages 11-12, 18, 34-35, 38 Pages 40, 42a-42d, 42f-44, 49 Pages 50c, 69-71
UP #2	8/24/09	Pages 26, 28, 32, 61, 63, 66
Update (UP) #1	7/1/09	Pages 46f-48
TN #91	5/15/09	Pages 31-34 Pages 65-68



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M0320 Changes

Changed With	Effective Date	Sections Changed
TN #DMAS-38	4/1/26	M0320.400
TN #DMAS-35	7/1/25	M0320.400 M0320.500 (formatting only)

Virginia Medical Assistance Eligibility Manual Chapter M03

Section Revision Date July 2025

M0320.000 AGED, BLIND & DISABLED GROUPS

M0320.400 MEDICAID WORKS

A. Policy

The Appropriations Act of 2006 authorized an amendment to the Virginia State Plan for Medical Assistance that allows disabled (including blind) individuals to work and earn higher income while retaining Medicaid coverage. This program is called MEDICAID WORKS and includes individuals:

- at least age 16 and are under age 65, **and**
- who have countable income less than or equal to 138% FPL **and**
- who have countable resources less than or equal to $2,000 for an individual and $3,000 for a couple; **and**
- who are working or have a documented date for employment to begin in the future.
- Current participation in the Social Security Administration (SSA) programs Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) will satisfy the condition for disability. Any applicant without SSA documentation of disability should be evaluated by the state's Disability Determination Services program before eligibility can be established.

These individuals can retain Medicaid coverage as long as they remain employed, and their Countable earned income is less than or equal to $6,250 per month. MEDICAID WORKS is Virginia's Medicaid Buy-In (MBI) program.

B. Relationship Between MEDICAID WORKS and 1619(b) Status

An individual with SSI or eligible for Medicaid as a Qualified Severely Impaired Individual (QSII) (1619(b)) must meet the 138% FPL income requirement for entry into MEDICAID WORKS and should not be discouraged from enrolling in MEDICAID WORKS. An individual who meets the criteria for 1619(b) status and the 138% income limit may choose to participate in MEDICAID WORKS because of the higher resource limit. SSI or eligible for Medicaid as a Qualified Severely Impaired Individual (QSII) (1619(b)) individuals are not automatically enrolled in Medicaid Works. They must be evaluated according to the non-financial and financial requirements used for all MEDICAID WORKS applicants and enrollees.

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Individuals may have their Social Security payments stop when their earnings are above the SSI threshold or SGA level. If the client would otherwise be eligible for a cash benefit if not for their earnings and has not had a determination of medical improvement following a Continuing Disability Review (CDR), they are still considered disabled for Medicaid Works purposes. Individuals receiving 1619(b) Medicaid protections who request enrollment in Medicaid Works are considered disabled but must have their income and resources evaluated according to the guidelines for initial eligibility.

C. Nonfinancial Eligibility

The individual must also meet the following additional non-financial criteria:

- The individual must be competitively employed in an integrated setting. Work must occur in a work setting in the community or in a personal business alongside people who do not have disabilities. Work performed in a supervised sheltered workshop designed to provide employment opportunities for individuals with disabilities or similar setting is not considered competitive employment in an integrated setting. Contact a Regional Medical Assistance Program Consultant if there is a question about whether the employment meets the criteria for MEDICAID WORKS.

- The individual must receive pay at the minimum wage or at the prevailing wage or "going rate" in the community, and the individual must provide documentation that payroll taxes are withheld. Self-employment must be documented according to the policy contained in S0820.210.

- The individual must establish a Work Incentive (WIN) Account at a bank or other financial institution, such as a checking or savings account which can be established prior to the application date. The individual must provide documentation for the case record designating the account(s) as a WIN Account. The account must either be a new account or an existing account with only earned income deposited into it. Increases in an enrollee's Social Security Disability benefits resulting from employment as a MEDICAID WORKS participant OR because of a COLA adjustment to the Social Security Disability benefits may also be deposited into the WIN account and will be excluded as described in M0320.400 D.3.b.3) if the increase is regularly deposited upon receipt into the WIN account. The WIN account cannot contain the individual's other Social Security benefits. The individual must provide statements from the institution where the account is held at application and renewal.

- If there is only one disabled individual on a jointly held account, we presume that all the funds in the account belong to that individual. A previously established ABLE account can be used as a WIN account.

- All individuals requesting enrollment in MEDICAID WORKS must also sign a MEDICAID WORKS agreement, available at Medical Assistance Forms or

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Medicaid Works Agreement. The agreement outlines the individual's responsibilities as an enrollee in the program.

D. Financial Eligibility

1. Assistance Unit

a. Initial eligibility determination

To qualify for MEDICAID WORKS, the individual must meet the assistance unit policy and procedures in chapter M05 that apply to ABD non-institutionalized individuals. Individuals receiving SSI or who have 1619(b) status must also meet the income requirement for entry into MEDICAID WORKS.

Income from a non-ABD spouse, non-applicant/member ABD spouse, or parents is not considered deemable income and is not counted for the initial eligibility determination for individuals requesting to participate in MEDICAID WORKS.

Resources from the individual's spouse with whom he lives or, if under age 21, the individual's parents with whom he lives, must be deemed available.

b. Ongoing eligibility

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

Note: Children and non-spouse dependents are not included in the assistance unit when determining eligibility for MEDICAID WORKS.

2. Resources

a. Initial eligibility determination

For the initial eligibility determination, the resource limit is $2,000 for an individual and $3,000 for a couple. Resources must be evaluated for all individuals, including SSI recipients and QSII/(1619(b) individuals, who wish to qualify for MEDICAID WORKS. The resource requirements in chapter S11 and Appendix 2 to chapter S11 apply for the initial eligibility determination. The individual's countable, nonexempt resources must be verified. All countable resources, must be added together to determine if the individual's countable resources are within the limit. WIN accounts and other non-countable resources are excluded from the resource determination.

b. Ongoing eligibility

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

1) For earnings accumulated after enrollment in MEDICAID WORKS, up to the current 1619(b) income threshold amount will be disregarded if deposited and retained in the WIN Account. The 2024 1619(b) threshold amount is $45,976 (decreased from the 2023 amount). The 2025 1619(b) threshold

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amount is $59,755.

2) Resources accumulated while in MEDICAID WORKS and held in Internal Revenue Service (IRS)-approved retirement accounts, medical or health savings accounts, medical reimbursement (flex) accounts, education accounts, independence accounts, and other similar State-approved accounts are excluded. Examples of these accounts include Archer Medical Savings Accounts, 401(k)/403(b)/457(b)/503(b) accounts, traditional Individual Retirement Accounts (IRAs), Roth IRAs, SEP-IRAs, SIMPLE IRAs, and Thrift Savings Plans. The account must be designated as a WIN Account to be excluded. Resources accumulated while in MEDICAID WORKS and held in IRS-approved accounts that have been designated as WIN Accounts are also excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees. The account must be exclusively used to hold resources accumulated while in MEDICAID WORKS (including interest) for the exclusion to continue. Resources can be spent however the individual chooses. Transfer of assets policy does not apply to Medicaid Works.
3) Resources can be spent however the individual chooses. Transfers will be evaluated to determine if a penalty should be calculated if the individual applies for (or is receiving) LTSS.
4) For all other resources, the resource requirements in chapter S11 and Appendix 2 to chapter S11 apply. All of the individual's countable, nonexempt resources must be verified and evaluated. All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements. The resource limit for resources not excluded in 1) or 2) above is $2,000 for an individual. Accounts are also excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees. The account must be exclusively used to hold resources accumulated while in MEDICAID WORKS (including interest) in order for the exclusion to continue.
5) For all other resources, the resource requirements in chapter S11 and Appendix 2 to chapter S11 apply. All the individual's countable, nonexempt resources must be verified and evaluated. All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements. The resource limit for resources not excluded in 1) or 2) above is $2,000 for an individual.

3. Income

a. Initial eligibility determination

For the initial eligibility determination on or after January 15, 2025, the limit for total countable income (unearned and earned) is less than or equal to 138% of the FPL ($1,801 per month for an individual or $2,434 when the applicant has an ABD spouse who is also applying for or covered by Medicaid). Use the rules in chapter M08 to determine income in the month of application. (see M0320.101).

b. Ongoing eligibility

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Once the individual is enrolled in MEDICAID WORKS, the following income policies apply:
1) The income limit for earned income is $6,250 per month ($75,000 per year) (no change for 2025) if the funds are deposited in a WIN Account. The policy for determining countable earned income is contained in subchapter M0820.
If the individual is self-employed, net earnings from self-employment (NESE) must be demonstrated through documentation of Internal Revenue Service (IRS) filings, quarterly estimated taxes, business records, and/or business plans. The individual's signed allegation of self-employment is acceptable if no other evidence of NESE can be obtained. Follow the policy in M0820.220 to determine NESE.

2) The income limit for unearned income remains less than or equal to 138% of the FPL. The policy for determining countable unearned income is contained in subchapter M0830.

3) Any increase in an enrollee's Social Security Disability benefits resulting from employment as a MEDICAID WORKS participant OR because of a COLA adjustment to the Social Security Disability benefits will not be counted as long as the increase is regularly deposited upon receipt into the individual's WIN account.

4. **Income Exceeds 138% FPL at Eligibility Determination**
Spenddown does not apply to the Medicaid Works covered group. Therefore, admission into MEDICAID WORKS is not available to individuals whose income exceeds 138% of the FPL. Evaluate the individual's eligibility in all other Medicaid covered groups.

G. Safety Net

Resources held in the WIN Account that are accumulated from the enrollee's earnings while in MEDICAID WORKS will be disregarded up to the 1619(b) threshold amount for this eligibility determination.

If found eligible and enrolled in another Medicaid covered group, the individual shall have a "safety-net" period of up to one year from MEDICAID WORKS termination and enrollment in another group to dispose of these excess resources before they are counted toward ongoing eligibility. If the individual resumes working within the safety-net period, he may be re-enrolled in MEDICAID WORKS provided that all eligibility requirements are met, except that the resources in the WIN Account are disregarded up to the 1619(b) threshold amount. If the individual wishes to be re-enrolled in MEDICAID WORKS after the one-year safety net period, any resources retained in the WIN Account remain exempt. **Resources accumulated while in MEDICAID WORKS and retained in an IRS approved account described in M0320.400 D. 2. b. 2) that has been designated as a WIN Account are excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees.**

H. Benefit Package

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Individuals enrolled in MEDICAID WORKS are entitled to the standard benefits available to full-benefit Medicaid enrollees (see Chapter M18). Medicaid Works members cannot be enrolled in Developmental Disabilities (DD) waivers or CCC Plus waivers, but the waiver slot will be held for up to six months if a DD Waiver recipient wants to try transitioning to Medicaid Works. Waiver slots are not held for CCC Plus recipients since there is no waiting list for CCC Plus waiver services. Participants can receive personal care services as a service provided by the assigned MCO plan. **No medical screening is required, and MEDICAID WORKS enrollees do not have a patient pay responsibility.** Intensive Behavioral Dietary Counseling is also covered for MEDICAID WORKS enrollees when a physician determines that the service is medically necessary.

I. Entitlement and Enrollment

Entitlement for MEDICAID WORKS is dependent upon meeting the requirements listed above. All requests for Medicaid Works should be evaluated and documented even if a member is currently eligible for Medicaid under another full or limited coverage category.

There is no retroactive coverage under MEDICAID WORKS. The application date *to be used for the Medicaid Works determination* in the Virginia Case Management System (VaCMS) is the date the *member requested a Medicaid Works determination*. *The request may be in writing or by phone, but must be documented in the case comments.* Coverage shall begin on the first day of the month following the month in which all requirements are met. If the applicant has a future start date for employment, the effective date of eligibility shall be no earlier than the first day of employment. However, unless employment begins on the first day of the month, MEDICAID WORKS enrollment will begin on the first of the following month. If the person is already enrolled in Medicaid, a new application is not required. Appendix D should be completed to gather additional information on resources. If the person is not currently enrolled in Medicaid, a full application is necessary.

The Aid Category for MEDICAID WORKS is **059**. Use the following procedures to enroll the individual in VaCMS:

<u>New Application – Applicant is Disabled and enrolled in Medicaid</u>

1. For the month of application and any retroactive months in which the person is eligible, enroll the individual in the appropriate AC in a closed period of coverage, beginning the first day of the month in which eligibility exists. The cancel date is the last day of the month in which the MEDICAID WORKS *request was received*. Use Cancel Code 042.
2. Reinstate the individual's coverage in MEDICAID WORKS using AC 059 beginning the first day of the following month (the first day of the month following the month in which the MEDICAID WORKS *request* is received). Use the same application date (the actual date of the initial application) that was used for the month of application.

DMAS approval is not required for participation in MEDICAID WORKS; however, information must be sent to DMAS after the individual is enrolled for tracking purposes. Use the MEDICAID

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WORKS Email Cover Sheet available at Medical Assistance Forms, and **email** it together with the following information to DMAS at **MedicaidWorks@dmas.virginia.gov**:

- *Documentation of the* MEDICAID WORKS *request*,
- the Work Incentive Account (WIN) information (a bank account statement or verification from the bank that the account was opened), and
- a pay stub showing current employment or an employment letter with start date or self-employment document(s) to verify employment.

Current Enrollee

1. Cancel current coverage using Cancel Code 042.
2. Reinstate in AC 059 beginning the first day of the following month. **Use the date the MEDICAID WORKS *request* for the application date**.

Send a Notice of Action to the applicant/recipient advising him of his eligibility and acceptance into MEDICAID WORKS. Do not send the Advance Notice of Proposed Action when a recipient moves to MEDICAID WORKS, because his Medicaid coverage has not been reduced or terminated.

Eligibility for MEDICAID WORKS continues as long as the enrollee continues to:

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

The MEDICAID WORKS enrollee continues to meet the disability criteria unless SSA has completed a Continuing Disability Review and has determined that the individual no longer has a disabling condition. The fact that the MEDICAID WORKS enrollee is earning over the SSA substantial gainful activity amount has no bearing on whether the disability criteria is met. In addition, an individual can still be considered disabled by SSA and not receive a monthly payment. After checking the disability status and termination date by electronic sources and if the enrollee's disability status remains unclear, contact a Regional Medical Assistance Program Consultant for assistance.

The individual's continuing eligibility must be determined at least every 12 months.

If the individual is no longer eligible for MEDICAID WORKS, evaluate the individual to determine if the individual remains eligible in any other covered group. **The policy in M0320.400 G. above must be reviewed to determine whether the resource exclusion safety net rules apply.** If the individual is not eligible for Medicaid in any other covered group, coverage shall be cancelled effective the first of the month following the expiration of the 10-day advance notice.

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Manual Title	Chapter	Page Revision Date	
Virginia Medical Assistance Eligibility	**M03**	**April 2026**	
Subchapter Subject	Page ending with		Page
M0320.000 AGED, BLIND & DISABLED GROUPS	**M0320.502**		**33**

M0320.502 ABD RECEIVING MEDICAID WAIVER SERVICES (CBC)

A. Policy

42 CFR 435.217 - The state plan includes the covered group of aged, blind or disabled individuals in the community who

- would be eligible for Medicaid if institutionalized;
- are authorized to receive Medicaid waiver services and have selected the option to receive Medicaid waiver services in lieu of nursing facility services;
- in the absence of the waiver services would require the level of care furnished in a hospital, nursing facility or ICF-MR; and
- have income that does not exceed 300% of the SSI individual payment limit (see M0810.002 A. 3).

Do not wait until the individual starts to receive the waiver services to determine eligibility in this covered group. Determine eligibility in this covered group if the individual is authorized (see subchapter M1420) to receive Medicaid waiver services and has selected the option to receive Medicaid waiver services in lieu of nursing facility services. Presume the individual will receive the services and go on to determine financial eligibility using the policy and procedures in C. below.

If the individual's eligibility was determined as an institutionalized individual prior to the receipt of waiver services, the EW must verify the receipt of Medicaid CBC services within *180* days of the date of the Notice of Action on Medicaid. If Medicaid CBC services did not start within *180* days of the date of the Notice of Action on Medicaid, the individual's continued eligibility must be re-evaluated as a non-institutionalized individual.

B. Financial Eligibility

1. Asset Transfer

The individual must meet the asset transfer policy in subchapter M1450.

2. Resources

a. Resource Eligibility - Unmarried Individual

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements in chapter S11 (ABD Resources). Pay close attention to:

1) equity in non-exempt property contiguous to the individual's home which exceeds $5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property, and
2) ownership of his/her former residence when the individual has been away from his home property for longer than 6 months. Determine if the home property is excluded in M1130.100.

DO NOT DEEM any resources from a blind or disabled child's parent

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M0330 Changes
Page 2 of 2

Changed With	Effective Date	Pages Changed
TN #DMAS-38	4/1/26	Page 15
TN #DMAS-35	7/1/25	Pages 1 and 9
TN #DMAS-33	10/1/24	Pages 1a, 24
TN #DMAS-32	7/1/24	Page 1a, 4
TN #DMAS-31	4/1/24	Pages 8, 26-28
TN #DMAS-30	1/1/24	Pages 1, 2, 4, 6, 8, 10, 12, 17, 20, 23, 34, 35, 38, 40
TN #DMAS-26	1/1/23	Page 10
TN #DMAS-24	7/1/22	Pages 1, 2, 15, 18, 29, 31, 32 Page 2a was added as a runover page.
TN #DMAS-23	4/1/22	Table of Contents Pages 1, 2, 5, 7, 8, 29, 37, 39, 40
TN #DMAS-20	7/1/21	Pages 1, 13, 14
TN #DMAS-19	4/1/21	Pages 14, 26
TN #DMAS-14	10/1/19	Pages 1, 2, 10a
TN #DMAS-12	4/1/19	Pages 26, 28
TN #DMAS-11	1/1/19	Pages 1, 2, 12, 14-16, 24, 25
TN #DMAS-10	10/1/18	Table of Contents Page 1-2, 30 Page 10a-b were added as runover pages.

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For example, a married pregnant woman applies for Medicaid on October 10. She received a medical service in the retroactive period. Her expected delivery date is January 15. She and her husband have been unemployed since June 23. Her husband began earning $3,000 a month on October 9; she remains unemployed. Since they had no income during the retroactive period, she is found eligible for retroactive coverage effective July 1.

Because her available income (from her husband) changed after she established eligibility on July 1, the change in income does not affect her eligibility and she remains eligible for Medicaid in October and subsequent months until she no longer meets the pregnant woman definition or other nonfinancial requirements.

b. Newborn

Income changes do NOT affect the certain newborn's eligibility for the first year of the child's enrollment as a certain newborn.

The mother's failure to complete a renewal of her own eligibility and/or the eligibility of other children in the household does NOT affect the eligibility of the certain newborn.

5. Income Exceeds Limit

If the pregnant woman's income exceeds the 143% FPL limit, she is not eligible in this covered group. Determine her eligibility for FAMIS MOMS. If the pregnant woman is not eligible for FAMIS MOMS, evaluate her eligibility as MN (see M0330.801). Ineligible women, other than incarcerated women, must be referred to the Health Insurance Marketplace for evaluation for the APTC.

D. Entitlement

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

The newborn's Medicaid coverage begins the date of the child's birth. A renewal must be completed for the newborn in the last month in which the child meets the Newborn Children Under Age 1 covered group and must include SSN or proof of application, as well as verification of income.

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

After her eligibility is established as a pregnant woman, the woman's Medicaid entitlement continues for 12 months following the end of the month in which her pregnancy ends (*with birth or for any reason)*, regardless of income changes. Medicaid coverage ends the last day of the 12th month.

If a Medicaid or FAMIS MOMS recipient who applied effective November 1, 2021 [or a CHIPRA214 (lawfully residing individual) who applied effective April 1, 2022] whose pregnancy has ended reapplies for coverage after July 1, 2022, she is entitled to the remainder of the 12 month post-partum period she would have received had her coverage not been canceled.

E. Enrollment

The AC for pregnant women who are not incarcerated is 091. The AC for pregnant women who are incarcerated is 109. The AC for newborns born to women who were enrolled in Medicaid is 093.

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M0520 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-38	4/1/26	Page 2
TN #DMAS-33	10/1/24	Page 4
TN #DMAS-19	4/1/21	Page 2
TN #DMAS-12	4/1/19	Page 1, 2
TN #DMAS-10	10/1/18	Page 2
TN #DMAS-3	1/1/17	Table of Contents Pages 3, 5-35 Pages 36-38 were removed.
TN #100	5/1/15	Page 2
TN #98	10/1/13	Title Page Table of Contents Pages 1,2,9
UP #7	7/1/12	Table of Contents Pages 2-5
Update (UP) #4	7/1/10	Pages 2, 2a

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4. Psychiatric Residential Treatment Facilities (PRTFs)

Children residing in a PRTF (formerly called a Level C PRTF) are not temporarily absent from home. They are indefinitely absent from home and are not living with their parents or siblings for Medicaid purposes, if their stay in the facility has been 30 calendar days or longer. Long-term care rules do not apply to these children.

If the child is placed in a PRTF, verify that the facility is on the *DMAS* website at *Rate Setting*. *Scroll down and c*lick on ***Behavioral Health; PRTF/ARTS; Rates Effective July 1, 2025***. If the facility is not a PRTF facility, the child is NOT considered living away from his parents.

5. Medical Facilities

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

6. Parent/ Caretaker-Relative Living in the Home

A parent/caretaker-relative who is absent from the home is considered living with a child in the household if the absence is temporary and the parent/caretaker-relative intends to return home when the purpose of the absence (such as military service, vacation, education, medical care or rehabilitation) is complete.

C. Procedure

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

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

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SECTION M1470.001: PATIENT PAY OVERVIEW

Last Section Revision Date: April 2026

A. Introduction

"Patient pay" is the amount of the long-term care (LTC) patient's income which must be paid as the share of the LTC services cost. This subchapter provides basic rules regarding the post-eligibility determination of the amount of the LTC patient's income which must be paid toward the cost of care. **MAGI Adults, Hospice recipients receiving services outside a facility and individuals participating in the Medicaid Works program have no responsibility for patient pay (see M03 for more information).** If an individual receiving LTC, also called long-term services and supports (LTSS), loses eligibility in one of these covered groups and is eligible in a different full coverage group, patient pay policy will apply.

B. Policy

The state's Medicaid program must reduce its payment to the LTC provider by the amount of the eligible patient's monthly income, after allowable deductions. Patient pay is calculated using actual verified income after an individual has been determined eligible for Medicaid and for Medicaid LTC services. A non-Medically Needy Medicaid recipient who is admitted to a nursing facility, facility for individuals with intellectual disability (ICF-ID) or Medicaid waiver services for less than 30 calendar days must have a patient pay determined for the month(s) in which the recipient is in the facility or waiver services**.** Medically Needy Medicaid does not cover services in ICF-ID or other facilities for less than 30 days. See M1470.320. The provider collects the patient pay from the patient or the authorized representative. Patient pay information is fed to the Automated Response System (ARS) and the MediCall Systems for provider verification of patient pay. These systems report the amount of patient pay and the date of service to the provider responsible for collecting patient pay.

C. VaCMS Patient Pay Process

The patient pay calculation is completed in VaCMS. Refer to the VaCMS Help feature for information regarding data entry. The patient pay must be updated in the system whenever the patient pay changes, but at least once every 12 months. If VaCMS is not able to process required transactions, a Patient Pay Correction Request *should be submitted through the Coverage Correction Portal (CCP) on the MES website.*, *Home | MES*. *To access the CCP and User Guides, LDSS, VDSS, CoverVA, and DMAS staff must sign into the MES using their current credentials and then sign into the MMIS with their eCode. The patientpay@dmas.virginia.gov mailbox will remain active to answer question from LDSS, VDSS, CoverVA, and DMAS staff*. If attested income was used to determine eligibility, actual income must be verified to calculate patient pay. If actual income was not obtained

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while determining eligibility the worker must request income verification to calculate patient pay by adding a comment on the notice. If the verified income affects eligibility for the individual, process as a change. If no additional verification is received, the estimated patient pay remains a liability for the individual.

D. Patient Notification

The patient or the authorized representative is notified of the patient pay amount on the Notice of Patient Pay Responsibility. VaCMS will generate and send the Notice of Patient Pay Responsibility. M1470, Appendix 1 contains a sample Notice of Patient Pay Responsibility generated by VaCMS. DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into the Medicaid Enterprise System (MES, formerly MMIS).

The provider is the only entity with the authority to take action when residents do not pay their patient pay amount. If a resident, or his authorized representative is negligent in paying his patient pay amount to the provider, the provider will provide written documentation regarding the requirement to pay the patient pay amount to the resident or authorized representative and follow the provider's collection procedures to collect the funds. The provider will report the resident's negligence in paying the patient pay amount to the LDSS.

The provider's failure to collect the patient pay, or the patient's failure to pay the patient pay, does not itself affect the patient's Medicaid eligibility. However, the EW must review the patient's resources each month to determine if the resources are within the Medicaid limit.

If the individual resides in a nursing facility and the above attempts to collect the patient pay amount are unsuccessful, DMAS has advised that the facility may take one of the following options:

1. **Facility Option #1**

   The facility will notify the LDSS no later than 120 calendar days from the due date of the payment. The facility will include in this notification a copy of the third collection statement, a written notification of the situation, documentation of contacts made with the resident or authorized representative, and the reasons why payment has not been made.

   The LDSS will take the following steps:

   - Upon receipt of the written notice from the facility, the local DSS will review the case to determine if the individual's resources are within Medicaid eligibility limits or if a transfer of assets has occurred.
   - If the individual alleges that he does not receive sufficient income to pay his patient pay, the eligibility worker will review the patient pay amount and make any necessary adjustments.



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2. Facility Option #2

Discharge or transfer the resident, including transferring the resident within the facility, except as prohibited by the Virginia State Plan for Medical Assistance Services.

Prior to discharge or transfer, the facility must provide reasonable and appropriate notice of the required patient pay, and the resident or authorized representative must be given at least 30 *calendar* days written notice prior to the discharge or transfer, which shall include appeal rights. If the resident or authorized representative does not agree with this action, they may submit an appeal request to DMAS. The individual will be allowed to continue residing in the facility during the appeal process.

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Subsection M1470.430: Medicaid CBC – Noncovered Medical Expenses

Last Subsection Revision Date: April 2026

A. Policy

B. Health Insurance Premiums

C. Noncovered Medical/Dental Services

Deductions for the cost of a patient's medically necessary medical or dental services not covered by Medicaid, other insurance (such as Medicare), or another person are subtracted from income to determine patient pay.

See M1470.430 B.3 for the procedures used to deduct Medicare Part D prescription drug co-pays for patients who have Medicare.

DMAS approval **is not** required for deductions of noncovered services from patient pay when the individual receives CBC services, regardless of the amount of the deduction.

1. **Zero Patient Pay Procedures** – If deductions from patient pay cannot be allowed because the recipient has no income remaining after deducting the personal maintenance allowance, dependent child allowance(s) and health insurance premiums, or the recipient has no income available for patient pay, deny the request.

   Notify the patient or the patient's representative using the Notice of Action.

   If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service has been approved, notify the patient or his authorized representative that the deduction for the new non-covered service will be made after the first noncovered service deductions are completed.

2. **Allowable Non-covered Expenses** – When a patient has income available for patient pay, the following can be deducted as noncovered expenses:
   a. **Old Bills**

      Old bills are deducted from patient pay as non-covered expenses. Old bills are unpaid medical, dental or remedial care expenses which:

      - were incurred prior to the Medicaid application's retroactive period, or during the retroactive period if the individual was not eligible for Medicaid in the retroactive period or the service was not a Medicaid-covered service,



- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and
- remain a liability to the individual.

b. **Medically Necessary Covered Services Provided by a Non-participating Provider**

Medically necessary medical and dental services that are covered by Medicaid, but that the recipient received from a provider who does not participate in Virginia Medicaid, are deducted from patient pay as non-covered services.

c. **Covered Services Outside of Medicaid's Scope**

Medically necessary medical and dental services that can be deducted from patient pay are:

- services exceeding Medicaid's amount, duration, or scope.
- services rendered during a prior period of Medicaid eligibility (i.e., LTC services not covered because of a property transfer).

d. **Other Allowable Noncovered Services**

Medically necessary medical and dental services that are NOT covered by Medicaid and can be deducted from patient pay include:

1) Medical supplies, such as antiseptic solutions, incontinent supplies (adult diapers, pads, etc.), dressings, EXCEPT for patients under the Technology-assisted Individuals Waiver (Medicaid covers these services for Technology-assisted Individuals Waiver patients). For Medicaid CBC recipients who have Medicare Part B, do not deduct the cost of supplies/equipment obtained from a Medicare/Medicaid supplier since the supplier receives direct payment from Medicare and Medicaid.

- Dental services not provided by a Medicaid provider or covered by Meidcaid**.** Effective July 1, 2021, Medicaid covers dental services for full-benefit adults, as well as children (see M1850.100.D) Pre-approval for dental services that exceed $500 must be obtained from DMAS prior to receipt of service
  2) Routine eye exams, eyeglasses and eyeglass repair
  3) Hearing aids (when medically necessary), hearing aid batteries and hearing aid repair
  4) Batteries for power wheelchairs or other power mobility items owned by the recipient, not to exceed four batteries in a 12-month period



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5) Chiropractor services, except for Medicare recipients (Medicare covers chiropractor services and Medicaid covers the Medicare deductible and coinsurance amounts)
6) Dipyridamole (Persantine) and other prescription medications not covered by Medicaid but ordered by the recipient's physician
7) Copayments for prescription drugs obtained under Medicare Part D

e. **Medicare Part D Copays**

Individuals who:

- qualify for Medicare Part D,
- are NOT enrolled in a Medicare PDP, and
- are NOT Medicaid eligible at the time of admission to CBC

will be fully responsible for their drug costs until Medicaid eligibility is determined and the Medicare Part D PDP enrollment process is completed. The individual remains responsible for any drugs purchased prior to the effective date of the PDP enrollment; Medicaid cannot pay for these drugs. The cost of drugs purchased before the PDP begin date can be deducted from patient pay.

Full benefit Medicaid enrollees who have Medicare, are receiving Medicaid CBC services, and are enrolled in a Medicare Part D PDP were responsible for the payment of co-pays for prescriptions filled prior to January 1, 2012. Effective January 1, 2012, individuals receiving Medicaid CBC services are not responsible for co-pays for prescriptions covered under their Medicare Part D PDP. CBC recipients are not subject to payment of deductibles or a coverage gap in their Part D benefits.

1) Monthly Statements – PDPs must issue a periodic (at least monthly) statement to the beneficiary explaining all benefits paid and denied. Part D drugs that are not covered by the PDP may not be covered by Medicaid and, absent other drug coverage, remain the responsibility of the individual. When a PDP denies coverage of a prescription, the beneficiary has the right to request an exception for coverage of the drug. The beneficiary is notified in writing of the decision on any exception requested.
2) Verifying Allowable Copays – To determine whether or not prescription expenses can be deducted from patient pay, apply the following rules:

   If the drug expense appears on the statement as a denial, and no exception was requested, **do not** allow the expense.

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If the drug expense appears on the statement as a denial, and an exception was requested and denied, allow the expense.

Enrollees should be advised to maintain these monthly statements if they wish to request patient pay adjustments for Medicare Part D co-pays and for drugs for which the PDP denied coverage.

3. **Services NOT Allowed**
    a. Medical supplies covered by Medicaid or Medicare when the recipient has Medicare, such as:
        - Diabetic and blood/urine testing strips
        - Bandages and wound dressings
        - Standard wheelchairs
        - Air or egg-crate mattresses
        - IV treatment
        - Splints
        - Certain prescription drugs (placebos)
    b. TED stockings (billed separately as durable medical supplies)
    c. Acupuncture treatment
    d. Massage therapy
    e. Personal care items, such as special soaps and shampoos
    f. Physical therapy
    g. Speech therapy
    h. Occupational therapy
    i. Services that are NOT medical/remedial care services, even if ordered by a physician:
        - Air conditioners or humidifiers
        - Refrigerators, whole house generators and other non-medical equipment
        - Assisted living facility (ALF) room and board and services
        - Personal comfort items, such as reclining chairs or special pillows
        - Health club memberships and costs
        - Animal expenses such as for seeing eye dogs
        - Cosmetic procedures
    j. Personal care or other waiver services in excess of the number of hours authorized by DMAS (i.e., private pay).
4. **Documentation Required**
    a. **Requests for Adjustments from a Patient or an Authorized Representative**

    Request the following documentation from the patient or representative:



- A copy of the bill
- The amount still owed by the patient
- If applicable, the amount owed that was not covered by the patient's insurance
- And proof that the service was medically necessary. Proof may be the prescription, doctor's referral or a statement from the patient's doctor or dentist. Proof applies to a physician, doctor, or dentist's current, and not "standing," order(s).

b. **Requests for Adjustments from CBC Providers**

If the request for an adjustment to patient pay to deduct a noncovered expense is made by a Medicaid CBC waiver service provider or case manager, the request must be accompanied by:

- the recipient's correct Medicaid ID number,
- the current physician's order for the non-covered service (not required for replacement of hearing aid batteries or eyeglass frames or for repair of hearing aids or eyeglasses),
- actual cost information,
- documentation that the recipient continues to need the equipment for which repair, replacement, or battery is requested, and
- a statement of denial or non-coverage by other insurance. The denial may be from the insurance carrier or may be a written statement from the facility that the insurance company was contacted and the item/service is not covered.

If the request from a provider or case manager does not include all the above documentation, return the request to the provider or case manager asking for the required documentation.

5. **Procedures**

a. **Determine Deduction** – When the individual receives CBC services, DMAS approval **is not required** for deductions of noncovered services from patient pay, regardless of the amount of the deduction.

Determine if the expense is deducted from patient pay using the following sequential steps:

1) Upon receipt of the requested documentation, determine the amount of the bill that is a valid deduction. Do not deduct more than the available income that remains after the personal needs, dependent child allowance(s), and health insurance premiums are deducted.



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If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service is requested, deduct the new noncovered services after the first noncovered service deductions have been completed.

2) Subtract the deduction for the current month. If the deduction exceeds the available income, the remaining balance can be carried over to the following month(s).

b. **Notice Procedures** – Upon the final decision to allow the deduction, use the VaCMS Patient Pay process to adjust the patient pay. VaCMS will generate and send the Notice of Patient Pay Responsibility If VaCMS is not able to process required transactions, a Patient Pay Correction Request *should be submitted through the Coverage Correction Portal (CCP) on the MES website.*, *Home | MES*. *To access the CCP and User Guides, LDSS, VDSS, CoverVA, and DMAS staff must sign into the MES using their current credentials and then sign into the MMIS with their eCode. The patientpay@dmas.virginia.gov mailbox will remain active to answer question from LDSS, VDSS, CoverVA, and DMAS staff.* DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into *MES*.

6. **Managed Care Organizations and CCC Plus (effective January 1, 2018)**

As of January 1, 2018, the majority of Medicaid-eligible individuals who receive long-term care (LTC) services are covered under the CCC Plus program through one of six (6) managed care organizations (MCO). As part of the CCC Plus program, each health plan offers enhanced benefits, such as adult dental services or hearing aids, outside of the required contracted Medicaid services. Some of these enhanced benefits are frequently submitted to the LDSS as patient pay adjustment.

If there are other coverage sources available for these services or items, Medicaid policy requires the request for coverage first be submitted to those sources and exhausted there, before the LDSS/DMAS may consider or approve a patient pay adjustment.

A process is in development to develop a process for distinguishing MCO enhanced benefit services from allowable patient pay deductions. Until further notice, providers and nursing facilities will continue sending all patient pay adjustment requests to the patient's LDSS eligibility worker.

Eligibility workers will review and process patient pay adjustment requests without requiring submission of the request to the individual's CCC Plus plan.

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D. EXAMPLE – CBC Deduction of Noncovered Services (Using January 2009 Figures)

An aged, single individual, with no dependent child and no guardian or conservator, who lives in Group II, applied for Medicaid for the first time in June. Is approved by the screener for long-term care under the *EDCD* waiver. Gross income is $950 Civil Service Annuity (CSA) and $500 SSA. Resources are within the Medicaid limit. Has Medicare and federal employee's health insurance (Medicare is withheld from the SSA check at the rate of $96.40 per month and $80 is withheld from his CSA for the Health Insurance). Because income is less than 300% of the SSI income limit, *the individual* meets the 300% SSI group.

Retroactive eligibility *is denied* because *there were* no Medicaid covered services in the retroactive period. *The individual* owes $1,500 on a hospital bill incurred the prior September and is making payments. Patient pay for June is determined in the following steps:

Step 1: Gross Income

Start with	$950	CSA
Add	$500	SSA
Equals	**$1,450**	Total gross income

Step 2: Deduct the correct personal maintenance allowance.

Start with	$1,450	Total gross income
Subtract	$1,112	Personal maintenance allowance
Equals	**$338**	Remaining income

Step 3: Deduct the appropriate medical expense deductions in the correct sequential order.

Start with	$338.00	Remaining income
Subtract	$176.40	$96.40 Medicare plus $80.00 heath insurance premium
Subtract	$161.60	Non-covered medical expenses ($1,50 minus $161.60 = $1,338.40)
Equals	**$0**	Patient pay for June

The $1,388.40 balance remaining from the $1,500 hospital bill that was not deducted from the June patient pay can be deducted in subsequent month(s) *if* it remains a liability.

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Subsection M1470.910: Retroactive Adjustment for Prior Months

Last Subsection Revision Date: April 2026

A. Retroactive Adjustment

If a change was reported timely and the patient pay for prior months is incorrect, adjust the patient pay for the prior months only in the following situations:

- A deceased individual had health insurance premiums or noncovered medical expenses that should have reduced patient pay, or
- A community spouse is owed money for a spousal allowance and the institutionalized spouse is deceased or no longer in long-term care. However, if the community spouse had decreased income and did not report the change in a timely manner, do not adjust the patient pay.
- Patient pay may be reduced in the past when there is no other way to make the member whole (e.g., ongoing patient pay is zero). The reduction must be for the most recent months and must be approved and completed by DMAS. *Submit a Patient Pay Correction form through the Coverage Correction Portal (CCP) on the MES website.*, *Home | MES*. *The patientpay@dmas.virginia.gov mailbox will remain active to answer question from LDSS, VDSS, CoverVA, and DMAS staff*.
- If an individual has moved from NF to CBC, adjust the patient pay effective the month after the change.

In these situations, adjust the patient pay retroactively using the VaCMS Patient Pay process for the prior months in which the patient pay was incorrect. **In all other situations when a change is reported timely, do not adjust the patient pay retroactively.** If VaCMS is not able to process required transactions, submit a Patient Pay Correction form *through the Coverage Correction Portal (CCP) on the MES website Home | MES.*

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Subsection M1470.930: Death or Discharge from LTC

Last Subsection Revision Date: April 2026

A. Policy

The LTC provider may not collect an amount of patient pay that is more than the Medicaid rate for the month. When a patient dies or is discharged from LTC to another living arrangement that does not include LTC services, do not recalculate patient pay for the month in which the patient died or was discharged. The provider is responsible for collecting an amount of patient pay for the month of death or discharge that does not exceed the Medicaid rate for the month.

B. Procedure

Refer to the VaCMS Help feature for procedures regarding death or discharge from LTC. Send a DMAS-225 to the provider regarding the eligibility status of the patient. Send a notice to the patient or the patient's representative that reflects the reduction or termination of services. If VaCMS is not able to process required transactions or additional correction is needed, submit a Patient Pay Correction form (*through the Coverage Correction Portal (CCP) on the MES website Home | MES. The patientpay@dmas.virginia.gov mailbox will remain active to answer question from LDSS, VDSS, CoverVA, and DMAS staff*.

DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into *MES*

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Virginia Medical Assistance Eligibility Manual

Chapter M18
Medical Services

Chapter M18 Changes

Date Converted to New Template: October 2025

Changed With	Effective Date	Subchapters Changed
TN #DMAS-26	1/1/23	Pages 6a, 7 and 8
TN #DMAS-22	1/1/22	Page 8 Page 7 is a runover page.
TN #DMAS-20	7/1/21	Page 7 Page 8 is a runover page.
TN #DMAS-12	04/01/2019	Page 3, 5
TN #DMAS -11	01/01/2019	Page 3
TN #DMAS-10	10/1/18	Pages 3-5
TN #DMAS-6	10/1/17	Table of Contents Pages 3-5 Page 6 is a runover page. Page 6a was added.
TN #100	5/1/15	Table of Contents Pages 1-9 Pages 10-17 were deleted. Appendix 1 was removed.
UP #9	4/1/13	Page 3
UP #7	7/1/12	Page 12
TN #96	10/01/11	Pages 3, 4, 16
TN #95	3/1/11	Page 9
TN #94	9/1/10	Page 12
TN #93	1/1/10	Pages 4, 5
TN #91	5/15/09	Page 2 Pages 5, 6 Page 8

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Subchapter M1810: Cardinal.Care.**Medicaid Eligibility Card**

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M1810 CHANGES

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TN #DMAS-38	4/1/26	M1810.100

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SECTION M1810.100: CARDINAL.CARE.MEDICAID ELIGIBILITY CARD

Last Section Revision Date: April 2026

A. *Cardinal Care* Medicaid Card Issuance

A *Cardinal Care* Medicaid card is issued to an individual who has been found eligible for Medicaid and is enrolled with the Department of Medical Assistance Services (DMAS). The card is plastic with the enrollee's name, gender and birth date on the front, and a strip on the back that providers can "swipe" to *determine* the type of coverage and the begin date of coverage. The card is intended to be permanent. Presentation of the card to the Medicaid-enrolled (certified) provider of medical services authorizes the provider to bill Medicaid for the needed services, if such services are covered by the Medical Assistance Program and DMAS has pre-authorized the service, when pre-authorization is required.

EXCEPTION: The following recipients do not receive a *Cardinal Care* Medicaid card:

- individuals eligible for Medicare premium payment only,
- individuals enrolled in a closed period of coverage in the past with no ongoing coverage, and
- incarcerated individuals eligible for Medicaid payment of inpatient hospitalization services only.

B. Use of the *Cardinal Care* Medicaid Card

1. General

Local social services departments must provide recipients with information concerning use of the *Cardinal Care* Medicaid card. This includes information that misuse of the card is fraud and can result in prosecution. Examples of misuse include:

- using the card following cancellation of eligibility,
- alteration of names, dates, or other information to secure medical care to which the individual is not entitled, and
- knowingly permitting another person to use an individual's card to secure medical care.

2. Foster Care Children in Institutional Facilities

The local department of social services (LDSS) should use the local department's address when enrolling a foster care child whose custody is held by the local department of social services and who is placed in an institution. Upon receipt of

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the Medicaid card, it should be sent to the appropriate institution for use on the child's behalf. The local department has the responsibility of advising the child caring institution of the medical and dental services covered by Medicaid.

3. Nursing Facility Patients

Patients in nursing facilities receive *Cardinal Care* Medicaid cards. The nursing facility also receives a computer-generated list at the first of the month which lists all eligible Medicaid patients in that facility.

This report reflects only those Medicaid-eligible patients for whom the nursing facility has submitted an "admission packet."

DMAS staff enters the patient information into the system and assigns a patient control number to the facility for use in billing Medicaid for the patient's care.

When a patient dies or is discharged from the facility, the facility is responsible for notifying DMAS and the LDSS of the date of discharge or death. Long-term *Services and Supports* (LTSS) providers have been instructed to notify the LDSS of death or discharge via the Medicaid Long-term Care Communication Form (DMAS-225).

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Subchapter M1820: Service Providers

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SECTION M1820.100: SERVICE PROVIDERS

Last Section Revision Date: April 2026

A. Enrollment Requirement

Providers of medical services must be enrolled by DMAS to receive Medicaid payment for their services. Lists of enrolled providers are available to local departments of social services and enrollees from DMAS and are available online at www.dmas.virginia.gov.

B. Out-of-State Providers

1. **Covered Services**

   Medicaid will cover medical services rendered by out-of-state providers when the use of such providers is:

   - the general custom of the eligible individual (e.g., a recipient living near the border of another state),
   - needed by a non IV-E Foster Care child placed outside Virginia,
   - necessitated when an eligible person is temporarily outside Virginia and has a medical emergency, or
   - indicated because of referral to an out-of-state facility when preauthorized by DMAS.

2. **Provider Enrollment**

   In instances where an out-of-state provider is not currently enrolled as a DMAS provider, DMAS will accept the provider's initial billing and will contact the provider to determine the provider's wish to become enrolled so that subsequent services can be paid through the computerized Medicaid claims processing system. *New Enrollment webpage can be accessed to enroll the provider online.*

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Subchapter M1830: Managed Care

Last Subchapter Revision Date: April 2026

M1830 CHANGES

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SECTION M1830.100: MANAGED CARE

Last Section Revision Date: April 2026

A. General Information

DMAS provides Medicaid coverage to enrollees primarily through two delivery systems: fee-for-service (FFS) and managed care. FFS benefits are administered by DMAS through participating providers within the traditional Medicaid program rules. Most Virginia Medicaid enrollees including individuals with other forms of health insurance (TPL) are required to receive medical care through a managed care organization.

B. *Cardinal Care*

The *Cardinal Care* managed care program is administered through DMAS' contracted managed care organizations (MCOs). *On October 1, 2023, Virginia Medicaid combined the two managed care programs of Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) into Cardinal Care Managed Care (CCMC). CCMC continues to offer members the same programs and services and does not reduce or change any existing coverage. CCMC are categorized in two benefit plans/populations:*

- *Acute (previously Medallion 4.0) and MLTSS (previously CCC Plus).*
    - *Provides services to qualified members in the areas of maternity care, including early prenatal care, case management, and postpartum care; care for infants and children (including foster care), including early intervention services, immunizations, screening, and preventive care; and wellness, behavioral health, community mental health services, behavioral therapy, family planning and chronic disease support for adults.*
- *MLTSS (Managed Long-term Services and Supports):*
    - *Designed to assist individuals with health or personal needs, activities of daily living, and instrumental activities of daily living over a period. LTSS can be provided at home, in the community, or in various types of facilities, including Nursing Facilities.*
    - *MLTSS is meant for members who cannot perform daily living tasks, private care can come to members' homes or communities to provide additional services.*

Some enrollees in the groups below are *served through Fee for Service* because they meet exclusionary criteria. The following is a **partial** list of enrollees excluded from managed care enrollment:

- Enrollees who meet a spenddown and are enrolled for a closed period of coverage
- Enrollees who are participating in Plan First



- Enrollees who have an eligibility period that is less than three months or who have an eligibility period that is only retroactive
- *Limited covered groups – Plan First, Qualified Medicare Beneficiaries (QMB) only, Special Low-income Medicare Beneficiaries (SLMB), and Qualified Individuals (QI)*
- *Enrollees in specialized settings – intermediate care facilities for individuals with intellectual disability (ICF-ID), Veterans' nursing facilities, psychiatric residential treatment facilities (PRTF), the Virginia Home, and the Piedmont, Catawba and Hancock state facilities*
- *Enrollees in hospice care (CCC Plus who elect hospice will remain in CCC Plus.)*
- *Enrollees in other programs – Medicaid or FAMIS Medallion 4.0 managed care, and the Program for All-inclusive Care for the Elderly (PACE)*

All *Cardinal Care* health plans offer enhanced benefits to members including, but not limited to:

- Boys and Girls Club membership (6-18 olds)
- Cell phone
- Centering pregnancy program
- Free meal delivery after inpatient hospital stays
- GED for Foster Care
- Sports physical at no cost (under age 21)
- Swimming lessons for members six (6) years and younger
- Vision for adults

NOTE: Not all health plans will offer all of the same enhanced benefits

Enrollees excluded from mandatory managed care enrollment shall receive Medicaid services under the current fee-for-service system. When enrollees no longer meet the criteria for exclusion, they shall be required to enroll in the appropriate managed care program.

Enrollees and their families may contact the Managed Care *Cardinal Care* Helpline at 1-800-643-2273 for information and assistance.

C. Managed Care Helpline

Eligible individuals can enroll in an MCO or obtain additional information, as well as assistance with coverage issues, by calling the Managed Care *Cardinal Care* Helpline at 1-800-643-2273 (TTY/TDD 1-800-817-6608). The Helpline is available Monday through Friday from 8:30 a.m. until 6:00 p.m. Information is available online at www.virginiamanagedcare.com.

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D. Family Access to Medical Insurance Security Plan (FAMIS) Managed Care

FAMIS benefits are *also* administered through *Cardinal Care (*DMAS contracted MCOs) or through FAMIS fee-for-service.

In all areas of the Commonwealth, FAMIS enrollees have the choice between 5 MCOs. When a child is first enrolled in FAMIS, *they are* able to access health care through the FAMIS fee-for-service program. Within 1 or 2 months after FAMIS enrollment, the child will be enrolled with a *Cardinal Care* MCO.

FAMIS benefits are slightly different than the benefits that children enrolled in Medicaid receive.

FAMIS enrollees may receive nurse practitioner services, nurse midwife services, and private duty nursing services. Skilled nursing services provided by a Local Education Association (LEA) include medical evaluations or assessments, state mandated health screenings, and other services that are determined to be necessary to assess, monitor, and provide nursing interventions to prevent or maintain health or a medical condition, under the scope of a licensed school nurse (RN or LPN working under the supervision of an RN).

Additionally, FAMIS enrollees are eligible for up to 180 days of Nursing Facility services in accordance with the base benchmark plan.

The following is a partial list of services (while covered under Medicaid) are **NOT** covered under FAMIS.

- Early and Period Screening Diagnosis and Treatment (EPSDT) services are not covered for FAMIS MCO members. Many of the services that are covered as EPSDT services by Medicaid are covered under FAMIS MCO's well child and immunization benefits. EPSDT services **are** covered for FAMIS FFS members because they receive the Medicaid benefit package.
- Psychiatric treatment in free standing facilities is not covered under FAMIS. However, psychiatric treatment is covered when provided in a psychiatric unit of an acute hospital.
- Routine transportation to and from medical appointments is not covered for FAMIS enrollees. Children enrolled in FAMIS FFS may receive non-emergency transportation services. Emergency transportation is covered for *all* FAMIS enrollees.
- Intensive in-home, therapeutic day treatment, mental health crisis intervention, and case management for children at risk of or experiencing a serious emotional disturbance are covered under FAMIS. Other community mental health rehabilitation services are not covered.

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Eligible FAMIS individuals can enroll in an MCO or obtain additional information, as well as assistance with coverage issues, by calling Cover Virginia at 1-855-242-8282, Monday through Friday from 8:00 a.m. until 7:00 p.m. and Saturdays from 9:00 a.m. – noon. Information is also available online at *Home | CoverVA*.

A summary of FAMIS covered services can be found online at: *Medicaid for Children and FAMIS | CoverVA*

E. Enrollment Corrections/Changes

DMAS pays a capitation rate for every month an individual is enrolled in managed care regardless of whether the individual receives *Cardinal Care* during the month. If an individual is incorrectly enrolled in a Medicaid managed care program, the eligibility worker must refer the case to DMAS at the following address for possible recovery of expenditures (see chapter M1700):

Recipient Audit Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

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Subchapter M1840: Utilization Review and Client Medical Management

Last Subchapter Revision Date: October 2017

M1840 CHANGES

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SECTION M1840.100: UTILIZATION REVIEW AND CLIENT MEDICAL MANAGEMENT

Last Section Revision Date: October 2017

A. Utilization Review

Federal regulations require the Department of Medical Assistance Services (DMAS) to regularly review recipients' use and need for the covered medical services they receive. Regulations require that Medicaid pay only for medically necessary covered medical services. Medicaid cannot pay for duplicate services since they are not necessary.

DMAS staff in the Program Integrity Division reviews provider claims and recipient utilization histories for medical necessity. If it is determined that services were not medically necessary, providers are obligated to reimburse DMAS for any Medicaid payment they have received.

B. Client Medical Management (CMM) Program

An enrollee’s utilization of Medicaid cards for physicians' services and pharmaceutical services is monitored regularly by DMAS. Whenever the utilization of one or both of these services is unusually high, the services will be reviewed for medical necessity. If some services are considered not medically necessary, recipients who are not enrolled in a managed care program will be placed in the CMM Program and required to select a primary physician and/or pharmacy or both.

Individuals identified as high utilizers will receive a letter of notification with instructions about selecting primary providers and identifying those providers to DMAS. Individuals who do not respond to the letter within the specified time will have their primary physician and pharmacy designated by DMAS.

For recipients who have been placed in the CMM Program, Medicaid payment for physicians' services will be limited to those services rendered by the primary physician (including a physician providing services to the patients of the primary physician when the primary physician is not available), physicians seen on referral from the primary physician, and emergency medical services.

Prescriptions may be filled by a non-designated pharmacy only in emergency situations when the designated pharmacy is closed or cannot readily obtain the drug.

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Subchapter M1850: Covered Services

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SECTION M1850.100: COVERED SERVICES

Last Section Revision Date: January 2023

A. General Information

Information on Medicaid covered services is provided to assist the eligibility worker in responding to general inquiries from applicants/recipients. Individuals who have problems with bills or services from providers of care should be referred as follows:

- Refer FFS Medicaid enrollees to the DMAS Recipient Helpline at 804-786-6145. Refer individuals who need assistance with transportation to the DMAS transportation broker at 1-866-386-8331.
- Refer individuals enrolled in managed care to the Managed Care Helpline at 1-800-643-2273 or directly to their MCO. Individuals in managed care who need assistance with transportation must contact their MCO directly.

B. Copayments

1. **Medicaid Enrollees without Medicare**

   Medicaid covered services *no longer* have a "copayment," which is the portion of the cost of the service for which the recipient is responsible.

2. **Medicare Beneficiaries**

   Medicaid covers the Medicare copayment for individuals with Medicare and full-benefit Medicaid (dual eligibles) and Qualified Medicare Beneficiaries (QMB). However, a provider is allowed to collect the Medicare copayment at the time of service. If the provider requires the individual to pay the Medicare copayment, the individual must be reimbursed or credited the difference between the Medicare and Medicaid copayments once the provider receives payment of the Medicaid claim.

3. Covered Services

The services listed below are covered:

- Behavioral health services, including clinic services, outpatient psychiatric services, mental health case management, psychosocial rehabilitation, mental health skill building, therapeutic day treatment for children and adolescents, intensive in-home services for children and adolescents, mental health partial hospitalization, mental health intensive outpatient, assertive community treatment, applied behavior analysis, multisystemic therapy, functional family therapy, mobile crisis response, community stabilization, 23-hour crisis stabilization, residential crisis stabilization unit services, therapeutic group homes and psychiatric residential treatment services

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- Case management services
- Certified pediatric nurse and family nurse practitioner services
- Clinical psychologist services
- Community-based services for individuals with intellectual disabilities, including day health rehabilitation services and case management
- Dental services for children enrolled in Medicaid and FAMIS, pregnant women enrolled in Medicaid, FAMIS MOMS, and FAMIS Prenatal Coverage, and effective July 1, 2021, all other adults with **full** Medicaid benefits
- *Dialysis services*
- Early Periodic Screening, Diagnostic and Treatment (EPSDT) services
- Emergency hospital services
- Family planning services
- Federally Qualified Health Center clinic services
- Home and community-based care waiver services (see subchapter M1440)
- Home health services: nurse, aide, supplies, treatment, physical therapy, occupational therapy, and speech therapy services
- Hospice services
- Inpatient hospital services
- Intensive Behavioral Dietary Counseling, for individuals in MEDICAID WORKS
- Intermediate care facility services for the intellectually disabled (ICF-ID)
- Laboratory and x-ray services
- Medicare premiums: Hospital Insurance (Part A); Supplemental Medical Insurance (Part B) for the Categorically Needy (CN) and Medically Needy (MN)
- Nurse-midwife services
- Nursing facility care
- Other clinic services: services provided by rehabilitation agencies, ambulatory surgical centers, renal dialysis clinics, and local health departments
- Outpatient hospital services
- Personal assistance services, for individuals in Medicaid Works
- Physical therapy and related services

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- Physician services
- Podiatrist services
- *Pregnancy related services*
- Prescribed drugs
- Prosthetic devices
- Rural Health Clinic services
- Skilled nursing facility services for individuals under age 21 years
- Substance abuse services
- Transplant services
- Transportation to receive medical services
- Vision services

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Subchapter M1860: Services Received Outside Virginia

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M1860 CHANGES

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SECTION M1860.100: SERVICES RECEIVED OUTSIDE VIRGINIA

Last Section Revision Date: May 2015

A. General

Medicaid must pay for covered medical services received by any eligible person who is temporarily absent from Virginia if the medical service provider agrees to accept Medicaid payment.

B. Out-of-State Institutional Placements

Virginia Medicaid will cover an enrollee who is placed in an LTC facility in another state only if the placement is preauthorized by the DMAS Long Term Care Section.

A child in IV-E Foster Care who is placed in an institution outside Virginia is eligible for Medicaid through the state in which he resides. A child in non-IV-E Foster Care is eligible for Virginia Medicaid when the child is in an institution outside Virginia, since the child is considered to be a resident of the locality which holds custody.

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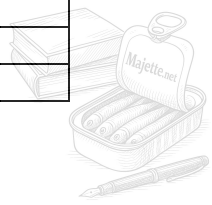
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Chapter M22
FAMIS MOMS

Chapter M22 Changes

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TN #DMAS-24	7/1/22	Pages 1, 2, 5, 6
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TN #DMAS-1	6/1/16	Page 4 Appendix 1, page 1
TN #100	5/1/15	Table of Contents Pages 1, 2, 5, 6, 7 Appendix 1 Pages 3 and 4 are runover pages.
TN #98	10/1/13	Table of Contents Pages 1-7 Appendix 1 Pages 8-10 were deleted.
UP #9	4/1/13	Appendix 1
UP #8	10/1/12	Pages 2, 3 Page 3a deleted
UP #7	7/1/12	Pages 2, 3
UP #6	4/1/12	Appendix 1
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TN #94	9/1/10	Page 3
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UP #2	8/24/09	Page 3
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Subchapter M2210: FAMIS Moms

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SECTION M2210.100: FAMIS MOMS GENERAL INFORMATION

Last Section Revision Date: April 2026

A. Introduction

The 2005 Appropriation Act directed the Department of Medical Assistance Services (DMAS) to expand medical coverage to uninsured pregnant women who are ineligible for Medicaid and have income in excess of the Medicaid limits, but whose family income is less than or equal to 200% of the federal poverty level (FPL). The Family Access to Medical Insurance Security (FAMIS) MOMS program was subsequently established. FAMIS MOMS was closed to new applications from January 1, 2014 until November 30, 2014. Enrollment in the program resumed on December 1, 2014.

Eligibility for FAMIS MOMS is determined by either the local DSS, including a VDSS outstationed site, or the Cover Virginia Central Processing Unit (CPU). Applications processed by the Cover Virginia CPU will be transferred to the appropriate local DSS for case maintenance.

Eligible women are enrolled for benefits effective the first day of the application month if all eligibility requirements are met in that month. There is no retroactive coverage in FAMIS MOMS. Pregnant women found eligible for FAMIS MOMS receive the same benefits as Medicaid pregnant women, including comprehensive dental services. An eligible woman will receive coverage through her pregnancy and for 12 months following the end of the month in which her pregnancy ends *(with birth or for any reason)*, regardless of income changes.

B. Policy Principles

FAMIS MOMS covers uninsured low-income pregnant women who are not eligible for Medicaid due to excess income, and whose countable income is less than or equal to 200% of the FPL.

A pregnant woman is eligible for FAMIS MOMS if all of the following are met:

- She is not eligible for Medicaid and has income in excess of the Medicaid limits.
- She is a resident of Virginia.
- She is uninsured.
- She is not an inmate of a public institution.
    A. She is **not** an inpatient in an institution for mental diseases at the time of application/re-evaluation.
- She has countable family income less than or equal to 200% FPL.

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Subchapter M2220: Nonfinancial Eligibility

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SECTION M2220.100: NONFINANCIAL ELIGIBILITY REQUIREMENTS

Last Section Revision Date: July 2022

A. Policy

The pregnant woman must meet, with certain exceptions, the Medicaid nonfinancial eligibility requirements in Chapter M02 and the nonfinancial eligibility requirements imposed by FAMIS.

B. M02 Applicable Requirements

The Medicaid nonfinancial eligibility requirements in Chapter M02 that must be met are:

- citizenship or noncitizen status, with the exception noted in M2220.100 C below,
- Virginia residency requirements,
- Provision of a Social Security Number (SSN) or proof of application for an SSN;
- assignment of rights,
- application for other benefits, and
- institutional status requirements regarding inmates of a public institution.

C. FAMIS MOMS Noncitizen Status Requirements

Lawfully residing pregnant women meet the FAMIS noncitizen requirements without regard to their date of arrival or length of time in the U.S. The lawfully residing noncitizen groups are contained in section M0220.314.

EXCEPTION to M02:

FAMIS MOMS does not provide emergency services only coverage for noncitizens who are not lawfully residing in the U.S., such as illegal noncitizens or those whose lawful admission status has expired. These noncitizens are not eligible for FAMIS MOMS but may be eligible for FAMIS Prenatal Coverage if they apply for coverage no later than the month their child is born. **Use Chapter M23 to evaluate the pregnant woman for eligibility under FAMIS Prenatal Coverage.**

D. FAMIS MOMS Covered Group Requirements

1. **Declaration of Pregnancy**

   The woman's pregnancy is declared on the application and requires no further verification unless the agency has received conflicting information. See M0310.124 for the definition of a pregnant woman.

2. **Must be Uninsured**

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The pregnant woman must be uninsured; that is, she must not be covered under any creditable health insurance plan offering hospital and medical benefits. If a pregnant woman has creditable health insurance that does not cover pregnancy, labor and/or delivery services, the pregnant woman is ineligible for FAMIS MOMS because she is insured. *If the pregnant woman obtains health insurance coverage after enrollment, she remains eligible for FAMIS MOMS coverage*.

3. IMD Prohibition

The pregnant woman cannot be in inpatient in an institution for the treatment of mental diseases (IMD) *at the time of application/reevaluation*.

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Subsection M2220.200: Health Insurance Coverage

Last Subsection Revision Date: May 2015

A. Introduction

The intent of FAMIS MOMS is to provide health coverage to low-income uninsured pregnant women. A pregnant woman who has creditable health insurance coverage is not eligible for FAMIS MOMS.

B. Definitions

- **Creditable Coverage** – For the purposes of FAMIS MOMS, creditable coverage means coverage of the individual under any of the following:
    - Church plans and governmental plans
    - Health insurance coverage, either group or individual insurance
    - Military-sponsored health care
    - A state health benefits risk pool
    - The federal Employees Health Benefits Plan
    - Medicare
    - A public health plan
    - Any other health benefit plan under section 5(e) of the Peace Corps Act

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

- **Employer-Sponsored Dependent Health Insurance** – Employer-sponsored dependent health insurance means the employer pays a portion of the premium payment. COBRA coverage in which the employer makes no contribution to the payment of the premium is not employer- sponsored insurance.

- **Health Benefit Plan** – "Health benefit plan" is defined in the Virginia Bureau of Insurance Regulations (14VAC5-234-30) and means:
    - Any accident and health insurance policy or certificate
    - Health services plan contract
    - Health maintenance organization subscriber contract
    - Plan provided by a Multiple Employer Welfare Arrangement (MEWA)

  Health benefit plan does NOT mean:
    - Medicaid,
    - accident only,
    - credit or disability insurance,
    - long-term care insurance,
    - dental only or vision only insurance,
    - specified disease insurance,
    - hospital confinement indemnity coverage,

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

- **Insured** – means having creditable health insurance coverage or coverage under a health benefit plan. A woman is considered to be insured if she is covered by a creditable health insurance plan, even if the policy or plan does not cover pregnancy-related services.

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

C. Policy

1. Must be Uninsured

A nonfinancial requirement of FAMIS MOMS is that the pregnant woman be uninsured. A pregnant woman **cannot:**

- have creditable health insurance coverage, or
- have coverage under a group health plan (TRICARE, federal employee benefit plan, private group insurance such as Anthem, etc.) or Medicare.

2. Prior Insurance

Prior insurance coverage is not a factor as long as the pregnant woman is uninsured during the month for which FAMIS MOMS eligibility is being determined.

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Subsection M2220.300: No Child Support Cooperation Requirements

Last Subsection Revision Date: June 2016

A. Policy

There are no requirements for FAMIS MOMS applicants or recipients to cooperate in pursuing support from an absent parent.

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Subchapter M2230: Financial Eligibility

Last Subchapter Revision Date: June 2016

M02230 CHANGES

Changed With	Effective Date	Sections Changed
TN #DMAS-1	June 2016	M2230

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SECTION M2230.100: FINANCIAL ELIGIBILITY

Last Section Revision Date: June 2016

A. Financial Eligibility

1. Income

Modified Adjusted Gross Income (MAGI) methodology contained in Chapter M04 is used for the FAMIS MOMS income evaluation. To the maximum extent possible, attested income must be verified by information obtained from electronic data sources, such as the federal hub or another reliable data source, prior to requesting paystubs or employer statements. For all case actions effective October 26, 2019, if the income attested to by the applicant is within 10% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required. If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return.

The FAMIS MOMS income limit is 200% of the FPL (see Appendix 1 to this chapter) for the number of individuals in the pregnant woman's MAGI household composition as defined in M04. The pregnant woman is counted as herself plus the number of children she is expected to deliver. Per MAGI policy in chapter M04, a 5% FPL income disregard is applicable.

2. Resources

Resources are not evaluated for FAMIS MOMS.

3. No Spenddown

Spenddown does not apply to FAMIS MOMS. If countable income exceeds the FAMIS MOMS income limit, the pregnant woman is not eligible for the FAMIS MOMS program. She must be referred to the Health Insurance Marketplace and be given the opportunity to have a MN Medicaid evaluation.

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Subchapter M2240: Application and Case Handling Procedures

Last Subchapter Revision Date: July 2022

M2240 CHANGES

Changed With	Effective Date	Sections Changed
TN #DMAS-24	July 2022	M2240

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SECTION M2240.100: APPLICATION AND CASE HANDLING PROCEDURE

Last Section Revision Date: July 2022

A. Application Requirements

The policies in subchapters M0120 and M0130 apply.

B. Eligibility Determination

1. **Pregnant *Individual* Under Age 19**

   Process an application by a pregnant individual under age 19 in the following order:

   a. Determine eligibility for Medicaid as a pregnant woman; if not eligible because of excess income, go to item b.

   b. Determine eligibility for FAMIS MOMS; if not eligible because of excess income, go to item c.

   c. If she is not eligible for FAMIS MOMS because of excess income, she must be referred to the Health Insurance Marketplace and given the opportunity to have a Medically Needy evaluation completed.

2. **Seven-Calendar Day Processing**

   Applications for pregnant women must be processed as soon as possible, but no later than seven calendar days from the date the signed application was filed. If all necessary verifications are not received, the application continues to pend until the 45-day processing time limit is met.

3. **Notice Requirements**

   The applicant/recipient must be notified in writing of the required information and the deadline by which the information must be received.

   The agency must have all necessary verifications within seven calendar days in order to determine eligibility. If the agency does not receive the verifications within the seven calendar days, the worker must send the applicant written notice on the seventh day. The notice must state why action on the application could not be taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 calendar days to submit the verification.

   Once all necessary verifications for the pregnant woman are received, an eligibility determination must be made immediately, and the applicant must be notified of the decision.



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C. Case Setup Procedures for Approved Cases

A woman enrolled as FAMIS MOMS may have the same base case number in the Medicaid Enterprise System (MES—formerly the Virginia Medicaid Management Information System, MMIS) as Medicaid enrollees.

D. Entitlement and Enrollment

1. ***Dates* of Coverage**

   Pregnant women determined eligible for FAMIS MOMS are enrolled for benefits effective the first day of the application month, if all eligibility requirements are met in that month. FAMIS MOMS coverage ends the last day of the 12th month after the end of the month in which the pregnancy ends.

2. **No Retroactive Coverage**

   There is no retroactive coverage in the FAMIS MOMS program.

3. **Aid Category**

   The FAMIS MOMS aid category (AC) is "005."

E. Notification Requirements

Written notice must be sent to the pregnant woman informing her of the action taken on the application. The notice must include the eligibility determination results for both Medicaid and FAMIS MOMS, as well as a referral to the Health Insurance Marketplace, if applicable.

If the pregnant woman is ineligible for both Medicaid and FAMIS MOMS due to excess income, she must be sent a written notice that she is not eligible for either program and that her case has been referred to the Health Insurance Marketplace. She must also be given the opportunity to have a Medicaid medically needy evaluation completed. Send the notice and a request for information about her resources to the pregnant woman and advise her that if the resource information is returned within 10 days the original application date will be honored.

F. Application Not Required for Newborn

The newborn child born to a FAMIS MOMS enrollee is deemed eligible for FAMIS coverage until the child's first birthday. Follow the procedures for enrolling a newborn in M0330.802, using the appropriate AC as follows:

- AC 010 = mother's income > 143% FPL but ≤ 150% FPL
- AC 014 = mother's income > 150% FPL but ≤ 200% FPL

Act on the enrollment of a deemed newborn as soon as feasible when the birth is reported to the local DSS office or to DMAS.



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Subchapter M2250: Adverse Actions

Last Subchapter Revision Date:

M2250 CHANGES

Changed With	Effective Date	Sections Changed
TN #DMAS-6	October 2017	M2250

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SECTION M2250.100: REVIEW OF ADVERSE ACTIONS

Last Section Revision Date: October 2017

An applicant for FAMIS MOMS may request a review of an adverse determination regarding eligibility for FAMIS MOMS. FAMIS MOMS follows the procedures established by Medicaid for client appeals (see Chapter M16).

The payment of medical services on the part of any pregnant woman or any right to participate in the program is not subject to review if the reason for denial or cancellation is that funds for the FAMIS MOMS program are exhausted.

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Appendix 1: FAMIS MOMS Income Limits

The following income chart has been moved to Chapter M00 - Appendix - Income Charts:

- FAMIS Moms 200% FPL Income Limits – All Localities

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Virginia Medical Assistance Eligibility Manual

Chapter M23
FAMIS Prenatal Coverage

Chapter M23 Changes

Date Converted to New Template: February 2026

Changed With	Effective Date	Sections Changed
TN #DMAS-34	1/1/25	Pages 6 & 7 Page 7a is added
TN #DMAS-33	10/1/24	Page 7
TN #DMAS-31	4/1/24	Appendix 1
TN #DMAS-30	1/1/24	Pages 1, 6, 7, 8
TN #DMAS-28	7/1/23	Appendix 1
TN #DMAS-25	10/1/22	Pages 5 & 6. Adjust pages 7-8
TN #DMAS-24	7/1/22	Page 6
TN #DMAS-23	4/1/22	Page 6 Appendix 1, page 1
TN #DMAS-21	10/1/21	Pages 6, 7

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Subchapter M2310: FAMIS Prenatal Coverage

Last Subchapter Revision Date: April 2026

M2310 CHANGES

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TN #DMAS-38	April 2026	M2310.100
TN #DMAS-30	January 2024	M2310

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SECTION M02310.100: FAMIS PRENATAL COVERAGE GENERAL INFORMATION

Last Section Revision Date: April 2026

A. Introduction

The 2021 Special Sessions I Appropriations Act directed the Department of Medical Assistance Services (DMAS) to amend the Family Access to Medical Insurance Security Plan (FAMIS) and expand medical coverage to uninsured pregnant women and their unborn children:

- who are ineligible for full-benefit Medicaid or FAMIS Moms due to the woman's immigration status, and
- whose Modified Adjusted Gross Income (MAGI) household income is less than or equal to 200% of the federal poverty level (FPL).

FAMIS Prenatal Coverage is effective beginning July 1, 2021.

Eligibility for FAMIS Prenatal Coverage is determined by either the local DSS, including a VDSS out stationed site, or the Cover Virginia Central Processing Unit (CPU). Applications processed by the Cover Virginia CPU will be transferred to the appropriate local DSS for case maintenance.

Eligible women are enrolled for benefits effective the first day of the application month if all eligibility requirements are met in that month. There is no retroactive coverage in FAMIS Prenatal Coverage. If the woman applies for coverage after the month in which the child is born but within the application's retroactive period, she may be eligible for Medicaid coverage of the labor and delivery as emergency services if the woman's countable MAGI household income is within the Medicaid limit. See M0220.400.

Pregnant women found eligible for FAMIS Prenatal Coverage receive the same benefits as Medicaid and FAMIS MOMS pregnant women, including comprehensive dental services.

An eligible woman will receive coverage through her pregnancy and the end of the month in which the 60th day following the end of the pregnancy occurs *(with birth or for any reason)*. An infant born to a woman enrolled in FAMIS Prenatal Coverage will receive ongoing coverage beginning on the date of the infant's birth and ending 12 months after the child's birth month. The infant's coverage will be in Medicaid or FAMIS, based on the mother's MAGI household unit income at the time of application. The infant's birth is evaluated as a case change; an application does not need to be submitted for the infant.

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B. Policy Principles

FAMIS Prenatal Coverage covers uninsured low-income pregnant women who are not eligible for Medicaid or FAMIS MOMS due to the woman's immigration status and whose countable income is less than or equal to 200% of the FPL.

A pregnant woman **of any age** is eligible for FAMIS Prenatal Coverage if all of the following are met:

- she applies for coverage while pregnant or in the month of the birth of her infant child,
- she does not meet the definition of a **lawfully residing noncitizen pregnant woman in M0220.314**,
- she is a resident of Virginia,
- she is uninsured,
- she is not an inmate of a public institution,
- she is not an inpatient in an institution for mental diseases, and
- she has countable MAGI household income less than or equal to 205% FP (200% FPL plus 5% FPL disregard).

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Subchapter M2320: Nonfinancial Eligibility

Last Subchapter Revision Date: July 2021

M2320 CHANGES

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TN #DMAS-20	July 2021	M2320

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SECTION M02320.100: NONFINANCIAL ELIGIBILITY REQUIREMENTS

Last Section Revision Date: July 2021

A. Policy

The pregnant woman must meet, with certain exceptions, the Medicaid nonfinancial eligibility requirements in Chapter M02 and must be uninsured.

B. M02 Applicable Requirements

The Medicaid nonfinancial eligibility requirements in Chapter M02 that must be met are:

- Virginia residency requirements (M0230)
- Assignment of rights (M0250)
- Application for other benefits (M0270)
- Institutional status requirements regarding inmates of a public institution (M0280).

The Social Security Number (SSN) requirement does not apply to the pregnant woman.

C. Noncitizen Status and FAMIS Prenatal Coverage

FAMIS Prenatal Coverage is limited to a pregnant woman of any age who **does not** meet the lawfully residing noncitizen status requirement for pregnant women for full-benefit coverage in M0220.314 and who applies for coverage while pregnant or no later than the month in which the infant is born.

A pregnant woman who does not meet the lawfully residing noncitizen status requirement and who applies for coverage after the month in which the child is born but within the application's retroactive period may be eligible for Medicaid coverage of the labor and delivery as emergency services if the woman's countable MAGI household income is within the Medicaid or limit or she is eligible as Medically Needy. See M0220.400.

D. FAMIS Prenatal Coverage Covered Group Requirements

1. **Declaration of Pregnancy**

   The woman's pregnancy and the number of unborn children are declared on the application and require no further verification unless the agency has received conflicting information. See M0310.124 for the definition of a pregnant woman.

2. **Must be Uninsured**

   The pregnant woman must be uninsured; that is, she must not be covered under any creditable health insurance plan offering hospital and medical benefits. If a pregnant woman has creditable health insurance that does not cover pregnancy,



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labor and/or delivery services, the pregnant woman is ineligible for FAMIS Prenatal Coverage because she is insured.

3. **IMD Prohibition**

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

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Subsection M02320.200: Health Insurance Coverage

Last Subsection Revision Date: July 2021

A. Introduction

A pregnant woman who has creditable health insurance coverage is not eligible for FAMIS Prenatal Coverage.

FAMIS Prenatal coverage provides the same coverage as FAMIS MOMS, including coverage of prenatal care, other medical care, dental care, and transportation to received covered services. Pregnant women enrolled in FAMIS Prenatal Coverage will receive care through a managed care organization (see M1830.100).

B. Definitions

- **Creditable Coverage** – For the purposes of FAMIS Prenatal Coverage, creditable coverage means coverage of the individual under any of the following:
    - Church plans and governmental plans
    - Health insurance coverage, either group or individual insurance;
    - Military-sponsored health care
    - A state health benefits risk pool
    A. The federal employees' health benefits plan; Medicare
    - A public health plan
    - Any other health benefit plan under section 5(e) of the peace corps act

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

- **Employer-sponsored Dependent Health Insurance** – means the employer pays a portion of the premium payment. COBRA coverage in which the employer makes no contribution to the payment of the premium is not employer-sponsored insurance.

- **Health Benefit Plan** – is defined in the Virginia Bureau of Insurance Regulations (14VAC5-234-30) and means:
    - any accident and health insurance policy or certificate,
    - health services plan contract,
    B. health maintenance organization subscriber contract, or
    - plan provided by a Multiple Employer Welfare Arrangement (MEWA)."

    Health benefit plan does NOT mean:
    - Medicaid,
    - accident only,
    - credit or disability insurance,
    - long-term care insurance,
    - dental only or vision only insurance,

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

- **Insured** – means having creditable health insurance coverage or coverage under a health benefit plan. A woman is considered to be insured if she is covered by a creditable health insurance plan, even if the policy or plan does not cover pregnancy-related services.

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

C. Policy

1. **Must be Uninsured**

   A nonfinancial requirement of FAMIS Prenatal Coverage is that the pregnant woman be uninsured. A pregnant woman **cannot:**

   - have creditable health insurance coverage, or
   - have coverage under a group health plan (TRICARE, federal employee benefit plan, private group insurance such as Anthem, etc.) or Medicare.

2. **Prior Insurance**

   Prior insurance coverage is not a factor as long as the pregnant woman is uninsured during the month for which FAMIS Prenatal Coverage eligibility is being determined.

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Subsection M02320.300: No Child Support Cooperation Requirements

Last Subsection Revision Date: July 2021

A. Policy

There are no requirements for FAMIS Prenatal Coverage applicants or members to cooperate in pursuing support from an absent parent.

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Subchapter M2330: Financial Eligibility

Last Subchapter Revision Date: October 2022

M2330 CHANGES

Changed With	Effective Date	Sections Changed
TN #DMAS-25	October 2022	M2330

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SECTION M02330.100: FINANCIAL ELIGIBILITY

Last Section Revision Date: October 2022

A. Financial Eligibility

1. Income

MAGI methodology contained in Chapter M04 is used for the FAMIS Prenatal Coverage income evaluation. To the maximum extent possible, attested income must be verified by information obtained from electronic data sources, such as the federal hub or another reliable data source, prior to requesting paystubs or employer statements. If the income attested to by the applicant is within 20% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required. If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return. If the documentation is delayed in the mail due to no fault of the applicant, accept delayed documentation and complete application processing.

The FAMIS Prenatal Coverage income limit is 200% of the FPL (see Appendix 1 to this chapter) for the number of individuals in the pregnant woman's MAGI household composition as defined in M04. The pregnant woman is counted as herself plus the number of children she is expected to deliver. Per MAGI policy in chapter M04, a 5% FPL income disregard is applicable.

2. Resources

Resources are not evaluated for FAMIS Prenatal Coverage.

3. No Spenddown

Spenddown does not apply to FAMIS Prenatal Coverage. If countable income exceeds the FAMIS Prenatal Coverage income limit, the pregnant woman is not eligible for the FAMIS Prenatal Coverage program. If the woman has no documentation of immigration status, DO NOT make a referral to the Health Insurance Marketplace.

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Subchapter M2340: Application and Case Handling Procedures

Last Subchapter Revision Date: January 2025

M2340 CHANGES

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TN #DMAS-34	January 2025	M2340

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SECTION M02340.100: APPLICATION AND CASE HANDLING PROCEDURES

Last Section Revision Date: January 2025

A. Application Requirements

The policies in subchapters M0120 and M0130 apply.

B. Eligibility Determination

1. **Seven-Calendar Day Processing**

   Applications for pregnant women must be processed as soon as possible, but no later than seven calendar days from the date the signed application was filed. If all necessary verifications are not received, the application continues to pend until the 45 day processing time limit is met.

2. **Notice Requirements**

   The applicant/recipient must be notified in writing of the required information and the deadline by which the information must be received.

   The agency must have all necessary verifications within seven calendar days in order to determine eligibility. If the agency does not receive the verifications within the seven calendar days, the worker must send the applicant written notice on the seventh day. The notice must state why action on the application could not be taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 calendar days to submit the verification.

   Once all necessary verifications for the pregnant woman are received, an eligibility determination must be made immediately, and the applicant must be notified of the decision.

C. Case Setup Procedures for Approved Cases

A woman enrolled as FAMIS Prenatal Coverage may have the same base case number in the Medicaid Enterprise System {MES—formerly the Virginia Medicaid Management Information System (MMIS)} as Medicaid enrollees.

D. Entitlement and Enrollment

1. **Begin Date of Coverage**

   Pregnant women determined eligible for FAMIS Prenatal Coverage are enrolled for benefits effective the first day of the application month, if all eligibility requirements are met in that month.

2. **No Retroactive Coverage**



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There is no retroactive coverage in the FAMIS Prenatal Coverage program.

3. **Aid Categories**

   The FAMIS Prenatal Coverage aid categories (AC) are:

   - 110 for pregnant women with income ≤143% FPL
   - 111 for pregnant women with income >143% FPL but ≤ 200% FPL.

   NOTE: A change in the MMIS enrollment system was effective July 1, 2022 to display the FAMIS Prenatal aid categories AC110 / AC111. Anyone enrolled prior to July 1, 2022 will remain in aid category AC005 *until renewal* if eligibility is not run and updated to the new AC.

4. **Coverage Period**

   After her eligibility is established as a pregnant woman, the woman's FAMIS Prenatal Coverage entitlement continues through her pregnancy and the 60-day period following the end of her pregnancy regardless of income changes. Her coverage ends the last day of the month in which the 60th postpartum day occurs. The 12-month coverage period for pregnant women in Medicaid and FAMIS MOMS is not applicable to FAMIS Prenatal Coverage.

E. Notification Requirements

Written notice must be sent to the pregnant woman informing her of the action taken on the application. The notice must include the eligibility determination results for FAMIS Prenatal Coverage.

If the woman is not eligible for FAMIS Prenatal Coverage and has no documentation of immigration status, DO NOT make a referral to the Health Insurance Marketplace.

F. Enrolling Infant Born to a Woman in FAMIS Prenatal Coverage

For women assigned to AC 110 under a fee for service (FFS) arrangement, her labor and delivery services are paid as emergency services, and the newborn is considered a deemed-eligible newborn. When the birth of the child born to a women enrolled in FAMIS Prenatal Coverage is reported, review the available systems to determine if the mother is assigned to AC110 under FFS. If so, the child is enrolled as a deemed newborn in AC 093 and is eligible for 12 months of continuous coverage. An infant born to a woman in FAMIS Prenatal Coverage who is assigned to AC 111 and/or enrolled in managed care must be evaluated for ongoing coverage. The infant is not considered a deemed-eligible newborn but has rather been enrolled prenatally through the mother's enrollment in FAMIS Prenatal Coverage, and the enrollment is treated as a change in circumstances. If the newborn's eligibility can be verified with information known to the agency, enroll the child effective the date of the birth with a 12-month certification period. If the child's eligibility can't be verified, the infant's birth is treated as an "add a person" case change in the enrollment



system and given a 12-month certification period starting with the mother's first month of enrollment.

To enroll the infant, the worker must have the information below. Use existing case data if possible. If additional information is needed, send a request for verification. *The newborn is protected by continuous eligibility until the end of their certification period. If a verification request is sent and returned, process it as a change in circumstances. If the child remains eligible, give them a new 12-month certification period. If the verification request is not returned or the information provided indicates that the child is ineligible, do not disenroll them. Eligibility will be reviewed through the annual redetermination process at the end of their current certification period.*

1. **Required Information**

    - Name, date of birth, sex (gender)
    - Information about the infant's MAGI household and income, if not available in the case record

    Unless the agency has information about the infant's father living in the home (i.e., for another program), use only the mother's reported income to enroll the infant. Do not request information about the father or the father's income unless the agency has *current* information about the father living in the home and his income. *Information on file can be used if less than six months old.*

    NOTE: The infant is not required to provide an SSN or proof of application for an SSN in order to be enrolled. Follow the procedures in M0240.200 B.3 90 days following the infant's enrollment to determine if an SSN has been assigned. If the SSN number has not yet been issued at 90 days, obtain the SSN or proof of application for an SSN at the first renewal of the infant's coverage.

2. **Enrollment and Aid Category**

    Update the case with the new infant's information, enrolling the child as a Medicaid child under 19 or in FAMIS, as appropriate based on the mother's countable income at the time of application. Use the appropriate AC below to enroll the infant:

    - Medicaid AC 090 for income > 109% FPL ≤ 143% FPL
    - Medicaid AC 091 for income ≤ 109% FPL
    - FAMIS AC 006 for income > 150% FPL and ≤ 200% FPL
    - FAMIS AC 008 for income > 143% FPL and ≤ 150% FPL

3. **Renewal**

    The infant's first renewal is due 12 months from the month of the child's enrollment.

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G. Examples

EXAMPLE #1: *Rose is pregnant and is carrying one unborn child. She was born outside the U.S. She applies for Medicaid on October 27, 2021. She reported on the application that she visited the emergency room in August 2021. The retroactive period for her application is July – September 2021.*

Rose is unable to verify that she is lawfully residing in the U.S.; therefore, she cannot be eligible for full-benefit Medicaid or FAMIS Moms and is evaluated for FAMIS Prenatal Coverage. Her verified countable monthly income is $1,756 per month, which is under the income limit for FAMIS Prenatal Coverage for her MAGI household size of two. She is approved for FAMIS Prenatal coverage and enrolled effective October 1, 2021, in AC 110, based on her countable income of under 143% FPL (see M23, Appendix 1). She is enrolled in Managed Care, so her infant will not be considered a deemed-eligible newborn.

Because she received an emergency service during the retroactive period and her income is under the Medicaid limit for a pregnant woman, she is evaluated for Emergency Services coverage.

Rose's son, AJ, is born on February 25, 2022, and is enrolled in AC 090 beginning February 25, 2022. His Medicaid renewal is due in February 2023. Rose's FAMIS Prenatal Coverage ends on April 30, 2022.

EXAMPLE #2: Jo lives with her husband Al and daughter Em, who was born on October 31, 2021. Jo was born outside the U.S. She applies for Medical Assistance on November 25, 2021 and requests retroactive coverage for her pregnancy. She does not request coverage for her husband.

Jo is unable to verify that she is lawfully residing in the U.S.; therefore, she cannot be eligible for full-benefit Medicaid or FAMIS Moms. Because Jo applied for coverage the month after her infant's birth, she cannot be eligible for FAMIS Prenatal Coverage.

Jo's MAGI household consists of three people—Jo, her infant, and her husband. The verified countable monthly income for the household is $3,473.

Jo's countable income is over the limit of 143% FPL for Medicaid and has excess resources for Medically Needy eligibility; therefore, she cannot be approved for Medicaid coverage of emergency services for the labor and delivery.

Em is determined to be eligible for FAMIS, which covers an eligible child who was born within the 3 months prior to the application month. Em is enrolled effective October 31, 2021, in AC 006. Her renewal is due in October 2022.

The eligibility worker sends a Notice of Action indicating Jo is not eligible for Medicaid or FAMIS Prenatal Coverage and Em has been enrolled in FAMIS.

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Subchapter M2350: Adverse Actions

Last Subchapter Revision Date: January 2025

M2350 CHANGES

Changed With	Effective Date	Sections Changed
TN #DMAS-34	January 2025	M2350

TN – Transmittal
UP – Update

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SECTION M02350.100: REVIEW OF ADVERSE ACTIONS

Last Section Revision Date: January 2025

An applicant for FAMIS Prenatal Coverage may request a review of an adverse determination regarding eligibility for FAMIS Prenatal Coverage. FAMIS Prenatal Coverage follows the procedures established by Medicaid for client appeals (see Chapter M16).

The payment of medical services on the part of any pregnant woman or any right to participate in the program is not subject to review if the reason for denial or cancellation is that funds for the FAMIS Prenatal Coverage program are exhausted.

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APPENDIX 1: FAMIS PRENATAL COVERAGE INCOME LIMITS

The following income charts have been moved to Chapter M00 – Appendix – Income Charts:

C. FAMIS Prenatal Coverage 200% FPL Income Limits - All Localities
- Enroll Using Aid Category 110
  - 143% FPL Yearly Amount
  - 143% FPL Monthly Amount
  - 148% FPL (143% FPL + 5% FPL Disregard)
- Enroll Using Aid Category 111
  - 200% FPL Yearly Amount
  - 200% FPL Monthly Amount
  - 205% FPL (200% FPL + 5% FPL Disregard)

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