



COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

July 15, 2005

MEDICAID MANUAL – VOLUME XIII

TRANSMITTAL #81

The following acronyms are used in this transmittal:

- DSS – Department of Social Services
- FPL – Federal Poverty Level
- LDSS – Local Department of Social Services
- QMB – Qualified Medicare Beneficiary
- SSA – Social Security Administration

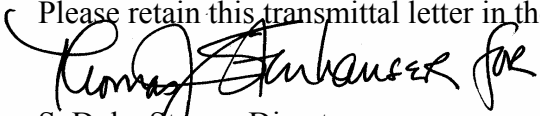
This transmittal contains the new Chapter M20, “Extra Help – Medicare Part D Low-income Subsidy.” Chapter M20 contains information about Medicare Part D prescription drug coverage and the state’s responsibility for determining eligibility for the low-income subsidy called “Extra Help” to assist with the cost of prescription drug coverage.

The policy and procedures contained in Chapter M20 are used only when a Medicare beneficiary specifically insists that the LDSS determine the beneficiary’s eligibility for Extra Help. Extra Help is for Medicare recipients who have incomes below 150% FPL and resources below \$10,000 for individuals or \$20,000 for married couples. Chapter M20 is not used when LDSS staff simply assist individuals with completing and submitting an SSA paper application or an on-line application for Extra Help. The agency is not determining eligibility for Extra Help in these instances.

Policy contained in this transmittal is effective for Extra Help eligibility determinations completed by LDSS on or after July 1, 2005.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Virginia DSS, Volume XIII Medicaid Eligibility Manual Table of Contents, page iii	Virginia DSS, Volume XIII Medicaid Eligibility Manual Table of Contents, page iii	On page iii of the Table of Contents, added Chapter M20 “Extra Help – Medicare Part D Low-income Subsidy.”
Subchapter M0310 pages 31-34	Subchapter M0310 pages 31-34	Page 31 is a reprint. On pages 32 and 33, added information about Medicare Part D and clarified procedures for Medicare beneficiaries. On page 34, corrected references for Medicare beneficiary covered groups.
Subchapter M0320 pages 35, 36	Subchapter M0320 pages 35, 36	On page 35, modified references to gender. On page 36, clarified that applicants eligible for QMB coverage must apply for Extra Help in order to receive the subsidy for the period of time between the month of Medicaid application and the month in which QMB entitlement begins.
	Chapter M20	Added Chapter M20 “Extra Help – Medicare Part D Low-income Subsidy” as a new chapter.

Please retain this transmittal letter in the back of Volume XIII.


S. Duke Storen, Director
Division of Benefit Programs

Attachment

M15 ENTITLEMENT POLICY & PROCEDURES

MEDICAID ENTITLEMENT.....M1510
MEDICAID ELIGIBILITY REVIEWM1520
DMHMRSAS FACILITIES.....M1550

M16 APPEALS PROCESS

M17 MEDICAID FRAUD AND RECOVERY

M18 MEDICAL SERVICES

M20 EXTRA HELP – MEDICARE PART D LOW-INCOME SUBSIDY

**M21 TITLE XXI: FAMILY ACCESS TO MEDICAL SECURITY
INSURANCE PLAN (FAMIS)**

M22 FAMIS MOMS

- 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 M0320.306 contains the detailed requirements for the LIFC covered group.

M0310.119 MEDICALLY INDIGENT (MI)

- A. Definition** "MI" is the short name for "medically indigent." MI is the name Virginia uses for the subclassification of federally mandated categorically needy covered groups that do not receive cash assistance and that have income within a percentage of the federal poverty income guidelines.
- An MI individual is one who is not eligible for cash assistance, but who meets the requirements of an MI covered group and has income within the specified percentage of the federal poverty limit.

- B. Procedure** The procedures used to determine if an individual meets an MI covered group are in subchapter M0320.

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. He is not eligible for a cash assistance payment because his income and/or resources exceed the cash assistance limits. MN individuals whose income exceeds the MN income limit may become eligible by incurring medical and/or remedial care expenses to establish eligibility (spenddown).

- B. Procedure** The procedures used to determine if an individual meets a MN covered group are in subchapter M0330.

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 Social Security 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

- 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 (QDWTs) and Qualified Individuals (QI). QMBs, SLMBs, and QIs are also referred to as Medicare Savings Programs (MSP).*

See sections M0320.206, 207 and 208 for the procedures to use to determine if an individual meets an MSP covered group. See section M0320.209 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

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 M0320.209 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 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 medically indigent QMB determination; the other is for the ABD spouse's CN or MN covered group.

2. Resources

The asset transfer rules in subchapter M1450 must be met by the medically indigent Medicare beneficiary.

The resource requirements in chapter S11 and Appendix 2 to chapter S11 must be met by the medically indigent 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 twice the medically needy resource limit for an individual; the resource limit for a couple is twice the medically needy resource limit for a couple (See Appendix 2 to chapter S11).

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 federal poverty level (*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 medically indigent 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 M0320.207.

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 approved.*

Because QMB coverage does not begin until the month following the month of approval, 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. Program Designations**

The following PDs are used to enroll individuals who are only eligible as qualified Medicare beneficiaries; they do not meet the requirements of another covered group:

- 23 for an aged QMB only;
- 43 for a blind QMB only;
- 63 for a disabled or end-stage renal disease QMB only.

2. Recipient's PD Changes To QMB

An enrolled recipient's PD cannot be changed to the QMB only PDs using a "change" transaction in the MMIS. If a Medicaid recipient becomes **ineligible** for full-coverage Medicaid because of an increase in income or resources, but is eligible as a QMB, the

CHAPTER M20

EXTRA HELP - MEDICARE PART D LOW-INCOME SUBSIDY

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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), enacted into law on December 8, 2003, amended Title XVIII of the Social Security Act by establishing a new Part D: the Voluntary Prescription Drug Benefit Program. Effective January 1, 2006, the new program establishes an optional prescription drug benefit for individuals who are entitled to Medicare Part A and/or enrolled in Medicare Part B.

Effective January 1, 2006, Medicaid will no longer provide prescription drug coverage for Medicaid recipients who are enrolled in Medicare. These individuals will receive their prescription drug coverage through Medicare Part D. They will have no premiums or deductibles, but will have copayments for prescription drugs. Medicare beneficiaries who are not eligible for Medicaid and who choose to participate in Medicare Part D will be subject to cost-sharing obligations, including monthly premiums, deductibles, and copayments. Subsidies will be available to assist low-income beneficiaries with their cost-sharing obligations. The subsidies are known as "Extra Help." Medicare beneficiaries who are enrolled in Medicaid are automatically eligible for the low-income subsidy and are enrolled using data matches from the Department of Medical Assistance Services (DMAS) and the Centers for Medicare and Medicaid Services (CMS). 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.

The MMA mandates that eligibility for Extra Help 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.

LDSS must determine eligibility for Extra Help only in situations where an individual specifically requests that the agency do so. If such a request is made, the LDSS must:

- determine eligibility,
- enroll the recipient if eligible,
- provide notice,
- participate in appeals,
- comply with reporting requirements, and provide ongoing case maintenance.

B. Legal Base

The MMA (Public Law 108-173) amended Title XVIII of the Social Security Act and established a new Medicare Part D program for voluntary prescription drug coverage effective January 1, 2006.

C. Definitions

1. Dual Eligible

for the purposes of Medicare Part D, means a person who is eligible for both Medicare and Medicaid benefits. Dual eligibles have no Medicare Part D premiums, deductibles, or threshold costs. All dual eligibles except individuals in nursing facilities have copays ranging from \$1 to \$5 per prescription.

2. 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.

3. Medicare Savings Programs (MSP)

are the Medicaid covered groups under which Medicaid provides coverage for the payment of Medicare premiums, copayments, and/or deductibles. The Medicare Savings Programs are:

- Qualified Medicare Beneficiary (QMB) – M0320.206
- Special Low-income Medicare Beneficiary (SLMB) – M0320.207
- Qualified Individuals (QI) – M0320.208

D. Relationship of MSP to Extra Help

Individuals who request assistance with Medicare costs must be screened for eligibility for the MSP. Individuals who appear eligible for MSP must be given the opportunity to apply for Medicaid. Individuals who are eligible for MSP are deemed eligible for Extra Help.

Because QMB coverage does not begin until the month following the month of approval, an applicant who appears to be eligible for QMB coverage will need to file an application for Extra Help in order to receive the subsidy for the period of time from the month of application to the month of enrollment. The applicant should be provided assistance with filing the Extra Help application.

Individuals who are screened and appear to be ineligible for a Medicare Savings Program may choose to apply for Extra Help through the SSA or the LDSS.

**E. Extra Help
Policy Principles**

Extra Help provides assistance with the out-of-pocket costs associated with Medicare Part D. An individual is eligible for Extra Help 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 of no more than 150% of the federal poverty level (FPL) for his assistance unit size,
- he has countable resources of no more than \$10,000 (or if he is married and living with a spouse, they have countable resources of no more than \$20,000), and
- he must reside 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).

M2020.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS**A. Introduction**

The nonfinancial eligibility requirements for Extra Help are different than the nonfinancial requirements for the Medicare Savings Programs (see chapter M02). An individual who does not meet the nonfinancial requirements for the Medicare Savings Programs may meet the nonfinancial requirements for Extra Help.

**B. Extra Help
Nonfinancial
Requirements**

Only the following nonfinancial eligibility requirements apply when Extra Help eligibility is determined by the LDSS:

- residency in Virginia, and
- entitlement to Medicare. The individual does not need to be enrolled in Medicare at the time of application, but Extra Help will not begin until he has enrolled in Medicare Part D.

M2030.100 DETERMINING EXTRA HELP SUBSIDY ELIGIBILITY**A. Introduction**

In the event that an applicant requests an Extra Help determination by the LDSS, the LDSS must comply with the request. Unless the applicant is later found to be deemed eligible for Extra Help or has been found eligible by SSA, the LDSS will also be responsible for ongoing case activity, including notices, appeals, and redeterminations.

B. Applicant's Representative

The applicant may be represented by any of the following individuals:

- an individual who is authorized to act on behalf of the applicant;
- if the applicant is incapacitated or incompetent, someone acting responsibly on his or her behalf; or
- an individual of the applicant's choice who is requested by the applicant to act as his or her representative in the application process;

Anyone may help the individual apply for the subsidy. The person assisting the applicant is required to attest to the accuracy of the information on the application.

C. Interview

A face-to-face interview is not required for Extra Help.

D. Screening for Deemed Status

LDSS must conduct its usual screening process to determine if the applicant is enrolled in Medicaid (full benefit or the limited benefit QMB, SLMB, or QI) or receives SSI. If the applicant is found to be in one of these programs, the applicant is deemed eligible for the subsidy and no application is required. M20, Appendix 1, Screening Script for Help with Medicare Costs (Form #032-03-701) and M20, Appendix 2, Screening Worksheet for Help with Medicare Costs (Form #032-03-702) are suggested screening tools.

E. Clearances

Eligibility workers should conduct their usual SDX/SVES/SOLQ clearances to verify the applicant's entitlement/enrollment in Medicare Parts A and B. If no Medicare entitlement/enrollment can be confirmed, deny the Extra Help application. If the available data confirm Medicare Buy-In in another U.S. jurisdiction, the applicant has already been deemed eligible for the subsidy. The LDSS must inform the applicant's former state of the change of address, and offer a Medicaid application to the applicant explaining that if he qualifies for Medicaid in Virginia, he automatically qualifies for Extra Help.

F. Spenddown

If the applicant is on a Medicaid spenddown in the month of application for the subsidy, continue with the Extra Help determination, using monthly countable income. If the applicant meets Medicaid eligibility during the month of subsidy application, he is deemed eligible for Extra Help. Once deemed, the individual will receive the subsidy for the remainder of the calendar year (in 2006).

G. Family Size

For the purpose of establishing the applicable income limit only, the following persons are counted in the family size:

- the applicant;
- the applicant's spouse, if living together; and
- any persons who are related by blood, marriage, or adoption, who are living with the applicant and spouse and who are dependent on the applicant or spouse for at least one half of their financial support. Accept the applicant's statement that he has a dependent.

M2040.100 FINANCIAL REQUIREMENTS

A. Introduction

Modified Supplemental Security Income (SSI) regulations are used to evaluate income and resources for Extra Help. For certain sections, the worker is referred to the on-line Program Operations Manual System (POMS) at <http://policy.ssa.gov/poms.nsf/aboutpoms> for more information. All types of countable income and resources must be verified.

The intent of the MMA was that the state and SSA determinations would be identical given the same information about the applicant/spouse. The guidance in this chapter and POMS must be used to determine eligibility for Extra Help.

M2040.200 RESOURCE REQUIREMENTS

A. Evaluating Resources

Resources of the applicant and his spouse if living together, but not resources of dependent family members are used to determine resource eligibility.

Count liquid resources which are cash or can be converted to cash within 20 days, including but not limited to:

- stocks;
- bonds;
- mutual fund shares;
- promissory notes (including mortgages held by the applicant);
- whole life insurance policies;

- financial institution accounts, including:
 - savings and checking accounts; and
 - time deposits, also known as certificates of deposit;
 - individual Retirement Accounts (IRAs) and
 - 401(K) accounts; and
- the equity value of real property not contiguous with home property (see M2040.200.E).

B. Resource Standards

The maximum subsidy resource standards are \$10,000 for one person and \$20,000 for a married couple. Resources at or below \$6,000 for an individual and \$9,000 for a married couple and income at or below 135% FPL will entitle the applicant(s) to the full subsidy.

The SSA subsidy application (SSA-1020) lists \$11,500 for an individual and \$23,000 for a married couple to reflect the burial fund exclusion of \$1500 for one person and \$3000 for a couple. These amounts apply **only** if the applicant/spouse indicates intent to use resources for burial or funeral arrangements. If the applicant/spouse has no intent to use resources for burial or funeral arrangements, the resource standards are \$10,000 for one person and \$20,000 for a married couple.

C. Resource Exclusions

The following resources are not to be considered for purposes of determining Extra Help eligibility:

- the applicant's home. For the purposes of this exclusion, a home is any property in which the applicant and his spouse have an ownership interest and which serves as his principal place of residence. There is no restriction on acreage of home property. This property includes the shelter in which an individual resides, the land on which the shelter is located, and any outbuildings;
- non-liquid resources, other than real property. These include, but are not limited to
 - household goods and personal effects;
 - automobiles, trucks, tractors and other vehicles;
 - machinery and livestock;
 - noncash business property;
- property of a trade or business which is essential to the applicant/spouse's means of self-support;
- nonbusiness property which is essential to the applicant/spouse's means of self-support;

- stock in regional or village corporations held by natives of Alaska during the twenty-year period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act;
- whole life insurance owned by an individual (and spouse, if any) if the total face value of all the life insurance policies on any person does not exceed \$1,500. When the total face value of all policies exceeds \$1,500, the cash surrender value of all policies is countable;
- term life insurance that has no cash surrender value;
- restricted, allotted Indian lands, 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;
- payments or benefits provided under a Federal statute where exclusion is required by such statute (see <http://policy.ssa.gov/poms.nsf/lnx/0501130050>);
- federal disaster relief assistance, including accumulation of interest, or comparable state or local assistance, received due to a Presidentially-declared major disaster;
- funds of \$1,500 for the individual and \$1,500 for the spouse who lives with the individual if these funds are intended to be used for funeral or burial expenses of the individual and spouse;
- burial spaces, including burial plots, gravesites, crypts, mausoleums, urns, niches, vaults, headstones, markers, plaques, burial containers, opening and closing of the grave site, and other customary and traditional repositories for the deceased's bodily remains, for the applicant/spouse;
- retained retroactive SSI or Social Security benefits for nine months after the month they are received;
- certain housing assistance;
- refunds of Federal income taxes and advances made by an employer relating to an earned income tax credit for the month following the month of receipt, and refunds of child tax credits for nine months after the month they are received;
- payments received as compensation incurred or losses suffered as a result of a crime (Victims' compensation payments), for nine months beginning with the month following the month of receipt;

- relocation assistance from a state or local government, for nine months, beginning with the month following the month of receipt;
- funds received from a government or nongovernmental agency, program, or health insurance policy whose purpose is to provide medical care or medical services or social services and conserved to pay for medical and/or social services.

**D. Determining
Countable
Resources**

Countable resources are determined as of the first moment of the first day of the month of application or redetermination for the subsidy.

E. Equity Value

Resources, other than cash, are evaluated according to the applicant/spouse's equity in the resources. The equity value of an item is the current market value of the item minus any encumbrances on it. Encumbrances include liens, mortgages, and other obligations against the value of the resource.

The current market value of an item is the documented value of the item or the going price for which it can reasonably be expected to sell on the open market in the particular geographic area involved, based on information from a knowledgeable source.

Documented value includes tax-assessed value for real property. Information from a knowledgeable source includes an estimate from a real estate broker, bank, mortgage company, or similar lending institution. There are other rules that apply in calculating the value of resources. See POMS at <http://policy.ssa.gov/poms.nsf/aboutpoms> for additional information, and contact your Medical Assistance Program Specialist for assistance if needed.

**F. Funds Held in
Financial
Institutions**

Cash received by the applicant or his spouse during a month is evaluated under the rules for counting income during the month of receipt. If the cash is retained until the first moment of the following month, the cash is countable as a resource unless it is otherwise excludable.

**1. Owner of
the Account**

Funds held in a financial institution account (including savings, checking, and time deposits also known as certificates of deposit) are considered the applicant/spouse's resources if he or she owns the account and can use the funds for his or her support and maintenance.

**2. Individually-
held Account**

If the applicant/spouse is designated as the sole owner by the account title and can withdraw and use funds from that account for his or her support and maintenance, all of the account's funds are the applicant/spouse's resource regardless of the source. For as long as these conditions are met, presume that the applicant/spouse owns 100 percent (%) of the funds in the account. This presumption is not rebuttable.

**3. Jointly-held
Account**

If the applicant/spouse is the only subsidy claimant or subsidy recipient who is an account holder on a jointly held account, presume that all of the funds in the account belong to the applicant/spouse. If more than one subsidy claimant or subsidy recipient are account holders, presume that the funds in the account belong to those individuals in equal shares. If the applicant/spouse disagrees with the ownership presumption described in this paragraph, he or she may rebut the presumption. Rebuttal is a procedure which permits an individual to furnish evidence and establish that some or all of the funds in the jointly-held account do not belong to him or her. See the SSA POMS at <http://policy.ssa.gov/poms.nsf/aboutpoms> for additional information.

M2040.300 INCOME REQUIREMENTS

A. Introduction

Income is anything the applicant/spouse receives in cash or in-kind that can be used to meet his needs for food or shelter. The gross income of the applicant and spouse if living together, but not dependent family members, will be considered, however, dependent family members will be counted in the family size.

Income to be counted is income expected to be received on a monthly basis. Convert income to a monthly amount by multiplying weekly income by 4.3, bi-weekly income by 2.15 and semi-monthly income by 2. Income from a terminated source must only be verified and counted when it was received in a month in which eligibility is being determined.

B. 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; and
- royalties earned by an individual in connection with any publication of his/her work and any honoraria received for services rendered.

1. Wages

Wages are counted at the earliest of the following points:

- when received;
- when credited to the person employed; or
- when set aside for the employee's use.

Net earnings from self-employment are counted on a taxable year basis. Net losses, if any, are deducted from other earned income, but not from unearned income.

Payments for services performed in a sheltered workshop or work activities center are counted when received or set aside for the employee's use.

**2. In-Kind
Earned
Income**

In-kind earned income is counted based on current market value. If the applicant/spouse receives an item that is not fully paid for and he or she is responsible for the balance, only the paid up value is income to the applicant. See M20, Appendix 3 for the maximum value of contributed food and shelter.

3. Honoraria

Honoraria for services rendered and royalty payments that an individual receives in connection with any publication of their work counts as earned income.

**4. Earned
Income
Exclusions**

Apply exclusions in the order listed below:

- refund of Federal income taxes and payments under the Earned Income Tax Credit;
- the first \$30 of earned income per calendar quarter that is received too irregularly or infrequently to be counted as income;
- any portion of the \$20 per month exclusion that has not been excluded from combined unearned income (see S02030.200.D);
- \$65 per month of the applicant/spouse's earned income;
- for applicants/spouses who are under age 65 and receive a Social Security Disability Insurance benefit based on disability, 16.3% of gross earnings for impairment related work expenses (IRWE).
- one half of the applicant/spouse's remaining earned income; and
- for applicants/spouses who are under age 65 and receive a Social Security Disability Insurance benefit that is based on blindness, 25% of gross earnings for blind work expenses (BWE).

C. Unearned Income

Unearned income is all income that is not earned income. Unearned income is counted at the earliest of the following points:

- when received;
- when credited to the applicant; or
- when set aside for the applicant's use.

Unearned income includes, but is not limited to:

- Social Security;
- Railroad Retirement;
- VA Benefits;

- Temporary Assistance for Needy Families (TANF);
- pensions;
- annuities;
- alimony and support payments
- rental income;
- Workers' Compensation;
- in-kind support and maintenance;
- death benefits;
- royalties not counted as earned income; and
- dividends and interest not otherwise excluded under SSI rules.

1. In-kind support and maintenance

In-kind support and maintenance is any food and shelter that is given to the applicant/spouse or received because someone else pays for it. This includes room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewage, and garbage collection services. The maximum amount of income countable for in-kind support and maintenance is limited to one third of the monthly SSI benefit rate for an individual or a couple (see M20, Appendix 3), if the applicant's spouse is counted, or the current market value of the support, whichever is lower.

Example 1: Mr. and Mrs. Maple live rent-free in a home that belongs to their son. The house would otherwise rent for \$900 per month. In 2005, one third of the SSI benefit for a couple is \$286.77; therefore, the Maples receive in-kind support valued at \$286.77 per month.

Example 2: Mr. Oak cannot manage his housing expenses on his income alone. His daughter helps him by paying his electric bill, which averages \$150 per month. In 2005, one third of the SSI benefit for one person is \$193; therefore, Mr. Oak receives in-kind support valued at \$150 per month.

2. Overpayments

When benefits are reduced for overpayments or garnishments, count the gross benefit before deductions.

Example: Mr. Poplar failed to pay income taxes and his Social Security check has been garnished to pay IRS. The gross amount of his benefit is \$1,150 per month; he actually receives \$750. The gross amount (\$1,150) is countable.

3. Expenses

If part of a payment reflects expenses the applicant/spouse incurred in getting the payment, such as legal fees, or damages, such as medical expenses, incurred because of an accident, reduce the payment by the amount of the expenses. Do not reduce the payment by the amount of personal income taxes owed on the payment.

4. VA Benefits

Subtract from VA Benefits any amount included in the payment for a dependent. If the applicant/spouse is the dependent, count the portion of the benefit attributable to the dependent if they reside with the veteran or receive their own separate payment from the Department of Veteran Affairs.

5. Death benefits

Subtract from death benefits the expenses of the deceased person's last illness and death paid by the applicant.

D. Unearned Income Exclusions

The following types of unearned income are not considered for purposes of determining Extra Help eligibility:

- Supplemental Security Income (SSI) benefits;
- any public agency's refund of taxes on real property or food;
- need-based assistance wholly funded by a State or one of its subdivisions, including State supplementation of SSI benefits but not a Federal/State grant program such as TANF;
- any portion of a grant, scholarship, fellowship, or gift used for paying tuition, fees, or other educational expenses. Any portion set aside or used for food, clothing or shelter is countable;
- food which the applicant or their spouse raise if it is consumed by them or their household;
- assistance received under the Disaster Relief and Emergency Assistance Act and assistance provided under any Federal statute because of a catastrophe which the President of the United States declares to be a major disaster;
- payments for providing foster care to a child who was placed in the applicant's home by a public or private nonprofit child placement or child care agency;
- any interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement which are left to accumulate and become part of the separate burial fund;
- home energy assistance (any assistance related to meeting the costs of heating or cooling a home);
- one-third of support payments made to or for the applicant by an absent parent if the applicant is a child;
- the first \$20 of any unearned income in a month other than income in the form of in-kind support and maintenance received in the household of another and income based on need;

- housing assistance any assistance paid with respect to a dwelling unit under:
 - The United States 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;
- any interest accrued on and left to accumulate as part of the value of an excluded burial space purchase agreement;
- gift of a domestic travel ticket received by the applicant or their spouse and not converted to cash;
- payments made to the applicant or their spouse from a fund established by the State to aid victims of crime;
- relocation assistance provided to the applicant or their spouse by the State or local government that is comparable to relocation assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;
- hostile fire pay received from one of the uniformed services;
- the first \$60 of unearned income received per calendar quarter that is received too irregularly or infrequently to be counted as income; or
- any dividends or interest earned on countable resources, any dividends or interest earned on resources excluded under a Federal statute other than the Social Security Act, and any dividends or interest excluded under the Social Security Protection Act of 2004 (see POMS SI 01130.050).

M2050.100 CALCULATING EXTRA HELP ELIGIBILITY

A. Introduction

When an applicant insists on an Extra Help determination by the LDSS, the eligibility worker must determine the applicant's eligibility for Extra Help and if eligible, the amount of the subsidy to which he is entitled. The amount of the subsidy is based on the amount of the individual's countable income and resources.

**B. Steps for
Determining the
Amount of the
Subsidy**

To determine the amount of the subsidy, use the following steps:

1. Using the family size reported by the applicant and their countable net income, determine where the applicant and his spouse, if living together, fall on the appropriate Extra Help Income Limits table to determine the percentage of the federal poverty level (FPL) (see M20, Appendix 3).
2. Using the percentage of the FPL and the applicant/spouse's countable resources, find the subsidy code (A through F) on the subsidy calculation table for one person or a couple (see M20, Appendix 4).
3. Using the subsidy code, identify the applicable benefits on the subsidy benefits table (see M20, Appendix 4). The SSA Calculator Tool may be used for this calculation. This resource may be found at www.ssa.gov under "Medicare Outreach."

Example: Mr. and Mrs. Spruce are Medicare beneficiaries who are raising their 15-year-old grandson. Their countable net income is \$1,500 per month. They have \$18,000 in countable resources.

1. Find their income range on the Family Size-3 line of the Extra Help Income Limits in M20, Appendix 3. The income limits show that their income falls below 135% of the FPL.
2. Using the percent of FPL and the total countable resources, find the subsidy code on the subsidy calculation table for couples (M20, Appendix 4). The correct code is "B".
3. Transpose the percentage of premium level for "B" onto the Spruces' approval notice.

M2060.100 NOTICES

A. Introduction

When the LDSS determines or redetermines eligibility for Extra Help, notice must be sent to the applicant. All notices must provide adequate information and meet the Medicaid advance notice requirements.

B. Approval Notice

When the LDSS approves an application for Extra Help, an approval notice must be sent and must include the following required information:

- application date;
- description of how the subsidy was calculated; what income, family size, and resources were used;
- premium percentage;
- effective date of eligibility;
- who made the decision and how to contact them;
- appeal rights and procedures; and
- a reminder to apply for a prescription drug plan.

M20, Appendix 5 contains the Notice of Approval on Your Application for Extra Help with Medicare Part D Costs (Form #032-03-703).

C. Denial Notice

When the LDSS denies an application for Extra Help, a denial notice must be sent and must include the following information:

- application date;
- reason for denial and policy citation;
 - not Medicare-eligible;
 - failure to complete the application process;
 - income exceeds 150% FPL;
 - resources exceed \$11,500/\$23,000;
 - not a resident of the State;
 - not a resident of U.S./incarcerated;
- description of how the denial was calculated; what income, family size, and resources were used;
- who made the decision and how to contact them;
- appeal rights and procedures; and
- depending on the denial reason, a reminder to apply for a prescription drug plan.

M20, Appendix 6 contains the Notice of Denial on Your Application for Extra Help with Medicare Part D Costs (Form #032-03-704).

D. Termination Notice

When the LDSS determines an individual is no longer eligible for Extra Help, a termination notice must be sent and must include the following information:

- reason for termination and policy citation;
 - not Medicare-eligible;
 - failure to complete the redetermination process;
 - income exceeds 150% FPL;
 - resources exceed \$11,500/\$23,000;
 - not a resident of the State;
 - not a resident of U.S./incarcerated.

- description of how the termination was calculated; what income, family size, and resources were used;
- effective date of termination;
- who made the decision and how to contact them;
- appeal rights and procedures; and
- depending on the termination reason, a reminder that he can still use his prescription drug plan.

M20, Appendix 7 contains the Notice of Termination of Your Extra Help with Medicare Part D Costs (Form #032-03-705).

E. Change Notice

When the LDSS determines that an individual's eligibility for Extra Help has changed, it is required to send a change notice containing the following information:

- reason for change in subsidy level and policy citation;
- new premium percentage;
- description of how the change was calculated; what income, family size, and resources were used;
- effective date of change;
- who made the decision and how to contact them;
- appeal rights and procedures; and
- reminder that he can still use his prescription drug plan but that his costs within the plan have changed.

M20, Appendix 8 contains the Notice of Change in the Amount of Extra Help with Medicare Part D Costs (Form #032-03-706).

All notices must meet the adequate and timely notice requirements of the Medicaid State Plan.

M2070.100 APPEALS AND FAIR HEARINGS

A. Decision made by LDSS

The applicant may appeal his Extra Help determination according to the appeal procedures found in chapter M16. The individual has 30 days from the receipt of the notice to file an appeal.

B. Decision made by SSA

SSA will be responsible for appeals of decisions made by SSA, including decisions made on SSA applications forwarded to SSA by the State.

M2080.100 PERIODS OF ELIGIBILITY

A. Introduction

Initial eligibility determinations made by the LDSS are effective as of the first day of the month of application, but not earlier than January 1, 2006, and remain in effect for a period not to exceed one year. Redeterminations must be made in the same manner and frequency as redeterminations are made under the State plan.

Note: There is no retroactive period for Extra Help.

B. Examples

The subsidy is effective the beginning of the month of application or January 1, 2006, whichever is later.

Example: Ms. Gingko files a subsidy application in August 2005. If she qualifies, her subsidy will be effective January 1, 2006.

Example: Mr. Dogwood files a subsidy application in March 2006. If he qualifies, his subsidy will be effective March 1, 2006.

M2090.100 INTERIM CHANGES (SUBSIDY-CHANGING EVENTS)

A. Introduction

Certain changes in the individual's circumstances can affect their eligibility for the subsidy or change the level of the subsidy. These changes include:

- changes in income,
- changes in resources,
- changes in marital status (marriage, divorce, annulment, etc), or
- changes in eligibility for Medicaid or SSI (deemed status).

The Notice of Approval on Your Application For Extra Help with Medicare Part D Costs instructs the individual to report changes within 10 days. When a change is reported, the eligibility worker must determine the individual's continued eligibility and amount of subsidy to which he is entitled as a result of the change.

If the level of subsidy is increased, decreased or terminated, notification of the action must be sent to the individual at least 10 days plus one day for mail before the action is taken describing the change, the effective date of the change, how the subsidy was calculated, and his right to appeal the decision.

B. Changes in Income or Resources

When a reported change in income or resources results in an increase in the amount of subsidy to which the individual is entitled, the change is effective the month following the month in which the change is reported.

When the reported change results in a decrease in the amount of subsidy to which the individual is entitled or ineligibility for the subsidy, the change is effective the month following the month in which the 10-day notice expires.

**C. Changes in
Marital Status**

When a reported change in marital status results in an increase in the amount of subsidy to which the individual is entitled, the change is effective the month following the month in which the change is reported.

When the reported change results in a decrease in the amount of subsidy to which the individual is entitled or ineligibility for the subsidy, the change is effective the month following the month in which the 10-day notice expires.

**D. Changes in
Deemed Status**

Individuals who become eligible for Medicaid, SSI, QMB, SLMB, and QI after being found eligible for the subsidy join the deemed population. The LDSS can then close its on-going subsidy case for the individual while maintaining the Medicaid case. CMS will notify the individual that he is now deemed eligible for Extra Help.

Individuals who lose deemed status will be notified by CMS of the need to apply at SSA or LDSS to retain eligibility for Extra Help.

M2090.200 REDETERMINATION

A. Introduction

Redeterminations of continued eligibility for Extra Help must be completed annually. A redetermination is due 12 months from the month of application or the last redetermination. For example, when the application is filed in June, the redetermination is due the following May. The next redetermination would be due in May of the following year.

M2090.300 MULTIPLE DETERMINATIONS FOR THE SAME APPLICANT

A. Introduction

The LDSS may not know if a subsidy application has also been filed at SSA. However, CMS is working with states and SSA to facilitate information sharing so that CMS will know whether an individual has been found eligible by SSA or a state.

In the case of multiple determinations based on applications in different months, the later application is void if the individual has received a positive subsidy determination on the earlier application with the State or SSA. This is so even if the earlier decision is a partial subsidy and the later decision is a full subsidy. If two approvals occur in the same month, the SSA decision takes precedence, even if it provides a lower level of subsidy. All decisions may be appealed, including denials, effective dates, and partial subsidies, with the agency that is responsible for the decision. M20, Appendix 9 contains the precedence of Extra Help decisions.

Screening Script for Help with Medicare Costs

“This is a preliminary, voluntary screening to see if you might be eligible for programs that help pay Medicare expenses. It is not an application for these programs. The information you provide will assist us in determining if you may be eligible for these programs.

Do you have Medicare Part A or Part B Yes _____ No _____

Are you: (1) single or married but not living with your spouse? _____ Go to A. below

or

(2) married and living with your spouse? _____ Go to B. below

A. Single or Not Living with Spouse

“Income includes Social Security benefits such as retirement, disability, or SSI; any pensions; earned wages; interest; dividends; monthly cash gifts; and contributions.”

Is your monthly income before any deductions less than \$1197 per month? Yes _____ No _____

“Resources are things such as cash on hand, bank accounts such checking, savings, certificates of deposit, IRAs, Christmas Clubs, and trusts; as well as stocks, bonds, the cash value of life insurance policies; and property that does not adjoin your home. Your home and adjoining property, vehicles, burial plots, household furnishings, and personal items such as jewelry are not counted as resources.”

Do you have less than \$10,000 in resources? Yes _____ No _____

B. Married and Living with Spouse

“Income includes Social Security benefits such as retirement, disability, or SSI; any pensions; earned wages; interest; dividends; monthly cash gifts; and contributions.”

Is your combined monthly income before any deductions less than \$1604 per month? Yes _____ No _____

“Resources are things such as cash on hand, bank accounts such checking, savings, certificates of deposit, IRAs, Christmas Clubs, and trusts; as well as stocks, bonds, the cash value of life insurance policies; and property that does not adjoin your home. Your home and adjoining property, vehicles, burial plots, household furnishings, and personal items such as jewelry are not counted as resources.”

Do you and your spouse have less than \$20,000 in resources? Yes _____ No _____

“Based on this screening, it appears that you (choose one) may / may not be eligible for Extra Help with your Medicare Part D costs. You may apply for Extra Help directly at the Social Security Administration office or by calling 1-800-772-1214. You may apply even if it appears that you may not be eligible. Your income and resources can be verified by the Social Security Administration.”

“If your income is less than \$1,077 for one person or \$1,444 for a couple and your resources are less than \$4,000 for one person or \$6,000 for a couple, you may want to apply for Medicaid. If you are found eligible, Medicaid will cover some or all of your Medicare expenses, and you will automatically be eligible for Extra Help with your Medicare Part D costs .”

Screening Worksheet for Help with Medicare Costs

- I. Do you have Medicare Part A or Part B Yes _____ No _____
- II. Marital status:
Is person single? Yes _____ No _____
Or married and living with spouse? Yes _____ No _____
(Count income and resources of a couple who are married and living together).
- III. Income:
a. Total monthly earned income: _____
b. Minus \$65 and ½ : _____ = countable earned
c. Total monthly unearned income _____
d. Minus \$20 _____ = countable unearned

Total countable income (add lines b. and d.): _____
- IV. Total countable resources: _____
- V. Dependents: Does the individual/couple live with any relatives for whom he/she provides at least 1/2 of their financial support? Yes _____ How Many? _____ No _____
- VI. Screen:

Countable Limits	MSP Eligible		Extra Help Eligible			
	1	2	1	2	3	4
Income	\$1,077	\$1,444	\$1,197	\$1,604	\$2,012	\$2,419
Resources	\$4,000	\$6,000	\$10,000	\$20,000 (C)	\$10,000 (S) \$20,000 (C)	\$10,000 (S) \$20,000 (C)

S = Single C = Married Couple

If income is less than or equal to 135% and resources do not exceed MSP limits, the individual may be eligible for Medicaid. A Medicaid application must be completed and all information must be verified.

If income is greater than 135% and/or resources do not exceed the Extra Help limits, offer to assist the individual with applying for Extra Help from the Social Security Administration.

EXTRA HELP INCOME LIMITS ALL LOCALITIES EFFECTIVE 7/1/05 MONTHLY GUIDELINES					
FAMILY SIZE	PERCENT OF FEDERAL POVERTY LEVEL (FPL)				
	100%	135%	140%	145%	150%
1	797.50	1,076.63	1,116.50	1,156.38	1,196.25
2	1,069.17	1,443.38	1,496.83	1,550.29	1,603.75
3	1,340.83	1,810.13	1,877.17	1,944.21	2,011.25
4	1,612.50	2,176.88	2,257.50	2,338.13	2,418.75
5	1,884.17	2,543.63	2,637.83	2,732.04	2,826.25
6	2,155.83	2,910.38	3,018.17	3,125.96	3,233.75
7	2,427.50	3,277.13	3,398.50	3,519.88	3,641.25
8	2,699.17	3,643.88	3,788.83	3,913.79	4,048.75

For family units of more than 8 members, add \$271.66 for each additional member.

MAXIMUM VALUE OF CONTRIBUTED FOOD AND SHELTER

SINGLE/COUPLE	MONTHLY AMOUNT
SINGLE	\$193.00
COUPLE	289.66

CALCULATION TABLES

Subsidy Calculation for One Person

Countable Resources in \$	<135% FPL	> 135% to <140% FPL	> 140% to < 145% FPL	> 145% to < 150% FPL	> 150%
< \$6,000	A	C	D	E	F
> \$6,000 to < \$10,000	B	C	D	E	F
> \$10,000	F	F	F	F	F

Subsidy Calculation for a Couple

Countable Resources in \$	< 135% FPL	> 135% to < 140% FPL	> 140% to < 145% FPL	> 145% to < 150%	> 150%
< \$9,000	A	C	D	E	F
> \$9,000 to < \$20,000	B	C	D	E	F
> \$20,000	F	F	F	F	F

Subsidy Benefits

Subsidy	Subsidized Monthly Premium	Yearly Deductible	Pre- Catastrophic Co-pay per Prescription	Coverage Gap? Y/N	Catastrophic Co-pay per Prescription
A	100%	\$0	\$2/\$5	N	\$0
B	100%	\$50	15%	N	\$2/\$5
C	75%	\$50	15%	N	\$2/\$5
D	50%	\$50	15%	N	\$2/\$5
E	25%	\$50	15%	N	\$2/\$5
F (No subsidy)	0%	\$250	25%	Y	@5%

Commonwealth Of Virginia
Department Of Social Services

County/City:	Case Number:
Case Name:	

**NOTICE OF APPROVAL ON YOUR APPLICATION FOR
EXTRA HELP WITH MEDICARE PART D COSTS**

[Last Name, First Name, Middle Initial]
[Address]
[City, Virginia, Zip Code]

Your application for Extra Help dated _____ has been approved. You are eligible for Extra Help with your Medicare prescription drug plan (Medicare Part D) costs beginning _____. To take advantage of this benefit, you must enroll in a Medicare-approved prescription drug plan or Medicare Advantage plan with prescription drug coverage, if you are not already enrolled in one. You will receive more information from Medicare about how to choose a prescription drug plan. You may also visit www.medicare.gov or call toll-free 1-800-MEDICARE (1-800-633-4227) for more information. If you are hearing impaired, you may call the Medicare TTY number toll-free at 1-877-486-2048.

What Help You Are Eligible For

You are eligible for Extra Help (subsidy) to pay your Medicare prescription drug costs. You are eligible for: _____ % subsidy to help pay your Medicare prescription drug plan premiums; \$ _____ prescription drug annual deductible; and reduced co-payment amounts when you have a prescription filled.

Information Used To Determine Your Eligibility

We used the following information you reported on your application for Extra Help to determine your eligibility:

Countable income of \$ _____ per month;
Countable resources of \$ _____;
Household size of _____ person/people. To determine your household size, we count you, your spouse who lives with you, and any relative who lives with you and receives one-half of his or her support from you or your spouse.

To determine your eligibility, we compared your countable income and resources to the limits adopted by law for your household size.

What To Do If Your Situation Changes

If your mailing address changes, report it to your eligibility worker listed below immediately. Certain changes may affect the amount of Extra Help you can receive. Please contact your eligibility worker within 10 days to report any of the following changes:

- You get married;
- Your spouse who lives with you dies;
- You and your spouse who lives with you divorce, or separate or have your marriage annulled;
- You and your separated spouse begin living together again, or
- Your income or resources change.

Your application was processed by:

_____	_____	_____	_____
Date Mailed	Worker's Name	Title	Worker's Phone Number

If You Disagree With This Decision

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. **You have 30 days to ask for an appeal.** The 30 days start the day after you receive this letter. You must have a good reason for waiting more than 30 days. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you desire free legal advice, you may contact your local legal aid office.

A fair hearing provides you the opportunity to review the way a local social services agency has handled your situation concerning your stated need for Extra Help. The fair hearing is a private, informal meeting at the local social services agency with you and anyone you wish to bring as a witness or to help you tell your story, such as a relative, friend, or lawyer. The person who conducts the hearing is someone from the Department of Medical Assistance Services, not someone from your local social services agency. The hearing officer makes a decision on your appeal.

To request an appeal, please send written notification of the action you disagree with within 30 days of receipt of the agency's notice about the action. You or your authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, at your department of social services, or by calling (804) 371-8488. It would be helpful to include a copy of the notice or letter about the action you are appealing. Please be sure to sign the request and mail it to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Appeal requests may also be faxed to: (804) 371-8491.

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

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

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

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

You will be notified in writing of the hearing officer's decision on your appeal within 90 days of the date your appeal request is received by the Department of Medical Assistance Services.

Commonwealth Of Virginia
Department Of Social Services

County/City:	Case Number:
Case Name:	

**NOTICE OF DENIAL ON YOUR APPLICATION FOR
EXTRA HELP WITH MEDICARE PART D COSTS**

[Last Name, First Name, Middle Initial]
[Address]
[City, State, Zip Code]

Your application for Extra Help with your Medicare prescription drug plan (Medicare Part D) costs dated _____ has been denied. The information below explains the reason(s) for the denial and how we determined you are not eligible for Extra Help.

Why Your Application Was Denied

Your application for Extra Help was denied for the following reason(s): Policy Citation: _____

- You are not Medicare-eligible.
- You did not complete the application process.
- Your income exceeds 150% (percent) of the Federal Poverty Guideline for your household size. This is the income limit for Extra Help established by law.
- Your resources exceed the limit of \$ _____ established by law for your income level and household size.
- You are not a resident of Virginia.
- You are incarcerated.

Information Used To Determine Your Eligibility

We used the following information you reported on your application for Extra Help to determine your eligibility:

Countable income of \$ _____ per month;
Countable resources of \$ _____;
Household size of _____ person/people. To determine your household size, we count you, your spouse who lives with you, and any relative who lives with you and receives one-half of his or her support from you or your spouse.

To determine your eligibility, we compared your countable income and resources to the limits adopted by law for your household size. We also used your information about where you live and whether you have Medicare to verify whether you meet the Virginia residency requirement and Medicare eligibility requirement for Extra Help.

About Medicare Prescription Drug Coverage

If you are not already enrolled in a Medicare-approved prescription drug plan, you may still enroll in one if you have Medicare Part B or are eligible for Medicare Part A. You will receive more information from Medicare about how to choose a prescription drug plan. You may also visit www.medicare.gov or call toll-free 1-800-MEDICARE (1-800-633-4227) for more information. If you are hearing impaired, you may call the Medicare TTY number toll-free at 1-877-486-2048.

Your application was processed by:

Date Mailed Worker's Name Title Worker's Phone Number

If You Disagree With This Decision

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. **You have 30 days to ask for an appeal.** The 30 days start the day after you receive this letter. You must have a good reason for waiting more than 30 days. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you desire free legal advice, you may contact your local legal aid office.

A fair hearing provides you the opportunity to review the way a local social services agency has handled your situation concerning your stated need for Extra Help. The fair hearing is a private, informal meeting at the local social services agency with you and anyone you wish to bring as a witness or to help you tell your story, such as a lawyer. The person who conducts the hearing is someone from the Department of Medical Assistance Services, not someone from your local social services agency. The hearing officer makes a decision on your appeal.

To request an appeal, please send written notification of the action you disagree with within 30 days of receipt of the agency's notice about the action. You or your authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, at your department of social services, or by calling (804) 371-8488. It would be helpful to include a copy of the notice or letter about the action you are appealing. Please be sure to sign the request and mail it to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Appeal requests may also be faxed to: (804) 371-8491.

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

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

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

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

You will be notified in writing of the hearing officer's decision on your appeal within 90 days of the date your appeal request is received by the Department of Medical Assistance Services.

Virginia DSS, Volume XIII

M20, Appendix 7

Commonwealth Of Virginia
 Department Of Social Services

County/City:	Case Number:
Case Name:	

**NOTICE OF TERMINATION OF YOUR
 EXTRA HELP WITH MEDICARE PART D COSTS**

[Last Name, First Name, Middle Initial]
 [Address]
 [City, Virginia, Zip Code]

Your Extra Help with your Medicare prescription drug plan (Medicare Part D) costs will be terminated effective _____. The information below explains the reason(s) for the termination and how we determined that you are no longer eligible for Extra Help.

Why Your Extra Help Was Terminated

Your application for Extra Help was terminated for the following reason(s): Policy Citation: _____

- You are not Medicare-eligible.
- You did not complete the redetermination process.
- Your income exceeds 150% (percent) of the Federal Poverty Guideline for your household size.
- Your resources exceed the limit of \$ _____.
- You are no longer a resident of Virginia.
- You are incarcerated.

Information Used To Determine You Are No Longer Eligible

We used the following information you reported to your local department of social services to determine that you are no longer eligible for Extra Help:

Countable income of \$ _____ per month;
 Countable resources of \$ _____;
 Household size of _____ person/people. To determine your household size, we count you, your spouse who lives with you, and any relative who lives with you and receives one-half of his or her support from you or your spouse.

To determine your continued eligibility, we compared your countable income and resources to the limits adopted by law for your household size. We also used your information about where you live and whether you have Medicare to verify whether you meet the Virginia residency requirement and Medicare eligibility requirement for Extra Help.

About Your Medicare Prescription Drug Coverage

Even though your Extra Help has been terminated, you will still have prescription drug coverage under your prescription drug plan if you have Medicare Part B or are eligible for Medicare Part A. If you have moved out of Virginia, you may need to choose a new prescription drug plan in your area. To find out how the termination of your Extra Help will affect you, please contact your prescription drug plan provider. You may also visit www.medicare.gov or call toll-free 1-800-MEDICARE (1-800-633-4227) for more information. If you are hearing impaired, you may call the Medicare TTY number toll-free at 1-877-486-2048.

The decision on the termination of your Extra Help was made by:

 Date Mailed Worker's Name Title Worker's Phone Number

If You Disagree With This Decision

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. **You have 30 days to ask for an appeal.** The 30 days start the day after you receive this letter. You must have a good reason for waiting more than 30 days. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you desire free legal advice, you may contact your local legal aid office.

A fair hearing provides you the opportunity to review the way a local social services agency has handled your situation concerning your stated need for Extra Help. The fair hearing is a private, informal meeting at the local social services agency with you and anyone you wish to bring as a witness or to help you tell your story, such as a lawyer. The person who conducts the hearing is someone from the Department of Medical Assistance Services, not someone from your local social services agency. The hearing officer makes a decision on your appeal.

To request an appeal, please send written notification of the action you disagree with within 30 days of receipt of the agency's notice about the action. You or your authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, at your department of social services, or by calling (804) 371-8488. It would be helpful to include a copy of the notice or letter about the action you are appealing. Please be sure to sign the request and mail it to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Appeal requests may also be faxed to: (804) 371-8491.

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

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

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

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

You will be notified in writing of the hearing officer's decision on your appeal within 90 days of the date your appeal request is received by the Department of Medical Assistance Services.

Commonwealth Of Virginia
Department Of Social Services

County/City:	Case Number:
Case Name:	

**NOTICE OF CHANGE IN THE AMOUNT OF
EXTRA HELP WITH MEDICARE PART D COSTS**

[Last Name, First Name, Middle Initial]
[Address]
[City, Virginia, Zip Code]

The amount of your Extra Help with Medicare prescription drug plan (Medicare Part D) costs will change effective _____. The information below explains the reason(s) for the change and how we determined that the change was necessary:

About Your New Extra Help Amount

The amount of your Extra Help, also known as subsidy, will change beginning on the effective date above. Your Extra Help will be:

_____ % subsidy to help pay your Medicare prescription drug plan premiums;
\$ _____ prescription drug annual deductible; and
reduced co-payment amounts when you have a prescription filled.

Why The Amount Of Your Extra Help Was Changed

Policy Citation: _____

The amount of your Extra Help was changed for the following reason(s):

- Your income is now under 135% (percent) of the Federal Poverty Guideline for your household size. This is the income limit for the full Extra Help subsidy established by law.
- Your resources are now under the limit of \$ _____ established by law for your income level and household size. This is the resource limit for the full Extra Help subsidy established by law.
- Your income now exceeds 135% (percent) of the Federal Poverty Guideline for your household size. This is the income limit for the full Extra Help subsidy established by law. You are now eligible for a partial subsidy.
- Your resources now exceed the limit of \$ _____ established by law for your income level and household size. This is the resource limit for the full Extra Help subsidy established by law. You are now eligible for a partial subsidy.

Information Used To Determine The Change

We used the following information you reported to your local department of social services to determine that the change in the amount of your Extra Help is necessary:

Countable income of \$ _____ per month;
Countable resources of \$ _____;
Household size of _____ person/people. To determine your household size, we count you, your spouse who lives with you, and any relative who lives with you and receives one-half of his or her support from you or your spouse.

To determine the amount of your Extra Help, we compared your countable income and resources to the limits adopted by law for your household size.

About Your Medicare Prescription Drug Coverage

You will still have prescription drug coverage under your prescription drug plan, but the amount of the costs within the plan will change. You will receive information about these changes from your prescription drug plan provider. If you have questions about these changes, please contact your prescription drug plan provider. You may also visit www.medicare.gov or call toll-free 1-800-MEDICARE (1-800-633-4227) for more information. If you are hearing impaired, you may call the Medicare TTY number toll-free at 1-877-486-2048.

If You Disagree With This Decision

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. **You have 30 days to ask for an appeal.** The 30 days start the day after you receive this letter. You must have a good reason for waiting more than 30 days. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you desire free legal advice, you may contact your local legal aid office.

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To request an appeal, please send written notification of the action you disagree with within 30 days of receipt of the agency's notice about the action. You or your authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, at your department of social services, or by calling (804) 371-8488. It would be helpful to include a copy of the notice or letter about the action you are appealing. Please be sure to sign the request and mail it to:

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

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

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

You will be notified in writing of the hearing officer's decision on your appeal within 90 days of the date your appeal request is received by the Department of Medical Assistance Services. The decision on the change in the amount of your Extra Help was made by:

Date Mailed

Worker's Name

Title

Worker's Phone Number

PRECEDENCE OF EXTRA HELP DECISIONS

Scenario	SSA	LDSS	Outcome
1	Denial	Approval	Approval is official determination. Beneficiary may appeal either decision.
2	Approval	Denial	Approval is official determination. Beneficiary may appeal either decision.
3	Denial	Denial	The beneficiary may appeal either decision. If both are appealed and overturned, see scenarios 4 and 5.
4	Approval (Different Month)	Approval (Different Month)	If the subsidy effective dates are in different months, the decision with the earlier effective date is the official determination. The second decision is void.
5	Approval (Same Month)	Approval (Same Month)	If the subsidy effective dates are the same, the SSA decision is the official determination. The beneficiary may appeal either decision.