



COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

January 1, 2010

MEDICAID MANUAL – VOLUME XIII

TRANSMITTAL #93

The following acronyms are used in this transmittal:

- ABD – Aged, Blind or Disabled
- BCCPTA - Breast and Cervical Cancer Prevention and Treatment Act
- CHIPRA - The Children's Health Insurance Program Reauthorization Act of 2009
- COLA – Cost of Living Adjustment
- CPI – Consumer Price Index
- DBHDS – Department of Behavioral Health & Developmental Services
- DMAS – Department of Medical Assistance Services
- DMHMRSAS – Department of Mental Health, Mental Retardation & Substance Abuse Services.
- F&C – Families and Children
- FAMIS – Family Access to Medical Insurance Security
- FPL – Federal Poverty Level
- IMD – Institution for Treatment of Mental Diseases
- LDSS – Local Departments of Social Services
- LIS – Low Income Subsidy
- LTC – Long-term Care
- MMIS – Medicaid Management Information System
- MSP – Medicare Savings Programs
- QDWI – Qualified Disabled Working Individual
- QI – Qualified Individual
- QMB – Qualified Medicare Beneficiary
- SLMB – Special Low Income Medicare Beneficiary
- SNAP – Supplemental Nutrition Assistance Program
- SOLQ-I – State On-line Query-Internet
- SPARK – Services Programs Answers Resources Knowledge
- SSA - Social Security Administration
- SSI – Supplemental Security Income
- SSN – Social Security Number
- SVES – State Verification Exchange System
- VDSS – Virginia Department of Social Services

This transmittal includes revised citizenship eligibility policy and procedures for the FAMIS and FAMIS MOMS programs, as well as other new and revised policies, that are effective on January 1, 2010, unless another date is indicated.

New Policy

Effective January 1, 2010, verification of citizenship and identity is required of FAMIS children applicants and recipients as well as FAMIS MOMS applicants and recipients. Policies that address this federal requirement, including the provision of a reasonable opportunity period, are included in Transmittal #93.

New and Amended Policy

States have been given the option, under Section 214 of the CHIPRA of 2009, to provide Medicaid coverage to certain individuals who are lawfully residing in the United States and are otherwise eligible for Medicaid. Virginia has elected to cover children under the age of 19 who are lawfully residing in the U.S. By doing so, Virginia is able to obtain federal Medicaid funds for the currently state-only funded “grandfathered aliens under age 19.” Therefore, the “grandfathered aliens under age 19” regulations are obsolete as of January 1, 2010, and are replaced with the “legal immigrant children under age 19” policy. This change in regulations does not change the effect of the policy because lawfully admitted immigrant children under age 19 will have a USCIS status that is a qualified, full-benefit status or is a status that meets the legal immigrant children under age 19 policy.

Policy governing the online Application for Adult Medical Assistance has been amended to recognize the use of this application in implementing the new federal MIPPA provision that requires states to treat data received from SSA from an application for Extra Help, the low-income subsidy (LIS), as an application for Medicaid. New policy about local agencies’ responsibilities regarding the online applications generated from LIS applications is in this Transmittal. Information regarding LIS data generated applications was first announced in Broadcast #5947. Detailed instructions for processing these online applications are posted on SPARK.

Revised Policy

Each January, the Medicaid Transmittal typically contains the new SSA/SSI COLA dollar amounts, as well as the new deeming amounts and LTC patient pay allowances that are based on the SSI dollar amount. The COLA is based on the CPI, which fell in 2008. Accordingly, SSA announced that there is no COLA for 2010. Most LTC spousal and maintenance standards are also based on the CPI and did not change. References to these standards and allowances have been revised in this Transmittal to indicate that they are unchanged in 2010. The LTC utility standard deduction increased effective October 1, 2009, and the new amount is included in this Transmittal.

There are changes in Medicare premiums and cost sharing for 2010. These changes were posted in Broadcast 5981 and are included in this Transmittal. The most notable change is that there are now two standard Medicare Part B premiums. For individuals who were enrolled in Medicare prior to January 1, 2010, the Medicare Part B premium did not increase from the 2009 amount of \$96.40. However, for individuals who enroll in Medicare on or after January 1, 2010, the Medicare part B premium is \$110.50.

Effective January 1, 2010, the resource limits for the MSPs (the QMB, SLMB, QI, and QDWI covered groups) will be equal to the resource limits for the full Extra Help LIS. The resource eligibility determination policies, including the resource exclusions, in S11 and/or the S11

Appendices continue to apply to these covered groups. Only the resource limit amounts have changed. Because the resource limits are subject to change on an annual basis, they have been placed in Chapter M20, Appendix 3 for reference purposes.

Chapter M20 has been revised to include new resource policies and cost sharing amounts for the Extra Help Medicare Part D low-income subsidy. SSA determines eligibility for Extra Help for the vast majority of applicants who are not deemed eligible for Extra Help on the basis of eligibility for Medicaid. While it is unlikely that LDSS staff will need to determine eligibility for Extra Help, LDSS are reminded that an individual may ask for Extra Help eligibility to be determined by the LDSS. Therefore, the Extra Help policy has been updated accordingly. Effective January 1, 2010, all in-kind contributions of food and shelter are excluded from countable income and all life insurance policies are excluded from countable resources for the Extra Help program only.

The life estate and remainder tables in M1130 and the life expectancy table in M1450 have been updated with the current figures used by SSI. These tables are used to determine the countable value of life estates and the actuarial soundness of an annuity.

SSI policies exclude interest earned on certain cash payments, such as German reparations payments and Agent Orange settlement payments, from countable income and resources when the interest was earned on payments received on or after July 1, 2004. Revisions were made to subchapter S0830 (ABD Unearned Income) and subchapter S1130 (ABD Resources Exclusions) to align Virginia's Medicaid policies with the SSI policies. If an individual receives one of the affected cash payments, any interest currently being earned on the payments should be excluded from income and resources. It is not necessary to exclude interest earned on or after July 1, 2004 but prior to January 1, 2010, **unless** the individual is able to provide clear documentation of (1) the dates and amounts of the cash payments and (2) the amount of interest earned on those particular payments.

The references to the community spouse's expected contribution to the institutionalized spouse's care in subchapter M1480 have been removed. Medicaid no longer requires a financial contribution from a community spouse toward the institutionalized spouse's cost of care. Only the amount, if any, that the community spouse actually contributes to the institutionalized spouse should be counted as available for the patient pay.

The names of a state agency and a major benefit program have recently changed. DMHMRSAS is now DBHDS. The Food Stamp Program is now SNAP. Throughout the manual, references to DMHMRSAS were changed to DBHDS, and references to Food Stamps were changed to SNAP in this Transmittal.

Clarified Policy

Information from SSA was used to clarify the use of SVES and SOLQ-I. SOLQ-I can be used instead of SVES if SVES is not available or the worker requires immediate verification to expedite the case.

The BCCPTA covered group policy was clarified by adding a benefit package section that includes LTC as one of the covered services available to this full-benefit covered group.

The use of the DMAS-225 has been clarified in M1410, M1470, and M1480. In addition to the other uses included in these sections, the policy specifies that, if the individual's LTC provider changes, the DMAS-225 is to be sent by the local DSS staff to the new provider to alert the provider that the individual's patient pay information is available on the provider verification systems.

Electronic Version

Transmittal #93 is available electronically on SPARK and the VDSS public web site. It has not been printed for distribution. The electronic version is the Transmittal of record. Significant changes to the manual are as follows:

Pages Changed	Significant Changes
Volume XIII Table of Contents, page iii	Changed the DMHMRSAS reference to DBHDS.
Subchapter M0110 pages 1, 6	On both pages, changed the DMHMRSAS references to DBHDS.
Subchapter M0120 Pages 1, 7, 9-16	On pages 1, 12, 13 and 14, changed the DMHMRSAS references to DBHDS. On page 7, clarified that the adoptive parent applies for medical assistance for an adopted child who receives adoption assistance. On page 9, deleted reference to the Application for Benefits not being valid for Plan First because Plan First was added to the Application for Benefits. On pages 10 and 11, added reference to the new LIS-generated online Applications for Adult Medical Assistance. Pages 15 and 16 are runover pages.
Subchapter M0130 Pages 4-6, 8	On pages 4, 5 and 8, clarified verification from SSA to specify use of SVES; SOLQ-I can be used instead of SVES if SVES is not available or the worker requires immediate verification to expedite the case. Page 6 is a runover page.
Subchapter M0220 Table of Contents Pages 7-8, 14-20, 22a Appendix 1 Appendix 3, page 3 Appendix 4, pages 1-2 Appendix 6, page 2	Updated the Table of Contents. On pages 7-8, 14a and 22a, replaced "grandfathered aliens" references with "legal immigrant children under age 19." Pages 14 and 14b are runover pages. On page 14c, changed the Food Stamps reference to SNAP. On pages 14d-17, replaced the "grandfathered aliens" policy with the legal immigrant children under age 19 policy. Pages 18-20 are runover pages. In Appendix 1, updated the address of the U.S. Citizenship & Immigration Services office where LDSS send requests. Updated Appendix 3, page 3. In Appendix 4, added spaces for telephone numbers to the form and updated the instructions. In Appendix 6, changed the Food Stamps reference to SNAP
Subchapter M0230 page 2	Changed the DMHMRSAS reference to DBHDS.
Subchapter M0240 pages 1-4	On pages 1-4, clarified verification from SSA to specify use of SVES; SOLQ-I can be used instead of SVES if SVES is not available or the worker requires immediate verification to expedite the case.

Subchapter M0280 page 13	Changed the DMHMRSAS reference to DBHDS, changed the DMAS-122 reference to DMAS-225 and added the information about patient pay information being available on the MMIS.
Subchapter M0310 page 35 Appendix 5, page 1	On page 35, corrected the reference to section M0320.304. In Appendix 5, updated the address for the Southwest Regional Office for Disability Determination Services.
Subchapter M0320 pages 11-12, 18, 34-35 pages 38, 40, 42a-42d pages 42f-44, 49, 50c pages 69-71	On page 11, updated the COLA policy to indicate that there is no COLA for 2010. On page 12, updated the Medicare Part B and Part A premiums for 2010. On page 18, added SOLQ-I as another method by which agencies can verify an individual's 1619b status. On pages 34-35, 38, 40, 42a-42b, and 42f, updated the MSPs covered groups' policies with a reference to the Chapter M20 Appendix 3 that contains the resource limits, and changed references to program designations to aid category (AC). On pages 42c-42d, re-organized the QI section and added the QI application/renewal policy from Broadcast #5914. On pages 43-44 and 50c, corrected references to program designations to "aid category (AC)" and the code numbers for the AC. On pages 69-71, clarified that covered services for the BCCPTA covered group include LTC.
Subchapter M0530 pages 11, 19 Appendix 1, page 1	On pages 11 and 19, changed the Food Stamps references to SNAP. In Appendix 1, updated the deeming allocations to indicate that there is no change for 2010.
Subchapter M0630 page 8	Changed the Food Stamps reference to SNAP.
Subchapter M0730 page 2	Changed the Food Stamps reference to SNAP.
Subchapter M0810 pages 1, 2	On both pages, updated the income limits that are based on the SSI amount to indicate that there is no change for 2010.
Subchapter S0820 pages 30, 31	On both pages, updated the blind or disabled student child earned income exclusion to indicate that there is no change for 2010.
Subchapter S0830 Table of Contents, page iv pages 28, 67, 119-120 pages 122-125	Updated the Table of Contents. On page 28, updated the toll-free telephone number for the Railroad Retirement Board. On page 67, added references for types of excluded interest income. On pages 119, 120, and 122-125, clarified that interest earned on certain types of cash payments is not counted as income.
Subchapter S1110 page 2	Revised the resource limits for the Medicare Savings Programs (the QMB, SLMB, QI, QDWI covered groups).
Subchapter S1120 page 22	On page 22, clarified the treatment of funds placed in a pooled trust by an individual age 65 years for the purposes of asset transfer evaluation.

Subchapter S1130 pages 63-65 pages 70, 74, 75	On pages 63-65, 70, 74, and 75, clarified that interest earned on the retained amounts of certain types of cash payments is not counted as a resource.
Subchapter S1140 pages 13-15 pages 24, 25	On pages 13-15, revised the Life Estate and Remainder Interest Tables to correspond with SSI policy. On page 24, clarified the maximum amount of United States Savings Bonds that an individual can purchase per calendar year. Page 25 is a runover page.
Subchapter S1340 page 18	Changed the DMHMRSAS reference to DBHDS.
Subchapter M1410 pages 1, 7, 9, 12	On pages 1 and 9, changed the DMHMRSAS reference to DBHDS. On page 7, corrected the numbering. On page 12, clarified that a new DMAS-225 is to be sent when there is a change in individual's LTC provider.
Subchapter M1420 pages 2, 3, 5 Appendix 3, page 1 Appendix 4, page 1	On all pages, changed the DMHMRSAS references to DBHDS.
Subchapter M1430 Appendix 1, page 1	Updated the addresses of the IMDs.
Subchapter M1440 pages 14, 16	On both pages, changed the DMHMRSAS references to DBHDS.
Subchapter M1450 Table of Contents pages 3, 17-18, 29 Appendix 2, page 1	Updated the Table of Contents. On page 3, changed the DMHMRSAS reference to DBHDS. On page 17, made the word "tables" singular. On pages 18 and 29, revised the examples. In Appendix 2, revised the Life Expectancy Table to correspond with SSI policy.
Subchapter M1460 pages 28, 35	On page 28, changed the Food Stamps references to SNAP. On page 35, updated the blind or disabled student child earned income exclusion to indicate that there is no change for 2010.
Subchapter M1470 pages 9, 13, 19-20, 23 pages 43, 44	On pages 9 and 23, revised the Medicare Part D benchmark premium for 2010. On page 13, changed the DMHMRSAS reference to DBHDS. On pages 19 and 20, updated the personal maintenance allowance and special earning allowance to indicate that there is no change for 2010. On page 43, clarified that a new DMAS-225 is to be sent when there is a change in individual's LTC provider. Page 44 is a runover page.
Subchapter M1480 Table of Contents, page ii pages 3, 8b, 18, 18c, 20a,	Updated the Table of Contents. On page 3, changed the Food Stamps references to SNAP. On page 8b, changed the DMHMRSAS reference to DBHDS. On pages 18, 20a, 50, and 51, removed the obsolete policy regarding the community spouse's expected contribution. On page 18c,

pages 21, 31, 50, 51 pages 66, 69, 70, 93 Appendix 4 was removed.	updated the spousal resource standards to indicate that there is no change for 2010. On pages 21 and 31, removed the reference to Appendix 4 and added the web addresses for the Institutionalized Spouse Resource Eligibility Worksheet and Resource Assessment and Eligibility Workbook. On pages 66, 69, and 70, updated the maintenance standards and patient pay allowances to indicate that there is no change for 2010. On page 66, changed the Food Stamps reference to SNAP. On page 93, clarified that a new DMAS-225 is to be sent when there is a change in individual's LTC provider. Appendix 4, removed the "Separated Spouse Expected Contribution Scale - Institutionalized Recipients," because it is obsolete.
Subchapter M1510 page 6	Changed the DMHMRSAS reference to DBHDS.
Subchapter M1520 pages 3, 4b, 5-6, 10, pages 21, 22	On pages 3, 6 and 10 clarified that SVES should be used rather than SOLQ-I whenever possible. On page 4b and 22, changed the Food Stamps references to SNAP. On page 5, clarified the process for reviewing eligibility for a pregnant woman. On pages 21 and 22, changed the DMHMRSAS references to DBHDS.
Subchapter M1550 Title page Table of Contents pages 1-9 Appendix 1, page 1	On all pages, changed the DMHMRSAS references to DBHDS and changed DMAS-122 references to DMAS-225. In Appendix 1, added the name of the Medicaid Technician located at Southwestern Virginia Mental Health Institute.
Chapter M17 page 3	Changed the Food Stamps reference to SNAP.
Chapter M18 pages 4, 5	On page 4, removed individuals in the " $\leq 80\%$ FPL" covered group from the list of individuals who are exempt from Medicaid Managed Care. On page 5, changed the DMHMRSAS reference to DBHDS.
Chapter M20 Table of Contents, page ii pages 3, 5, 6, 7, 10 pages 11, 15 Appendix 1, page 1 Appendix 2, page 1 Appendix 3, page 1 Appendix 4, page 1	Updated the Table of Contents. On pages 3 and 15, removed the actual Extra Help resource limits and added a referral to Appendix 3, which lists them. On page 5, removed life insurance from the list of countable resources. On page 6, clarified the explanation about how the SSA treats the resource limits for Extra Help. On page 7, clarified that all life insurance is excluded as a resource. On pages 10 and 11, clarified that in-kind contributions of food and shelter are not countable as income. Updated the Appendices 1 and 2 to reflect that the resource limits did not change for 2010. In Appendix 3, added the resource limits for the Medicare Savings Programs and Extra Help. In Appendix 4, updated the Subsidy Benefits table with the Medicare Part D cost-sharing amounts for 2010.
Chapter M21 pages 2-4, 8	On pages 2-4, added the FAMIS citizenship and identity verification requirements and clarified that the Medicaid legal immigrant children under age 19 alien policy does not apply to the FAMIS program. On

	page 8, clarified that SSI is excluded from countable income.
Chapter M22 pages 2-10	On pages 2 and 3, revised the FAMIS citizenship and identity verification requirements and clarified that the Medicaid legal immigrant children under age 19 alien policy does not apply to the FAMIS MOMS program. Pages 4-5 are runover pages. On page 6, clarified that SSI is excluded from countable income. Pages 7-10 are runover pages.

Please retain this Transmittal letter for future reference. Should you have questions about information contained in this Transmittal, please contact Stephanie Sivert, Manager, Medical Assistance Programs, at 804-726-7660 or stephanie.sivert@dss.virginia.gov.


Anthony Conyers, Jr.
Commissioner

Electronic Attachment

TABLE OF CONTENTS Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/2010	page iii
Update (UP) #2	08/24/09	page iii

M15 ENTITLEMENT POLICY & PROCEDURES

MEDICAID ENTITLEMENT.....M1510
MEDICAID ELIGIBILITY REVIEWM1520
DEPARTMENT OF BEHAVIORAL HEALTH
AND DEVELOPMENTAL SERVICES (DBHDS)
FACILITIESM1550

M16 APPEALS PROCESS

M17 MEDICAID FRAUD AND RECOVERY

M18 MEDICAL SERVICES

M20 EXTRA HELP – MEDICARE PART D LOW-INCOME SUBSIDY

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

M22 FAMIS MOMS

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M0110 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/10	pages 1, 6

M0110 General Information

M0110.100 Legal Base and Agency Responsibilities

A. Introduction

Medicaid is an assistance program that pays medical service providers for medical services rendered to eligible individuals. The Medicaid 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 Medicaid must be made in written form on an official Medicaid application or in the Application/Benefit Delivery Automation Project (ADAPT) system.

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

B. Legal Base

The Medical Assistance Program (Medicaid) 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.

Virginia law provides that the Medicaid program 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 Department of Social Services (DSS).

Exception: DSS carries direct responsibility for the determination of eligibility of certain patients in *Virginia Department of Behavioral Health and Developmental Services (DBHDS)* facilities and for their enrollment in the Medicaid program.

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,
- the handling of appeals related to medical assistance,
- the approval of providers authorized to provide medical care and receive payments under Medicaid,

for the Medicaid, State and Local Hospitalization (SLH), 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 Medicaid 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 that 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. 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 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.

EXCEPTION: Patients in *DBHDS* facilities may have applications submitted by *DBHDS* staff.

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.

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M0120 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/2010	pages 1, 7, 9-16
Update (UP) #1	07/01/2009	page 8
TN #91	05/15/2009	page 10

M0120.000 Medical Assistance Application

M0120.100 Right to Apply

An individual cannot be refused the right to complete an application 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 himself or any person for whom he is a legally responsible or authorized to represent. An applicant may be assisted with the application by an individual of his choice. A face-to-face interview is not required.

M0120.200 Who Can Sign the Application

- A. Patients in DBHDS Facilities** Patients of any age in the Department of *Behavioral Health and Developmental Services (DBHDS)* facilities may have applications submitted and signed by DBHDS staff. The DBHDS facilities are listed in subchapter M1550.
- 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. If the applicant cannot sign his or her name 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: _____

- 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. 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 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.

EXCEPTION: Patients in the DBHDS facilities may have applications submitted by DBHDS staff.

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 Medicaid 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

A Medicaid 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 Medicaid 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 Medicaid application form and a separate Medicaid 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.

A Medicaid 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 Medicaid 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:

- 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 Medicaid application.

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

- his guardian or conservator,

B. Application Forms

Medical assistance must be requested on a form prescribed (published) by the Department of Medical Assistance Services (DMAS) and the Virginia Department of Social Services (VDSS).

An applicant may obtain a prescribed application form from a number of sources, including a variety of human service agencies, hospitals, and the internet.

There are specialized forms intended for use with certain covered groups, including pregnant women, children, SSI recipients, and women who have been screened under the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). These forms should be used whenever possible because they do not ask the applicant to provide information that is not used in the eligibility determination for those specific covered groups.

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

- 1. Application For Benefits**

Application for Benefits, form #032-03-824, also referred to as the Combined Application, may be used by any applicant (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>). Eligibility for all medical assistance programs, except BCCPTA, can be determined with this application form.
- 2. Application/Redetermination For SSI Recipients**

The Application/Redetermination for Medicaid for SSI Recipients, form #032-03-091 (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) is used for SSI recipients. If the applicant is not eligible for Medicaid in the SSI recipients covered group, his eligibility in other Medicaid covered groups, for FAMIS and for SLH can be determined using this application form.
- 3. Medicaid Application/Redetermination For Medically Indigent Pregnant Women**

The Medicaid Application/Redetermination for Medically Indigent Pregnant Women, form #032-03-040 (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) is acceptable if submitted for pregnant women. If any additional information is necessary (individual requires a resource evaluation for medically needy spenddown or for SLH), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant.
- 4. Health Insurance For Children and Pregnant Women**

The Health Insurance for Children and Pregnant Women, form FAMIS-1 (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) is an application form for children and/or pregnant women. If any additional information is necessary (individual requires a resource evaluation for medically needy spenddown or for SLH), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant.

5. **BCCPTA Medicaid Application** The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application, form #032-03-384, is used only by women 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).
6. **ADAPT Statement of Facts** A signed ADAPT Statement of Facts (SOF) is a valid application for anyone in an ADAPT case, including ABD Medicaid applicants who are in an ADAPT case, EXCEPT for Plan First and BCCPTA. The SOF cannot be used as a Plan First or BCCPTA application. If any additional information is necessary (individual requires a resource evaluation), the appropriate pages from an Application for Benefits or Eligibility Review Form Part B if that form was obtained for Food Stamps can be used to collect the additional information. The pages must be signed by the applicant and attached to the SOF.
7. **Title IV-E Foster Care & Medicaid Application/Redetermination** The Title IV-E Foster Care & Medicaid Application/Redetermination, form #032-03-636 (available at: <http://spark.dss.virginia.gov/divisions/dfs/fc/files/forms/032-03-0636-02-eng.doc>) is used for foster care or adoption assistance children who are eligible under Title IV-E of the Social Security Act. If any additional information is necessary (individual requires a resource evaluation for medically needy spenddown or for SLH), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant's guardian.
- For a IV-E FC child whose custody is held by a local department of social services or a private FC agency, or for a IV-E adoption assistance (AA) child, the Title IV-E Foster Care & Medicaid Application/Redetermination, form #032-03-636, 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 FC and IV-E AA children, and for non-IV-E FC children in the custody of a local agency in Virginia. This form is **not** used for children in non-custodial agreement cases or non-IV-E AA. 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 completed and signed by the parent or guardian.
- 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.
8. **Application for Adult Medical Assistance** The Application for Adult Medical Assistance is intended for adults who are aged, blind or disabled or who need long-term care. The paper form is available online at: www.localagency.dss.state.va.us/divisions/bp/me/forms/general.cgi. The online application is available at: <https://jupiter.dss.state.va.us/VDAMedicaid>. *In addition to online*

Applications for Adult Medical Assistance that individuals may submit on their own behalf, starting in January 2010, LDSS will receive online Applications for Adult Medical Assistance that are generated as a result of Extra Help low-income subsidy (LIS) data on individuals received by VDSS from the Social Security Administration (SSA). These Adult Medical Assistance Applications are designated in the SPARK Adult Medical Assistance Application administrative web site by the term "LIS." The Medicare Patient and Provider Improvement Act (MIPPA) requires LIS application data submitted by SSA to states to be treated as an application for Medicaid if the LIS applicant agrees.

9. Auxiliary Grant (AG)

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

10. Plan First Application Form

The Plan First Application is for men and women who wish to apply for Medicaid coverage of family planning services only. Individuals who wish to apply for family planning services must complete and sign the Plan First Application. The Plan First Application form is available on SPARK at: <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.

11. SLH Application Form

The following form has been prescribed as the application form for SLH:

- Application for Benefits, form #032-03-824, also referred to as the Combined Application.

M0120.400 Place of Application

A. Principle

The place of application is ordinarily the office of the local social service department serving the locality in which the applicant resides. Verification of locality residence is not required. Medicaid applications are also taken 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.

Medical assistance applications that are completed and filed online are sent to the LDSS in the applicant's locality of residence.

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 Medicaid application/ enrollment purposes.

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 local department of social services 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 local department of social services or a private child placing agency apply at the agency that holds custody.

Children in the custody of another state's social services agency who are not Title IV-E eligible do not meet the Virginia residency requirement for Medicaid and are not eligible for Medicaid in Virginia (see M0230).

2. Adoption Assistance

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

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

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

Children in the custody of the Virginia Department of Juvenile Justice or who are the responsibility of a court (corrections children) apply at the local agency where the child is residing.

C. Institutionalized Individual (Not Incarcerated)

When an individual of any age is a resident or patient in a medical or residential institution, except DBHDS facilities and the 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 Food Stamps, responsibility for processing the Medicaid application and determining Medicaid eligibility rests with the department of social services 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 department of social services in the locality in which the institution where he is receiving care is located.

D. Individuals in DBHDS Facilities

1. Patient in a DBHDS Facility

If an individual is a patient in a state *DBHDS* institution, is not currently enrolled in Medicaid, and is eligible in an Aged, Blind or Disabled (ABD) covered group, responsibility for processing the application and determining

eligibility rests with the state department of social services' eligibility technicians located in *DBHDS* facilities. A listing of facilities and technicians as well as further information on the handling of cases of Medicaid applicants and recipients in *DBHDS* facilities is located in Subchapter M1550.

If an individual is a patient in a State *DBHDS* Institution, is not currently enrolled in Medicaid, and is eligible in a Families and Children's (F&C) covered group, 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.

**2. Patient
Pending
Discharge
(Pre-release
Planning)**

a. General Policy

For *DBHDS* facility patients who will be discharged, local agencies will take the applications received on behalf of these patients and process them within the established time frames. Eligibility will be determined based on the type of living arrangement to which the patient will be discharged.

If the patient was not Medicaid eligible in the *DBHDS* facility but Medicaid eligibility in the patient's new circumstances needs to be determined, an application must be sent to the appropriate local department of social services. The facility physician or discharge planning authority must attach a written statement that includes the following information:

- the date of the proposed discharge,
- the type of living arrangement and address to which the patient will be discharged (nursing facility, adult care residence, private home, relative's home, etc.), and
- the name and title of the person who completed the statement.

The discharge planner or case manager must follow up the application and statement with a telephone call to the agency worker on or after the patient's actual discharge to confirm the discharge date and living arrangement. The agency cannot enroll the patient without the confirmation of the discharge date and living arrangement.

b. Pending Discharge to a Facility

If a patient who was not Medicaid eligible in the *DBHDS* facility is being discharged to an assisted living facility or nursing facility, an application for Medicaid will be filed with the department of social services in the locality in which the patient last resided prior to entering an institution.

c. Pending Discharge to the Community

If a patient who was not Medicaid eligible in the *DBHDS* facility will live outside of an institution, the responsibility for processing the application and determining eligibility rests with the locality in which he will be living.

d. Eligibility Determination and Enrollment

The local agency determines the patient's Medicaid eligibility BEFORE actual discharge, based on the type of living arrangement to which the patient will be discharged. If the patient is found eligible for Medicaid in the locality, he is not enrolled in Medicaid until the day he is discharged from the *DBHDS* institution.

When the individual is discharged, the *DBHDS* discharge planner, or the individual, may call the local agency worker on the discharge date. The worker can then enroll the patient in the MMIS and give the enrollee number to the discharge planner.

E. Individuals In Virginia Veteran's Care Center

Medicaid 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.

F. Incarcerated Individuals Pre-release Planning

Inmates of state correctional facilities may apply for Medicaid as part of pre-release planning. Responsibility for processing the application and determining eligibility rests with the local department of social services in the locality where the inmate was living prior to incarceration. Applications are to be processed in the same manner and within the same processing time standards as any other Medicaid application, but if the incarcerated individual is found eligible, he is **not** enrolled in the Medicaid program until after he has been released from the correctional facility.

Applications are not to be refused because an applicant is an inmate of a public institution at the time of application.

a. Department of Corrections Procedures

The following procedures will be followed by correctional facility staff when an inmate in a Virginia Department of Corrections facility will require placement in a nursing facility upon release:

- The correctional facility staff will complete the Medicaid application and, if a disability determination is needed, the disability report and medical release forms. The correctional facility staff will notify the assigned Medicaid consultant and mail the forms to the local department of social services in the locality where the inmate was living prior to incarceration.
- The correctional facility staff will request a pre-admission screening for nursing home or community-based care from the health department or local department of social services in the locality where the correctional facility is located. This screening is to be done simultaneously with the determination of disability and determination of Medicaid eligibility. The staff will coordinate with nursing facilities in order to secure a placement.

b. Eligibility Determination and Enrollment

The local department of social services determines the patient's Medicaid eligibility BEFORE actual release, based on the type of living arrangement to which the applicant will be released. If the applicant is found eligible for Medicaid in the locality, he is not enrolled in Medicaid until the day he is released from the Department of Corrections facility.

The Corrections facility's pre-release planner or the individual may call the local agency worker on the release date. The worker can then enroll the eligible applicant in the MMIS and provide the enrollee number.

M0120.500 Receipt of Application

A. General Principle An applicant or authorized representative may submit a written application for Medicaid only or may apply for Medicaid 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 that such individual(s) may represent him in subsequent contacts with the agency.

**B. Qualified
Individuals (QI)**

Eligibility for Medicaid as a QI begins the first day of the application month, and ends December 31 of the calendar year, if funds are still available for this covered group. A QI must submit a new Medicaid application on or after January 1 of each year in order to receive continued coverage. Applications for QI coverage for an upcoming year may not be taken until January 1 of that year (see M0320.208).

C. Application Date

The application date is the earliest date the signed, written application for Medicaid or the Request for Assistance is received by the local agency, an outstationed 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, or hand delivery. The date of delivery to the agency must be stamped on the application. If an application is received after the agency's business hours, the date of the application is the next business day.

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 complete an Application for Benefits in order to request a medically needy evaluation. If the Application for Benefits is submitted within 10 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.

M0120.600 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. 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, the following:

- 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.

M0130 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/2010	pages 4-6, 8
Update (UP) #2	08/24/09	pages 8, 9

- 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) record verification. 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 MMIS 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 Medicaid or other medical assistance is requested must be provided by the applicant and verified by the worker through SSA. *The State Verification Exchange System (SVES) is used to verify an SSN. If SVES is not available or the worker requires immediate verification to expedite the case, the State Online Query-Internet system (SOLQ-I) can be used instead of SVES.*
- B. Required Verifications**

An individual must provide verifications of most Medicaid eligibility requirements. Before taking action on the application, the applicant must be notified in writing of the required information.

The eligibility worker must allow at least 10 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.

 - 1. Copy Verification Documents**

Legal documents and documents that may be needed for future eligibility determinations must be copied and preserved for the record. These include citizenship and identity documents, alien status documentation, verification of legal presence, trusts, annuities, contracts, wills, and life insurance policies.

It is not necessary to retain a copy of verifications of income or the current value of resources in the case record. However, if a copy is not retained, the worker must document electronically or in the case record the date and method used to obtain the information (viewed, telephone call, etc.), the type of verification, the source, and a description of the information.
 - 2. 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.
- C. Verification of Nonfinancial Eligibility Requirements**

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:

 - 1. Verification Not Required**

Verification is not required for:

 - Virginia state residency,
 - application for other benefits,

- institutional status,
- age for children under age 19,
- health insurance information (see sections F and G below), and
- dependent child information for individuals applying as parents or the caretaker-relative of a dependent child.

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 19 or older;
- age of applicants age 65 and older;
- disability and blindness; and
- pregnancy.

See item 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, disability and pregnancy.

D. Social Security Numbers

Applicants must provide the Social Security number (SSN) of any person for whom they request Medicaid. 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

SVES is used to verify an SSN. If SVES is not available or the worker requires immediate verification to expedite the case, SOLQ-I can be used instead of SVES.

2. Exceptions to SSN Requirements

- Children under age one born to Medicaid-eligible mothers are deemed to have applied and been found eligible for Medicaid, whether or not eligibility requirements have actually been met. A child eligible in this covered group does not need a Social Security number.
- Illegal aliens who are eligible only for Medicaid payment of emergency services are not required to provide or apply for SSNs (see M0220).

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 Office (SSA). An Enumeration Referral Form, form #032-03-400, available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi> must be completed by the applicant. 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 MMIS. Applicants who refuse to furnish an SSN or to show proof of application for a number will be ineligible for Medicaid.

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 ADAPT or MedPend, use the date the individual applied for an SSN, or the individual's date of birth, preceded by "APP" as the individual's SSN. For example, an individual applied for an SSN on October 13, 2006, enter "APP101306" as the individual's SSN. If entering the individual directly in MMIS, use the date the individual applied for an SSN, or the individual's date of birth, preceded by "888" as the individual's SSN. For example, an individual applied for an SSN on October 13, 2006, enter "888101306" 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.

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.

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 on-line at: <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>.

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;
- all earned and unearned income; and
- asset transfer information for individuals in need of long-term care services, including the date of transfer, asset value, and compensation received.

Social Security and/or Supplemental Security Income must be verified through SSA. The State Data Exchange (SDX) system should only be used as an alternate method when the State Verification Exchange System (SVES) *is not available or the worker requires immediate verification to expedite the case*. If the SDX system is used to verify benefits, the case record must be documented to show why SVES was not used. *The State Online Query-Internet system (SOLQ-I) cannot be used instead of SVES unless the need for verification is immediate and cannot wait until the next day.*

Chapters M05 through M11 include specific instructions for the verification of resources and income. Subchapter M1450 includes instructions for verifying the transfer of assets.

M0130.300 Eligibility Determination Process

A. Evaluation of Eligibility Requirements

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.

The evaluation of eligibility requirements must be documented in writing for cases not processed in the ADAPT system. The Evaluation of Eligibility

M0220 Transmittal Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/10	Table of Contents pages 7-8 page 14a pages 14c-14d pages 15-20 page 22a Appendix 1 Appendix 3, page 3 Appendix 4, pages 1 and 2 Appendix 6, page 2
TN #92	05/22/09	Table of Contents pages 1-6a Appendix 8 (18 pages) pages 4a-4t were removed and not replaced.
TN #91	05/15/2009	page 7 pages 14a, 14b page 18 page 20 Appendix 3, page 3

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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, or victim of a severe form of trafficking 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);
- a qualified Afghan or Iraqi immigrant admitted to the U.S. on a Special Immigrant Visa, but only for **eight months** beginning with the month of entry into the U.S. or the date of conversion to Special Immigrant status, if not admitted under that status. **Note that effective 3-10-09, the time limit for Afghan Special Immigrants changed from six months to eight months, beginning with the date of entry into the U.S. or the date of conversion to Special Immigrant Status. This includes individuals enrolled as of 3-10-09.**
- a qualified lawful permanent resident 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);
- a qualified alien who meets the veteran or active duty military requirements in M0220.311 below; or
- a *legal immigrant child under age 19* 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.

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 *legal immigrant child under age 19*. Section M0220.314 defines a *legal immigrant child under age 19*.

If the alien is NOT a *legal immigrant child under age 19*, go to Step 5.

If the alien is a *legal immigrant child under age 19*, 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 M0220.700 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.

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.

- 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).

- 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. First 8 Months of Residence in U.S.** Two laws, P.L. 110-16 effective December 26, 2007, and P.L. 110-181, effective January 28, 2008, granted limited eligibility for full Medicaid benefits to qualified Afghan or Iraqi Special Immigrants, their spouses, and their children under age 21 who live in the home. For a limited time, these Special Immigrants are eligible for full Medicaid benefits available to the covered group they meet (if they meet all other Medicaid eligibility requirements).

Effective December 26, 2007, Afghan and Iraqi Special Immigrants became eligible for full Medicaid benefits for **six months** beginning with the month of entry in the U.S. or the date of conversion to Special Immigrant status, if not admitted under that status.

Effective January 28, 2008, the period of eligibility for **Iraqi Special Immigrants only** was extended to include **eight months** beginning with the month of entry into the U.S. or the date of conversion to Special Immigrant status. Effective March 10, 2009, the period of eligibility for **Afghan Special Immigrants**, including those enrolled as of March 10, 2009, was also extended to include **eight months**, beginning with the month of entry into the U.S. or the date of conversion to Special Immigrant status. Eligibility for full Medicaid coverage cannot be granted for periods prior to the effective dates of the laws granting benefits to these immigrants.

After the applicable limited time period expires, individuals aged 19 years and older are no longer eligible for full-benefit Medicaid and are eligible for Medicaid payment of emergency services only unless the requirements in M0220.313 B for Lawful Permanent Residents are met. Children under age 19 *who* meet the requirements in M0220.314 B.1 for *legal immigrant children under age 19 may be eligible for continued Medicaid coverage*.

- B. First 7 Years of Residence in U.S.** During the first seven 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 the full package of Medicaid benefits available to the covered group they meet (if they meet all other Medicaid eligibility requirements). These 4 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.

Refugee status is usually adjusted to Lawful Permanent Resident status after 12 months in the U.S. For the purposes of establishing Medicaid eligibility, such

individuals may still be considered refugees. 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.

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.
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.

- C. **AFTER 5 Years of Residence in U.S.** After five years of residence in the U.S., one group of qualified aliens (as defined in M0220.310 above) 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 they meet (if they meet all other Medicaid eligibility requirements). This group of qualified aliens who entered the U.S. on or after 8-22-96 is the **lawful permanent resident who has at least 40 qualifying quarters of work.**

1. **Lawful Permanent Residents (LPRs)** 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 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.

AFTER 5 years have passed from the date of entry into the U.S., Lawful Permanent Residents who have at least 40 qualifying quarters of work are “full benefit” aliens. Lawful Permanent Residents 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 6 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-formerly Food Stamps)* and Medicaid) **cannot** be credited to the alien for purposes of meeting the 40 quarter requirement.

D. AFTER 7 Years of Residence in U.S.

After seven years of residence in the U.S., the qualified refugee, Amerasian, asylee, deportee, Cuban or Haitian entrant, or victim of a severe form of trafficking (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.

E. Services Available To Eligibles

1. Refugee, Amerasian, Asylee, Deportee, Cuban or Haitian Entrant, Victim of a Severe Form of Trafficking

A qualified refugee, Amerasian, asylee, deportee, Cuban or Haitian entrant, or victim of a severe form of trafficking (as defined in M0220.310 above) 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, or victim of a severe form of trafficking 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 With 40 Work Quarters

After five years of residence in the U.S., a lawful permanent resident alien with 40 or more qualifying quarters of work 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.

F. Entitlement & Enrollment of Eligibles

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.

M0220.314 LEGAL IMMIGRANT CHILDREN UNDER AGE 19

A. Policy

Section 214 of CHIPRA of 2009 gives states the option to provide Medicaid 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 who are lawfully residing in the U.S.

Children who are in one of the legal immigrant children alien groups must have their immigration status verified at the time of the initial eligibility determination and at each annual renewal of eligibility to ensure that the children are lawfully residing in the U.S. and that their immigration status has not changed.

B. Eligible Alien Groups

Non-citizen children under 19 who are legal immigrants meet one of the following alien groups:

1. Lawful Permanent Resident

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

2. Refugees

an alien who is admitted to the U.S. under the Immigration and Nationality Act as a refugee under any section of the INA. The refugee will have a Form I-94 identifying him/her as a refugee under the INA.

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. Parolee

parolees are:

- *aliens paroled into the United States, including Cuban/Haitian entrants, pursuant to section 212(d)(5) of the INA (8 USC 1182(d)(5)); or*
- *admitted to the United States for similar reasons as a refugee, i.e., humanitarian. However, this group, unlike refugee status, does not grant legal residence status. Parole status allows the alien temporary status until an USCIS determination of his/her admissibility has been made, at which time another status may be granted.*

Aliens in this group will have a Form I-94 either indicating that the bearer has been paroled pursuant to section 212(d)(5) of the INA or stamped "Cuban/Haitian Entrant (Status Pending) Reviewable [date]" "Employment authorized until [date]." Possession of a properly annotated Form I-94 constitutes evidence of permanent residence in the U.S. under color of law, regardless of the date the Form I-94 is annotated.

**5. Deportation
Withheld**

an alien with "deportation withheld" status is

- *an alien granted a stay of deportation by court order, statute or regulation, or by individual determination of USCIS pursuant to section 245 of the INA (8 USC 1253 (a)) or USCIS Operations Instruction 245.3 whose departure USCIS does not contemplate enforcing, or*
- *an alien who is in deportation proceedings but deportation has been withheld because of conditions similar to those leading to a granting of refugee status, i.e., fear of persecution.*

Aliens in this group have been found to be deportable, but USCIS may defer deportation for a specific period of time due to humanitarian reasons. These aliens will have an order from an immigration judge showing that deportation has been withheld under section 245(h) of the INA (8 USC 1253(h)) and/or a Form I-94.

**6. Immediate
Relative
Petition**

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 USCIS does not contemplate enforcing. An immediate relative for USCIS purposes is: husband, wife, father, mother, or unmarried child under age 21.

- a. *Aliens in this group are the immediate relatives of an American citizen or a lawful permanent resident and have had filed on their behalf a Form I-130 petition for issuance of an immigration visa. If this petition has been approved, a visa will be prepared, which will allow the alien to remain in the United States permanently.*
- b. *Aliens in this group will have a Form I-94 and/ or I-210 Letter. These documents will indicate that the alien is to depart on a specified date (usually 3 months from date of issue), however, USCIS expects the alien's visa to be available within this time. If it is not, extensions will be granted until the visa is ready. Also indicated on these documents is the authorization for employment.*

**7. Status
Adjustment
Applicants**

aliens who have filed applications for adjustment of status pursuant to section 245 INA (8 USC 1255) that USCIS has accepted as "properly filed" (within the meaning of 8 CFR 242.5(a) or (b)) or has granted, and whose departure the USCIS does not contemplate enforcing.

- a. *Aliens in this group have filed for lawful permanent resident status.*

- b. Aliens in this group will have a Form I-181 or their passports will be stamped with either of the following: "adjustment application" or "employment authorized during status as adjustment applicant."

**8. Deferred
Action Status**

Aliens granted deferred action status pursuant to USCIS operating instructions.

- a. Aliens in this group are similar to those under an order of supervision except there have been no formal deportation proceedings initiated.
- b. Aliens in this group will have a Form I-210 or a letter indicating that the alien's departure has been deferred.

**9. Deportation
Suspended**

Aliens granted suspension of deportation pursuant to section 244 of the INA (8 USC 1254) whose departure the USCIS does not contemplate enforcing.

- a. Aliens in this group have been found deportable, have met a period of continuous residence and have filed an application for USCIS to suspend deportation in an effort to be granted lawful permanent resident status.
- b. If the suspension is granted, the alien must wait through two full sessions of the Congress. If the Congress does not take action on the application, USCIS will grant the alien lawful permanent residence.
- c. These aliens will have a letter/order from the immigration judge and a Form I-94 with employment authorized for 1 year. After lawful permanent residence is granted, the alien will have a Form I-551, or I-151.

**10. Compact of
Free
Association
States**

Aliens who are citizens of a Compact of Free Association State (Federated States of Micronesia, Republic of the Marshall Islands and the Republic of Palau) who have been admitted to the U.S. as a non-immigrant and are permitted by the Department of Homeland Security to reside permanently or indefinitely in the United States.

**11 Other Eligible
Groups**

- a. Aliens described in 8 CFR 103.12(a)(4) who do not have a permanent residence in the country of their nationality and are in statuses that permit them to remain in the U.S. for an indefinite period of time pending adjustment of their status. This includes:
1. aliens currently in temporary resident status as an Amnesty beneficiary pursuant to section 210 or 245A of the Immigration and Nationality Act (INA);
 2. aliens currently under a Temporary Protected Status pursuant to section 244 of the INA;
 3. aliens classified as a Family Unit beneficiary pursuant to section 301 of Public Law 101-649 as well as pursuant to section 1504 of Public Law 106-554;
 4. aliens currently under a Deferred Enforced Departure pursuant to a decision made by the President; and

5. *alien children whose parent is a U.S. citizen, whose visa petition has been approved and who has a pending application for adjustment of status.*

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 M0220.700 contains the entitlement and enrollment procedures for emergency services aliens.

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.
 3. **Parolees** A qualified parolee who enters the U.S. on or after 8-22-96 is an “emergency services” alien.
 4. **Battered Aliens** A qualified battered alien who enters the U.S. on or after 8-22-96 is an “emergency services” alien.
- B. AFTER 5 Years of Residence in U.S.** **AFTER** 5 years have passed from the date of entry into the U.S., the following groups of aliens who entered on or after 8-22-96 are eligible for emergency services only:

1. **Lawful Permanent Residents Without 40 Work Quarters** 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. Lawful Permanent Residents who have at least 40 qualifying quarters of work become full benefit aliens after 5 years of residing in the U.S.
 2. **Conditional Entrants** A qualified Conditional Entrant who enters the U.S. on or after 8-22-96 is an “emergency services” alien.
 3. **Parolees** A qualified parolee who enters the U.S. on or after 8-22-96 is an “emergency services” alien.
 4. **Battered Aliens** A qualified battered alien who enters the U.S. on or after 8-22-96 is an “emergency services” alien.
- 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.
- D. 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. Afghan Special Immigrants are eligible for full Medicaid benefits for **six months**, beginning with the month of entry in the U.S. or the date of conversion to Special Immigrant status, if not admitted under that status. From December 26, 2007 through January 27, 2008, Iraqi Special Immigrants are eligible for full Medicaid benefits for **six months**, beginning with the month of entry in the U.S. or the date of conversion to Special Immigrant status.
- Effective January 28, 2008, Iraqi Special Immigrants only are eligible for full Medicaid benefits for **eight months**, beginning with the month of entry in the U.S. or the date of conversion to Special Immigrant status. Effective March 10, 2009, **both Iraqi and Afghan Special Immigrants** are eligible for full Medicaid benefits for **eight months**, beginning with the month of entry in the U.S. or the date of conversion to Special Immigrant status. This includes Afghan Special Immigrants enrolled in Medicaid as of March 10, 2009.

After the applicable limited time period expires, individuals become “emergency services” aliens unless the requirements in M0220.313 B. or M0220.314 are met.

- E. Services Available To Eligibles** An emergency services alien who meets all Medicaid eligibility requirements is eligible for Medicaid coverage of emergency services only.
- F. Entitlement & Enrollment of Eligibles** The Medicaid entitlement policy and enrollment procedures for emergency services aliens are found in section M0220.700 below.

M0220.411 UNQUALIFIED ALIENS

- A. Unqualified Aliens** Aliens who do not meet the qualified alien definition M0220.310 above and who are **NOT** “grandfathered” aliens (M0220.314 above) are “unqualified” aliens and are eligible for emergency services only if they meet all other Medicaid eligibility requirements. Unqualified aliens include illegal and non-immigrant aliens.
- 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. Non-immigrants, such as visitors, tourists, some workers, and diplomats, are not eligible for Medicaid because of the temporary nature of their admission status (they do not meet the state residency requirement). 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;
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. **Foreign Students** foreign students;
7. **International Organization** international organization representatives and personnel, and their families and servants;
8. **Temporary Workers** temporary workers including some agricultural contract workers;
9. **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);

Aliens who are visitors (non-immigrants) usually do not meet the Virginia state residency requirements because their visas will expire on a definite date. Ask the non-immigrant alien "Where do you intend to go after your visa expires?" If the visitor states in writing that he/she "intends to reside in Virginia permanently or indefinitely after his visa expires," then the alien has stated his intent to reside in Virginia permanently or indefinitely and can meet the Virginia state residence eligibility requirement for Medicaid.

2. **Social Security Number (SSN)** the SSN provision/application requirements (M0240);

NOTE: An alien eligible only for Medicaid payment of emergency services does not have 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.

M0220.600 FULL BENEFIT ALIENS 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 on the Medicaid computer (MMIS) using the following data:
- 1. Cty** In this field, Country of Origin, enter the code of the alien's country of origin.
 - 2. CI** In this field, Citizenship code, enter the MMIS citizenship code that applies to the alien. Next to the MMIS code is the corresponding Alien Code from the Alien Code Chart in Appendix 3 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 Z) during six- or eight-month period of full eligibility.
 - E = entrant (Alien Chart code D1).
 - P = full benefit qualified aliens (Alien Chart codes A1, A2, A3, B1, B3, C1, E1, H1, H2, I1, J1, J2).
 - 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. 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 date the alien's Medicaid entitlement begins.

UNITED STATES CITIZENSHIP AND IMMIGRATION SERVICES (USCIS) OFFICE

All agencies needing to correspond with USCIS are to use the following address:

*Attn: Status Verification Unit
U.S. Citizenship and Immigration Services
300 N. Los Angeles Street, B120
Los Angeles, CA 90012*

	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	Illegal aliens – aliens not lawfully admitted or whose lawful admission status has expired	Emergency Only V1	Emergency Only V2	Emergency Only V3
W	Visitors (non-immigrants): tourists, diplomats, foreign students, temp. workers, etc. [I-688B – 274a.12(b)(1)-(20); I-94; I-185: I-1186; SW-434; I-95A]	Emergency Only W1	Emergency Only W2	Emergency Only W3
LEGAL IMMIGRANT CHILDREN UNDER AGE 19				
Y	<i>Non-citizen (alien) children under the age of 19 lawfully residing in the U.S. who meet the requirements in M0220.314.</i>	N/A	Full Benefits	Full Benefits

	AFGHAN AND IRAQI SPECIAL IMMIGRANTS	First Six/Eight Months after Entry into U.S.	Greater than Six/Eight Months after Entry into U.S., first 5 years	Greater than Six/Eight Months after Entry into U.S., after 5 years
Z	Afghan 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, QQ1, SQ2, or SQ3 and bearing Department of Homeland Security stamp or notation]	From 12-26-07 – 3-9-09, full Benefits for SIX (6) MONTHS beginning with month of entry or date of conversion to SIV status. Coverage cannot begin prior to 12-26-07. Beginning 3-10-09, full benefits for EIGHT (8) MONTHS beginning with month of entry or date of conversion to SIV status. Includes individuals enrolled as of 3-10-09.	Emergency Only	See Line Items B and C on page 1 of this appendix.
Z	Iraqi Special Immigrants admitted on a Special Immigrant Visa, 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, QQ1, SQ2, or SQ3 and bearing Department of Homeland Security stamp or notation]	From 12-26-07 – 1-27-08, full Benefits for SIX (6) MONTHS beginning with month of entry or date of conversion to SIV status. Coverage cannot begin prior to 12-26-07. Beginning 1-28-08, full benefits for EIGHT (8) MONTHS beginning with month of entry or date of conversion to SIV status.	Emergency Only	See Line Items B and C on page 1 of this appendix.

Commonwealth of Virginia
Department of Social Services

APPLICANT'S NAME: _____

CASE NUMBER: _____

EMERGENCY MEDICAL CERTIFICATION

TO: DIVISION OF PROGRAM OPERATIONS
DEPT. OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET, SUITE 1300
RICHMOND, VA 23219

I. REFERRAL SECTION

THE ABOVE-NAMED INDIVIDUAL HAS APPLIED FOR MEDICAID. A DETERMINATION OF EMERGENCY NEED AND DURATION IS NEEDED NO LATER THAN _____.

(DATE)

INDIVIDUAL'S STATUS: A B C

ATTACHED IS INFORMATION ON THE EMERGENCY MEDICAL TREATMENT.

SIGNED: _____ WORKER #: _____ TELEPHONE # _____ DATE: _____

AGENCY NAME: _____

AGENCY ADDRESS: _____

II. CERTIFICATION SECTION

I HAVE REVIEWED THE MEDICAL EVIDENCE AND DETERMINED THAT THE MEDICAL CONDITION

IS AN EMERGENCY IS NOT AN EMERGENCY

THE REASON FOR DETERMINATION, OR SPECIFICS OF COVERED SERVICES AND DURATION OF COVERAGE ARE DETAILED BELOW.

SIGNED: _____ TITLE: _____ TELEPHONE # _____ DATE: _____

III. NOTIFICATION SECTION

TO: MEDICAID SERVICE PROVIDERS

THE ABOVE-NAMED INDIVIDUAL HAS BEEN DETERMINED INELIGIBLE FOR MEDICAID BENEFITS.

REASON FOR DENIAL: _____

THE ABOVE-NAMED INDIVIDUAL IS ELIGIBLE FOR MEDICAID TO COVER EMERGENCY SERVICES. ONLY SERVICES DIRECTLY RELATED TO THE EMERGENCY ARE COVERED FOR THE TIME PERIOD SPECIFIED BELOW. THIS FORM SERVES AS YOUR NOTIFICATION OF ELIGIBILITY IN LIEU OF A MEDICAID CARD. IF YOU HAVE ANY QUESTIONS, CALL THE PROVIDER HELPLINE AT 1-800-552-8627.

PERIOD OF COVERAGE: _____

MEDICAID NUMBER: _____

OTHER INSURANCE: _____

SIGNED: _____ TITLE: _____ DATE: _____

Appendix 4: EMERGENCY MEDICAL CERTIFICATION**FORM NUMBER** - 032-03-628**PURPOSE**

1. To request from the Department of Medical Assistance Services (DMAS) certification that the medical service received by an emergency services alien was an emergency.
2. To certify that the medical service was an emergency as defined by law and to provide the reason(s) for the decision and the duration of the emergency coverage.
3. To notify the medical service provider(s) that the emergency services alien is either ineligible or eligible for Medicaid, and for what coverage period, in lieu of generating a Medicaid card.

USE OF FORM - Completed for all emergency services alien applicants.**NUMBER AND DISTRIBUTION OF COPIES** - Prepare original; make copy for agency record before sending original to DMAS. DMAS will complete Section II and return the "Local Agency" and "Emergency Service Provider" copies to the agency. After completing Section III, the agency will keep the "Local Agency" copy of the original in the eligibility case folder and send the "Emergency Service Provider" copy to the provider(s).

Forms must be retained for a period of three years following the current fiscal year if a federal audit has been made within that period and no audit questions have been raised. If such an audit has not been made within that time, the form must be retained until an audit has been made or until the end of five years following the current fiscal year, whichever is earlier. In all cases, if audit questions are raised, the form must be retained until the questions are resolved.

INSTRUCTIONS FOR PREPARATION OF FORM**SECTION I - REFERRAL SECTION** -Enter the date which is 45 days or 90 days if applicant is applying as disabled) from the application date in the blank marked "(Date)". Check the individual's status; "A" for the Qualified Alien, "B" for the Unqualified Aliens and "C" for the Undocumented Alien. The worker must sign his/her own name and worker number, *telephone number*, the date the section was completed and the agency name and address.**SECTION II - CERTIFICATION SECTION** - The authorized DMAS staff person completes this section, signs his/her name, title, *telephone number* and the date, keeps the copy marked "DMAS", and sends the original and provider copy back to the agency.**SECTION III - NOTIFICATION SECTION** - The worker checks the appropriate box. If the applicant is ineligible, briefly state why. If the applicant is eligible, note the begin and end dates of coverage and the recipient's Medicaid I.D. number, and other health insurance. The worker must sign his/her own name, title, *telephone number* and the date this section was completed, which should also be the date this notice is sent to the emergency service provider. Send the carbon copy marked "Emergency Service Provider" to the provider(s) of emergency services received within the coverage period. This notice serves in place of a Medicaid card as verification of the applicant's Medicaid coverage. A separate "Notice of Action on Medicaid" form #032-03-008 is sent to the applicant and **no Medicaid card is generated.**

- 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 form 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. If an applicant cannot meet the 40-quarter minimum without using a questionable quarter, SSA will investigate the questionable quarter(s) and will either confirm or deny the quarter. 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 or later, 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

M0230 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/2010	page 2

- 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.

M0240 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/2010	pages 1-4
Update (UP) #1	07/01/2009	pages 1, 2
TN #91	05/15/2009	pages 1, 2

M0240.000 SOCIAL SECURITY NUMBER REQUIREMENTS

M0240.001 GENERAL PRINCIPLES

A. Policy

1. Medicaid

To be eligible for Medicaid, an individual must provide his Social Security number (SSN) as well as the SSN of any person for whom Medicaid is requested, or must provide proof of application for an SSN, **UNLESS** the applicant

- is an alien who is eligible only for Medicaid payment of emergency services, as defined in subchapter M0220, or
- is a child under age one born to a Medicaid-eligible mother, as long as the mother would still be eligible for Medicaid had the pregnancy not ended and the mother and child continue to live together (see M0320.301 B. 2.).

An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

2. FAMIS & FAMIS MOMS

To be eligible for FAMIS or FAMIS MOMS, an individual is **not** required to provide or apply for an SSN.

B. Failure to Meet SSN Requirement

Any Medicaid family unit member for whom an application for an SSN has not been filed or for whom the SSN is not furnished is **not eligible** for Medicaid EXCEPT for:

1. Child Under Age 1

a child under age one born to a Medicaid-eligible mother; a newborn is deemed to have applied and been found eligible for Medicaid, whether or not the eligibility requirements, including SSN, have actually been met.

2. Emergency-Services-Only Alien

an alien eligible for Medicaid payment of emergency services only, as defined in M0220.410 and M0220.411; an emergency-services-only alien does not have to provide or apply for an SSN.

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

The individual's SSN must be verified by the Social Security Administration (SSA). *The State Verification Exchange System (SVES) is used to verify an SSN. If SVES is not available or the worker requires immediate verification to expedite the case, the State Online Query-Internet system (SOLQ-I) can be used instead of SVES.*

- 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.

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). An Enumeration Referral Form, form #032-03-400, available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi> must be completed by the applicant. 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 Medicaid Management Information System (MMIS).
- 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.
- 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.
- B. Exceptions** Any Medicaid family unit member for whom an SSN has not been applied **is not eligible** for Medicaid EXCEPT for:
- 1. Child Under Age 1** a child under age one born to a Medicaid-eligible mother, who meets the definition in M0320.301 of a newborn "deemed" eligible for Medicaid. A newborn is deemed to have applied and been found eligible for Medicaid, whether or not the eligibility requirements, including SSN, have actually been met. See M0320.301 for a newborn's eligibility as a child under age 1.
- 2. Emergency-Services-Only Alien** an alien eligible for Medicaid payment of emergency services only, as defined in M0220.410 and M0220.411; an emergency-services-only alien does not have to apply for an SSN.

M0240.200 FOLLOW-UP REQUIREMENTS FOR SSN

- A. Policy** 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.
- B. Procedures**
- 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**

When entering the individual in ADAPT or MedPend, use the date the individual applied for an SSN, or the individual's date of birth, preceded by "APP."

For example, an individual applied for an SSN on October 13, 2006. Enter "APP101306" as the individual's SSN.

When enrolling an eligible individual in MMIS, use the date the individual applied for an SSN, or the individual's date of birth, preceded by "888."

3. Follow-up**a. Follow-up in 90 Days**

After enrollment of the eligible individual, the agency must follow-up within 90 days of the Social Security number application date or 120 days if application was made through hospital enumeration:

b. Check for Receipt of SSN

Check the MMIS and ADAPT records for the enrollee's SSN. If the SSN still has "888" or "APP" as the first 3 digits, contact the enrollee to obtain the enrollee's SSN verbally or by mail.

c. Verify SSN

Verify the SSN by a computer system inquiry of the SSA records.

d. Enter Verified SSN in Systems

Enter the enrollee's SSN in MMIS, and in ADAPT if the enrollee is in ADAPT. If the enrollee is in an active Medicaid case in ADAPT, and his pseudo SSN is not changed to a valid SSN at renewal, ADAPT will determine him ineligible for Medicaid.

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 MMIS and ADAPT. Check the MMIS and ADAPT records for the enrollee's SSN. If the SSN has "888" or "APP" 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

Verify the SSN by a computer system inquiry of the SSA records.

c. Enter Verified SSN in Systems

Enter the enrollee's SSN in MMIS, and in ADAPT if the enrollee is in ADAPT. If the enrollee is in an active Medicaid case in ADAPT, and his pseudo SSN is not changed to a valid SSN at renewal, ADAPT will determine him ineligible for Medicaid.

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 an SSA administrative problem, such as a backlog of SSN applications causing the delay in issuing an SSN to the enrollee, the enrollee continues to meet the Medicaid SSN eligibility requirement. The worker will assist the enrollee with obtaining the SSN and will periodically check with the computer systems and the enrollee.

If the problem is **not** an SSA administrative problem, the worker must cancel Medicaid coverage for the enrollee whose SSN is not provided.

Virginia DSS, Volume XIII

M0280 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/2010	page 13

M0280.600 DEPARTMENTAL RESPONSIBILITY**A. Department of Behavioral Health & Developmental Disabilities (DBHDS) Patients****1. ABD Covered Groups**

Medicaid eligibility of patients who are:

- in State-owned *Department Behavioral Health and Developmental Services (DBHDS)* institutions for the treatment of mental disease and mental retardation,
- not currently enrolled in Medicaid, and
- eligible in an Aged, Blind, or Disabled (ABD) covered group

is determined by the Medicaid Technician staff of the Division of Benefit Programs, Department of Social Services, who also carries responsibility for enrollment. (See subchapter M1550).

2. F&C DBHDS Patients

Local social services departments continue to carry responsibility for the determination of eligibility for Medicaid of a child eligible in a Families and Children's covered group who have been admitted to a *DBHDS* institution for treatment of the mentally retarded, and for the child's enrollment in Medicaid.

B. All Other Institutions

Local social services departments carry responsibility for the Medicaid eligibility determination and enrollment of individuals in institutions that are not operated by *DBHDS*. 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.

M0310 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/10	page 35 Appendix 5, page 1
Update (UP) #2	08/24/09	Table of Contents page 39
TN #91	05/15/09	pages 23-25 Appendix 4, page 1 Appendix 5, page 1

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 M0320.304 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 is medically determined to be pregnant meets the definition of a pregnant woman.

1. Effective Date

The pregnant woman definition is met the first day of the estimated month of conception as medically verified, or the first day of the earliest month which the medical practitioner certifies as being a month in which the woman was pregnant.

The definition of "pregnant woman" is met for sixty days 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 60th day occurs.

Example #3: a pregnant woman applies for Medicaid in May 1997; she received medical treatment in March and April 1997. The physician gives her a written statement dated May 20, 1997 saying that he "treated her in March 1997. She was approximately 3 months pregnant at that time. She is still pregnant this date." Therefore, her pregnancy is

DDS Regional Offices

Send all expedited and non-expedited disability referrals to the DDS Regional Office to which the local DSS agency is assigned, as indicated in the table below.

DDS Regional Office	Local DSS Agency Assignments
<p>Central Regional Office Disability Determination Services 9960 Mayland Drive, Suite 200 Richmond, Virginia 23233</p> <p>Phone: 800-523-5007 804-367-4700 FAX: 866-323-4810</p>	<p>Amelia, Brunswick, Buckingham, Charles City, Charlotte, Chesterfield, Colonial Heights, Cumberland, Danville, Dinwiddie, Emporia, Essex, Goochland, Greenville, Halifax, Hanover, Henrico, Hopewell, King and Queen, King William, Lancaster, Lunenburg, Mecklenburg, Middlesex, New Kent, Northumberland, Nottoway, Petersburg, Pittsylvania, Powhatan, Prince Edward, Prince George, Richmond County, Richmond City, South Boston, Surry, and Sussex</p>
<p>Tidewater Regional Office Disability Determination Services 5850 Lake Herbert Drive, Suite 200 Norfolk, Virginia 23502</p> <p>Phone: 800-379-4403 757-466-4300 FAX: 866-773-0244</p>	<p>Accomack, Chesapeake, Franklin, Gloucester, Hampton, Isle of Wight, James City, Mathews, Newport News, Norfolk, Northampton, Portsmouth, Poquoson, Southampton, Suffolk, Courtland, Virginia Beach, Williamsburg, York</p>
<p>Northern Regional Office Disability Determination Services 11150 Fairfax Boulevard, Suite 200 Fairfax, Virginia 22030</p> <p>Phone: 800-379-9548 703-934-7400 FAX: 866-843-3075</p>	<p>Albemarle, Alexandria, Arlington, Augusta, Caroline, Charlottesville, Clarke, Culpepper, Fairfax City, Fairfax County, Falls Church, Fauquier, Fluvanna, Frederick, Fredericksburg, Greene, Harrisonburg, Highland, King George, Loudoun, Louisa, Madison, Manassas City, Orange, Page, Prince William, Rappahannock, Rockingham, Shenandoah, Spotsylvania, Stafford, Staunton, Warren, Waynesboro, Westmoreland, and Winchester</p>
<p>Southwest Regional Office Disability Determination Services 612 S. Jefferson Street, Suite 300 Roanoke, Virginia 24011-2437</p> <p>Phone: 800-627-1288 540-857-7748 FAX: 866-802-5842</p>	<p>Alleghany, Amherst, Appomattox, Bath, Bedford City, Bedford County, Bland, Botetourt, Bristol, Buchanan, Buena Vista, Campbell, Carroll, Covington, Craig, Dickenson, Floyd, Franklin, Galax, Giles, Grayson, Henry, Lee, Lexington, Lynchburg, Martinsville, Montgomery, Nelson, Patrick, Pulaski, Radford, Roanoke County, Roanoke City, Rockbridge, Russell, Salem, Scott, Smyth, Tazewell, Washington, Wise, and Wythe</p>

M0320 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/10	Pages 11-12, 18, 34-35, 38 Pages 40, 42a-42d, 42f-44, 49 Pages 50c, 69-71
Update (UP) #2	08/24/09	pages 26, 28, 32, 61, 63, 66
Update (UP) #1	07/01/09	pages 46f-48
TN #91	05/15/09	pages 31-34 pages 65-68

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 CNNMP 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.

Cost-of-living calculation formula:

$$a. \frac{\text{Current Title II Benefit}}{1.058 \text{ (1/09 Increase)}} = \frac{\text{Benefit Before}}{1/09 \text{ COLA}}$$

- b. $\frac{\text{Benefit before 1/09 COLA}}{1.023 \text{ (1/08 Increase)}} = \text{Benefit Before 1/08 COLA}$
- c. $\frac{\text{Benefit Before 1/08 COLA}}{1.033 \text{ (1/07 Increase)}} = \text{Benefit Before 1/07 COLA}$
- d. $\frac{\text{Benefit Before 1/07 COLA}}{1.041 \text{ (1/06 Increase)}} = \text{Benefit Before 1/06 COLA}$
- e. $\frac{\text{Benefit Before 1/06 COLA}}{1.027 \text{ (1/05 Increase)}} = \text{Benefit Before 1/05 COLA}$
- f. $\frac{\text{Benefit Before 1/05 COLA}}{1.021 \text{ (1/04 Increase)}} = \text{Benefit Before 1/04 COLA}$

Contact a Medical Assistance Program Consultant for amounts for years prior to 2004.

5. Medicare Premiums

a. Medicare Part B premium amounts:

1-1-10 \$110.50*
1-1-09 \$96.40
1-1-08 \$96.40
1-1-07 \$93.50
1-1-06 \$88.50
1-1-05 \$78.20

**This amount is for individuals enrolled in Medicare on or after 1-1-10 or for individuals subject to increased Medicare premiums based on their income. The Medicare Part B premium for individuals enrolled in Medicare prior to January 1, 2010 remains \$96.40 for 2010.*

b. Medicare Part A premium amounts:

1-1-10 \$461.00
1-1-09 \$443.00
1-1-08 \$423.00
1-1-07 \$410.00
1-1-06 \$393.00
1-1-05 \$375.00

Contact a Medical Assistance Program Consultant for amounts for years prior to 2004.

6. Classification

Individuals who are eligible when a cost-of-living increase is excluded are eligible as categorically needy non-money payment (CNNMP).

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 MI 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.

M0320.105 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 continues 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 eligible for Medicaid.

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 State Online Query Internet (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.

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 Medicaid Long-term Care services available under the EDCD Waiver must have a patient pay calculation for the EDCD 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.

M0320.206 QMB (QUALIFIED MEDICARE BENEFICIARY)**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 chapter M20, Appendix 3, for the *current resource limits*; and

has income that does not exceed 100% of the federal poverty limits.

B. Nonfinancial Eligibility

The Qualified Medicare Beneficiary must meet all the nonfinancial eligibility requirements in chapter M02.

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 M0320.209 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 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 *the resource limit for the Medicare Savings Programs (MSPs)*. See chapter M20, Appendix 3, for the current resource limits.

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.

**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 classification and 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". Reinstated the coverage with the begin date as the first day of the month of admission to long-term care.

M0320.207 SLMB (SPECIAL LOW INCOME MEDICARE BENEFICIARY)

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 (M0320.206 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 chapter M20, Appendix 3, for the *current resource limits*; and
- has income that exceeds the QMB limit (100% of the federal poverty limits) but is less than 120% of the poverty limits.

**B. Nonfinancial
Eligibility**

The SLMB must meet all the nonfinancial eligibility requirements in chapter M02.

**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.

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 limit *are the resource limits for the Medicare Savings Programs (MSPs). See chapter M20, Appendix 3, for the current resource limits.*

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 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 SLMB income eligibility.

**4. Income
Equals or
Exceeds
SLMB Limit**

Spenddown does not apply to the medically indigent 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. Recipient's AC
Changes To
SLMB**

An enrolled recipient's AC cannot be changed to AC "053" using a "change" transaction in the MMIS. If a Medicaid recipient becomes ineligible for full-coverage Medicaid or QMB-only coverage because

2. Qualified Individual (QI)

A Qualified Individual (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 M20, Appendix 3, for the current resource limits*; and
- has income that is equal to or exceeds the SLMB limit (120% of the federal poverty limit) but is less than the QI limit (135% of the poverty limit).

B. Nonfinancial Eligibility

QIs must meet all the nonfinancial eligibility requirements in chapter M02.

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).

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 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 QI; he/she 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/she is not eligible for Medicaid as 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 Qualified Individuals.

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 medically indigent QI determination; the other is for the ABD spouse's CN, CNNMP or MN covered group.

2. Resources

The asset transfer rules in subchapter M1450 must be met by the QI.

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 Medicare Savings Programs (MSPs). See chapter M20, Appendix 3, 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.

5. Income Equals or Exceeds QI Limit

Spenddown does not apply to the medically indigent income limits. If the individual's income is equal to or exceeds the QI limit (135% of FPL), **he/she is not eligible as QI** and cannot spenddown to the QI limit.

D. QI Entitlement

Coverage under this group cannot begin earlier than January 1 of the calendar year.

QIs are eligible for retroactive coverage as a QI. Retroactive eligibility cannot begin earlier than January 1 of the current calendar year.

If all eligibility factors are met in the application month, eligibility for Medicaid as a QI begins the first day of the application month, **and ends December 31 of the calendar year**, if funds are still available for this covered group.

The Notice of Action on Medicaid must state the recipient's **begin and end dates** of Medicaid coverage.

E. Enrollment

1. Aid Category

QI = 056

2. Begin and End Dates

The begin date of coverage cannot be any earlier than January 1 of the calendar year. An edit is in place in the MMIS to prevent enrollment prior to January 1 of the current year.

Do not enter an end date of coverage.

3. MMIS

The MMIS will:

- automatically cancel the QI recipient's coverage effective December 31 of each calendar year, and
- send a notice to the recipient to reapply for Medicaid coverage for the next calendar year.

F. QI Applications & Renewals

1. New Applicants

Applications for individuals who are not currently enrolled in Medicaid can be taken at any time.

2. QI Enrollees

On or after November 1 of each year, send the [ABD Medicaid Renewal Form \(#032-03-0186\)](#) to all individuals currently enrolled in the QI covered group, AC 056. Follow the ABD Medicaid renewal procedure to request verifications and complete the evaluation.

a. Renewal form returned BEFORE December 31st

If the renewal form is returned to the LDSS on or before December 31st and the individual remains eligible, send a [Notice of Action on Medicaid and FAMIS \(form #032-03-0008\)](#) indicating that the individual's coverage continues and the date of the next renewal.

b. Renewal form returned AFTER December 31st

If the renewal form is not returned by December 31st the individual must submit a new application for Medicaid. The MMIS-generated cancellation notice will serve as the 10-day advance notice for cancellation of the individual's QI coverage.

G. Enrollee's Covered Group Changes To QI

1. Before November Cut-off

An enrolled recipient's AC cannot be changed to "056" using a "change" transaction in the MMIS. If, **before November cut-off**, a Medicaid recipient becomes ineligible for full-coverage Medicaid or QMB-only coverage because of an increase in income or resources, 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". Reinstated 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.

2. After November Cut-off

If, **after November cut-off**, a Medicaid recipient becomes ineligible for full-coverage Medicaid or QMB-only coverage because of an increase in income or resources, but is eligible as a QI, the agency must send an advance notice of proposed action to the recipient to cancel the recipient's Medicaid coverage effective December 31. The notice must specify that he must reapply for Medicaid if he/she wants Medicaid to pay his/her Medicare Part B premium. Cancel the recipient's full coverage effective December 31, using cancel reason "007".

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.**

income is within CNNMP, 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.

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 medically indigent QDWI determination; the other is for the ABD spouse's 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 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 limits used for this group are the resource limits for the Medicare Savings Programs (MSPs). See chapter M20, Appendix 3, for the current resource limits.

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 medically indigent 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."

2. Recipient's AC Changes To QDWI

An enrolled recipient's AC cannot be changed to AC "055" using a "change" transaction in the MMIS. If a Medicaid recipient becomes ineligible for full-coverage Medicaid, but is eligible as a QDWI, 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 A premiums as a QDWI.

Cancel the recipient's full coverage effective the last day of the month, using cancel reason "007." Reinstate the recipient'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 classification and 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 classification and covered group, using cancel reason "024;"
- reinstate the recipient'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.

**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 classification and 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.” Reinstated the coverage with the begin date as the first day of the month of admission to long-term care.

M0320.210 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.

Eligibility in the ABD 80% FPL covered group is limited to those ABD individuals who do not meet the requirements for any other full benefit Medicaid covered group. ABD individuals who meet the requirements for the 300% SSI covered groups (see M0320.203 and 204) or are medically needy without a spenddown (see M0330) are to be enrolled in these groups and not in the ABD 80% FPL covered group. An eligible individual's resources must be within the SSI resource limits.

**B. Nonfinancial
Eligibility**

An individual in this covered group must meet the nonfinancial requirements in chapter M02:

- aged, blind, or disabled definition in subchapter M0310;
- citizenship/alien status;
- Virginia residency;
- Social Security number provision/application requirements;
- assignment of rights to medical benefits requirements;
- application for other benefits; and
- institutional status.

M0320.302 PLAN FIRST - FAMILY PLANNING SERVICES (FPS)**A. Policy**

Since October 2002, family planning services (FPS) have been available to eligible women up to 24 months after the receipt of a Medicaid-covered pregnancy related service.

Effective January 1, 2008, a new family planning services health program known as Plan First is available to **uninsured** men and women who have countable income within 133% FPL and have not had a sterilization procedure. The previous requirements for receipt of a Medicaid-paid pregnancy-related service by women and the time limitations have been eliminated from the Plan First requirements.

The Plan First Application Form *or the Application for Benefits form* may be submitted for eligibility to be determined in this covered group.

1. Plan First Applications

Uninsured men and women who have countable income within 133% FPL and have not had a sterilization procedure may be eligible for Plan First. A Plan First Application Form *or an Application for Benefits form may be used* for initial eligibility and for each annual renewal.

Retroactive coverage is NOT available in the Plan First covered group.

2. Determine Medicaid Eligibility First**a. Application Indicates Potential Full-benefit Medicaid Eligibility**

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 and has income within the LIFC income limit for the family unit size), the worker must determine whether eligibility for full benefit Medicaid coverage exists before the individual(s) can be determined eligible for Plan First.

b. Additional Information Needed For Full Benefit Medicaid

If additional information is needed to complete the eligibility determination for a full-benefit 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, the worker will determine the applicant's eligibility for Plan First only.

c. Applicant Eligible for Plan First Only

If the applicant is not eligible for full benefit Medicaid but is eligible for Plan First, enrollment in Plan First must be made directly in the MMIS. ADAPT will not enroll eligible individuals in Plan First, even if the eligibility determination for full benefit Medicaid was done in ADAPT.

- 4. **Income** The income requirements in chapter M07 must be met by the child. The income limits are 133% of the FPL and are found in subchapter M0710, Appendix 6.

- 5. **Income Changes** Any changes in an MI child’s income that occur after his eligibility has been established affect eligibility. Recalculate income and compare to the MI 133% FPL income limits.

- 6. **Income Exceeds MI Limit** A child under age 19 whose income exceeds the MI income limit may be eligible for Virginia’s Title XXI program, Family Access to Medical Insurance Security (FAMIS). The income limit for FAMIS is 200% FPL. See chapter M21 to determine FAMIS eligibility.

Spenddown does not apply to the medically indigent. If the child’s income exceeds the medically indigent limit, he/she is not eligible as medically indigent regardless of medical expenses. Eligibility as medically needy (MN) must then be determined in order for spenddown to apply, and all medically needy eligibility requirements must be met, including resource limits.

D. Entitlement

Eligible MI 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; however, the income limit for children age 6 – 19 cannot exceed 100% FPL for any period prior to September 1, 2002.

Eligible MI children are entitled to all Medicaid covered services as described in chapter M18.

E. Enrollment

The ACs for the MI child are:

AC	Meaning
090	MI child under age 6; income greater than 100% FPL, but less than or equal to 133% FPL
091	MI child under age 6; income less than or equal to 100% FPL
092	<ul style="list-style-type: none"> • MI child age 6-19; insured or uninsured with income less than or equal to 100% FPL; • MI child age 6-19; insured with income greater than 100% FPL and less than or equal to 133% FPL
094	MI child age 6-19; uninsured with income greater than 100% FPL and less than or equal to 133% FPL

Do not change the AC when a child’s health insurance is paid for by Medicaid through the HIPPA program.

M0320.312 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 with breast and cervical cancer. Virginia chose to cover this group beginning July 1, 2001.

Women 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 women must not have creditable health insurance coverage for treatment of breast or cervical cancer.

Women diagnosed with cancer by a provider who is not operating under the BCCEDP are not eligible in this covered group.

B. Nonfinancial Eligibility

1. Required Nonfinancial Requirements

BCCPTA women must meet the following Medicaid nonfinancial requirements in chapter M02:

- citizenship/alien status;
- Virginia residency;
- Social Security number provision/application requirements;
- assignment of rights to medical benefits requirements;
- application for other benefits; and
- institutional status.

In addition, BCCPTA women must not be eligible for Medicaid under the following mandatory categorically needy covered groups:

- LIFC;
- MI Pregnant Women;
- FAMIS Plus (MI Child Under Age 19);
- SSI recipients.

2. Creditable Health Insurance Coverage

BCCPTA women must not have creditable health insurance coverage for the treatment of breast or cervical cancer. 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 a woman 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.

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 women for this program.

Women 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 women who meet the BCCPTA non-financial requirements have been streamlined to facilitate the prompt enrollment and immediate access to services for women 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.

Women who meet the description of individuals in the LIFC, MI Pregnant Women, FAMIS Plus, or SSI recipients covered groups must complete the appropriate Medicaid application for the covered group and must have a Medicaid eligibility determination completed prior to determining their eligibility in the BCCPTA covered group. If not eligible in the LIFC, MI Pregnant Women, FAMIS Plus, or SSI recipients covered groups, 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. The application includes the BCCEDP certification of the woman'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 women who do not meet the description of an individual in the LIFC, MI 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 women who meet the description of an individual in the LIFC, MI Pregnant Women, FAMIS Plus, or SSI recipients 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 woman later has a positive diagnosis as a result of the screening and is determined to be in need of treatment for her breast and/or cervical cancer.

Eligible BCCPTA 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.

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).

F. Enrollment

The aid category for BCCPTA women 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 her 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.

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M0530 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/2010	pages 11, 19 Appendix 1, page 1

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

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 M0310,

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,

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

2009 and 2010: \$1,011 - \$674 = \$337

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 = \$674 for 2009 and 2010

The living allowance for both parents living with the child is the SSI payment for a couple.

SSI payment for both parents = \$1,011 for 2009 and 2010

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

2009 and 2010: \$1,011 - \$674 = \$337

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M0630 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/2010	page 8

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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M0730 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/10	page 2
TN #91	05/15/2009	Table of Contents pages 7-8a

- 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.

M0810 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/10	pages 1, 2
Update (UP) #1	07/01/2009	page 2

GENERAL

M0810.001 INCOME AND ELIGIBILITY

A. Introduction The following sections explain how to treat income in the Medicaid program. 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 Non-Money Payment-Protected Cases Only

Categorically-Needy Non-Money Payment Protected Covered Groups Which Use SSI Income Limits		
Family Unit Size	2010 Monthly Amount	2009 Monthly Amount
1	\$674	\$674
2	1,011 <i>(no change in 2010)</i>	1,011
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size	2010 Monthly Amount	2009 Monthly Amount
1	\$449.33	\$449.33
2	674.00 <i>(no change in 2010)</i>	674.00

**3. Categorically
Needy-Non
Money Payment
(CNNMP) –
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.

Categorically Needy-Non Money Payment 300% of SSI		
Family Size Unit	2010 Monthly Amount	2009 Monthly Amount
1	\$2,022 <i>(no change in 2010)</i>	\$2,022

**4. Medically
Needy (Effective
July 1, 2009)**

a. Group I		
Family Unit Size	Semi-annual	Monthly
1	\$1,684.75	\$280.79
2	2,145.14	357.52
b. Group II		
Family Unit Size	Semi-annual	Monthly
1	\$ 1,943.94	\$323.99
2	2,394.04	399.00
c. Group III		
Family Unit Size	Semi-annual	Monthly
1	\$2,527.13	\$421.18
2	3,047.07	507.84

**5. ABD Medically
Indigent**

**For:
ABD 80% FPL,
QMB, SLMB, &
QI without Social
Security (SS) and
QDWI, effective
1/23/09;
ABD 80% FPL,
QMB, SLMB, &
QI with SS,
effective 3/01/09;
MEDICAID
WORKS,
effective 1/23/09**

ABD 80% FPL	Annual	Monthly
1	\$8,664	\$722
2	11,656	972
QMB 100% FPL	Annual	Monthly
1	\$10,830	\$903
2	14,570	1,215
SLMB 120% of FPL	Annual	Monthly
1	\$12,996	\$1,083
2	17,484	1,457
QI 135% FPL	Annual	Monthly
1	\$14,621	\$1,219
2	19,670	1,640
QDWI and MEDICAID WORKS 200% of FPL	Annual	Monthly
1	\$21,660	\$1,805
2	29,140	2,429

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S0820 Changes

Transmittal Number	Effective Date	Pages Changed
TN #93	01/01/2010	pages 30, 31
TN #91	05/15/2009	Table of Contents pages 29, 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 2009 *and* 2010, up to \$1,640 per month, but not more than \$6,600 in a calendar year, of the earned income of a blind or disabled student 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.

6. 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
- S0810.430 amount to fulfill a plan for achieving self-support

For exclusions applicable only to earned income, see S0820.510 - S0820.570.

S0820.510 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 years 2009 and 2010	\$1,640	\$6,600

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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S0830 Changes

Transmittal Number	Effective Date	Pages Changed
TN #93	01/01/2010	Table of Contents, page iv pages 28, 67, 119-120 pages 122-125
TN #91	05/15/2009	Table of Contents, page i page 29

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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.

**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 <input type="checkbox"/>
	the individual does not have a reasonable explanation for the discrepancy	<input type="checkbox"/> use account records 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.*

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** 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.

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)."

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.

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.

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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S1110 Changes

Transmittal Number	Effective Date	Pages Changed
TN #93	01/01/2010	page 2
TN #91	05/15/2009	pages 14-16

M1110.003 RESOURCES LIMITS

A. Introduction

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 Cat-Needy Nonmoney Payment Medically Needy	\$2,000	\$3,000
ABD With Income \leq 80% FPL	\$2,000	\$3,000
<i>The resource limit used for these groups is the Medicare Savings Program (MSP) resource limit:</i> QDWI QMB SLMB QI	<i>Refer to M20, Appendix 3 for current resource limits</i>	<i>Refer to M20, Appendix 3 for current resource limits</i>

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 M1110.530B.

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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S1120 Changes

Transmittal Number	Effective Date	Pages Changed
#93	01/01/2010	page 22

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, or
- a court,

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 trust containing the assets of a disabled individual (no age requirement) must meet the following conditions, to be exempt from the trust policy in M1120.201.

- The trust is established and 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.

NOTE: 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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S1130 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/2010	pages 63-65 pages 70, 74, 75
TN #91	05/15/2009	page 13

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.

- 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.

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

**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.

2. Development and Documentation

If an individual alleges that his or her resources include unspent EITC refunds or payments:

- verify the source, date(s), and amount(s) of such refund(s) or payment(s) in accordance with S0820.400 ff.; and
- obtain a statement as to the date(s) and amount(s) of any account deposits corresponding to the EITC refunds or payments.

C. References

Commingled funds, S1130.700.

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.

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.*

S1140 Changes

Transmittal Number	Effective Date	Pages Changed
TN #93	01/01/2010	pages 13-15 pages 24, 25
TN #91	05/15/2009	pages 11-12a

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

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

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

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.

The maximum savings bond purchase per individual per calendar year is limited to \$5,000 in paper and \$5,000 in electronic bonds each for Series EE and I bonds, or a total of \$20,000 (\$5,000 paper EE, \$5,000 paper I, \$5,000 electronic EE and \$5,000 electronic I). There is no maximum for Series H bonds.

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).

- 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.

S1340 Changes

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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. State/Local Hospitalization (SLH).
2. General Relief (GR).
3. Community Service Boards (CSB) services.
4. *Department of Behavioral Health and Developmental Services (DBHDS)* institutional services.
5. Medical College of Virginia (MCV) and University of Virginia (UVA) clinics and hospitals.
6. Crime Victims Compensation (Virginia Industrial Commission).
7. Local “free” clinics funded and administered by local governments that do not charge any fee to any patient for any service.
8. 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.

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:

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M1410 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/2010	pages 1, 7, 9, 12
TN # 91	05/15/2009	pages 11-14

M1410.010 GENERAL--LONG-TERM CARE**A. Introduction**

Chapter M1410 contains the rules that apply to individuals needing long-term care (LTC) services. 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 care (LTC), 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, if the individual is a child under age 18 years
- attorney-in fact (person who has the individual's power-of-attorney)
- legally appointed guardian
- legally appointed conservator (formerly known as the committee)
- trustee.

EXCEPTION: Patients in the *Department of Behavioral Health and Developmental Services (DBHDS)* facilities may have applications submitted by *DBHDS* staff.

2. Institutionalization

Institutionalization means receipt of 30 consecutive days of

- care in a medical institution (such as a nursing facility), or
- Medicaid Community-Based Care (CBC) services; 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 CBC. The date of discharge into the community (not in LTC) 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

5. Individual and Family Developmental Disabilities Support Waiver (DD Waiver)

The Individual and Family Developmental Disabilities (DD) waiver provides home and community-based services to individuals with developmental disabilities who do not have a diagnosis of mental retardation. The developmental disability must have manifested itself before the individual reached age 21 and must be likely to continue indefinitely.

The services provided under this waiver include:

- support coordination (case management)
- adult companion services
- assistive technology
- crisis intervention/stabilization
- environmental modifications
- residential support
- skilled nursing
- supported employment
- therapeutic consultation
- respite care
- personal attendant services
- consumer-directed personal and respite care.

6. Day Support Waiver for Individuals with Mental Retardation

The Day Support Waiver for Individuals with Mental Retardation (DS Waiver) is targeted to provide home and community-based services to individuals with mental retardation who have been determined to require the level of care provided in an ICF/MR. These individuals may currently reside in an ICF/MR or may be in the community at the time of assessment for DS Waiver services. Only those individuals on the urgent and non-urgent waiting lists for the MR Waiver are considered for DS Waiver services. Individuals may remain on the MR Waiver waiting list while receiving DS Waiver Services.

The services provided under this waiver include:

- day support
- prevocational services

7. Alzheimer's Assisted Living Waiver

The Alzheimer's Assisted Living (AAL) Waiver is available only to individuals who are Auxiliary Grants (AG) recipients, have a diagnosis of Alzheimer's Disease or a related dementia, no diagnosis of mental illness or mental retardation, and who are age 55 or older. 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 in this waiver do not have Medicaid eligibility determined as institutionalized individuals, and there are no post-eligibility requirements.

The services provided under the AAL waiver include:

- assistance with activities of daily living
- medication administration by licensed professionals

M1410.060 POST-ELIGIBILITY TREATMENT OF INCOME (PATIENT PAY)

- A. Introduction** Medicaid-eligible individuals must pay a portion of their income to the LTC 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.”
- 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 LTC 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.

Community-Based Care (CBC) applicants apply in their locality of residence.

ABD patients in state *Department of Behavioral Health and Developmental Services (DBHDS)* facilities for more than 30 days have eligibility determined by Medicaid technicians located in the state *DBHDS* facilities. When an enrolled ABD Medicaid recipient is admitted to a state *DBHDS* facility, the local department of social services transfers the case to the Medicaid technician after the recipient has been in the facility for 30 days or more. See section M1520.600 for case transfer policy.

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.

B. Forms to Use

1. **Notice of Action on Medicaid & FAMIS (#032-03-0008)**

The EW must send the Notice of Action on Medicaid, available on SPARK at: <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>, 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 LTC services.
2. **Notice of Obligation for Long-Term Care Costs (#032-03-0062)**

The Notice of Obligation for Long-term Care Costs 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 Medicaid Management Information System (MMIS) on the day the patient pay information is entered into MMIS. The report of all Notices sent by MMIS each day is posted by FIPS code on SPARK in the Medicaid Management Reports.
3. **Medicaid LTC Communication Form (DMAS-225)**

The Medicaid Long-term Care (LTC) Communication Form is available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi.. The form is used by LTC providers and local departments of social services (LDSS) to exchange information, other than patient pay information, such as:

 - the Provider National Provider Identifier (NPI)/Atypical Provider Identifier(API) number;
 - *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 enrollee's income, resources or deductions;
 - admission, death or discharge to an institution or community-based care service;
 - 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 MMIS, 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.

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M1420 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/2010	pages 2, 3, 5 Appendix 3, page 1 Appendix 4, page 1

M1420.200 RESPONSIBILITY FOR PRE-ADMISSION SCREENING

- A. Introduction** In order to qualify for Medicaid payment of LTC services, an individual must be determined to meet both functional and medical components of the level of care criteria through the pre-admission screening process. The pre-admission screening is completed by a designated screening team or committee. The screening team or committee that completes the pre-admission screening depends on the type(s) of services needed by the individual. Below is a listing of the types of LTC services an individual may receive and the committees/teams responsible for completion of the pre-admission screening certification for those services.
- B. Nursing Facility Screening** This evaluation is completed by local teams composed of agencies contracting with the Department of Medical Assistance Services (DMAS) or by staff of acute care hospitals.
- The local committees usually consist of the local health department director, a local health department nurse, and a local social services department service worker.
- Patients placed directly from acute care hospitals are usually screened by hospital screening teams.
- A state level committee is used for patients being discharged from State *Department of Behavioral Health and Developmental Services (DBHDS)* institutions for the treatment of mental illness, and mental retardation.
- Patients in a Veterans Administration Medical Center (VAMC) who are applying to enter a nursing facility are assessed by VAMC staff. VAMC discharge planning staff use their own Veterans' Administration assessment form, which serves as the pre-admission screening certification.
- C. CBC Screening** Entities other than hospital or local health committees are authorized to screen individuals for CBC. The following entities are authorized to screen patients for Medicaid CBC:
- 1. Elderly or Disabled with Consumer-Direction (EDCD) Waiver** Local and hospital screening committees or teams are authorized to screen individuals for the EDCD waiver.
 - 2. Technology-Assisted Individuals (Tech)Waiver** Local and hospital screening committees or teams are authorized to screen individuals for the Tech waiver.

- 3. Mental Retardation (MR) Waiver** Local Community Mental Health Services Boards (CSBs) and the Department of Rehabilitative Services (DRS) are authorized to screen individuals for the MR waiver. Final authorizations for MR waiver services are made by *DBHDS* staff.
- 4. AIDS Waiver** Local and hospital screening committees or teams are authorized to screen individuals for the AIDS waiver.
- 5. Individual and Family Developmental Disabilities Support (DD) Waiver** DMAS and the Virginia Health Department child development clinics are authorized to screen individuals for the DD waiver.
- 6. Alzheimer's Assisted Living (AAL) Waiver** Local screening committees or teams 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. Documentation of the verbal assurance by the screeners must be included in the case record.
- 7. Day Support Waiver for Individuals with Mental Retardation (DS) Waiver** Local CSB and *DBHDS* case managers are authorized to screen individuals for the DS waiver. Final authorizations for DS waiver services are made by *DBHDS* staff.
- D. PACE** Local screening committees or teams and hospital screening committees or teams are authorized to screen individuals for PACE. If the individual is screened and approved for LTC, the committee/team will inform the individual about any existing PACE program that serves the individual's locality.

M1420.300 COMMUNICATION PROCEDURES

- A. Introduction** To ensure that nursing facility/PACE placement or receipt of Medicaid CBC services are arranged as quickly as possible, there must be prompt communication between screeners and eligibility staff.
- B. Procedures**
- 1. LDSS Contact** The LDSS agency should designate an appropriate staff member for screeners to contact. Local social services staff, hospital staff and DRS staff 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 initiated and completed.

Medicaid payment for CBC services cannot begin prior to the date the screener's certification form is signed and prior authorization of services for the individual has been given to the provider by DMAS or its contractor.

**1. Nursing
Facility/PACE**

Individuals who require care in a nursing facility or elect PACE will have a DMAS-96 signed and dated by the screener and the supervising physician.

The "Medicaid Authorization" section will have a number in the box that matches one of the numbers listed under the "Pre-admission Screening" section. These numbers indicate which of these programs was authorized. Medicaid payment of PACE services cannot begin prior to the date the DMAS-96 is signed and dated by the supervising physician and prior-authorization of services for the individual has been given to the provider by DMAS.

2. EDCD Waiver

Individuals screened and approved for the EDCD waiver must have a DMAS-96 signed and dated by the screener and the physician.

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.

3. Tech Waiver

Individuals screened and approved for the Tech Waiver will have either a DMAS-96 signed and dated by the screener and physician, or a Technology Assisted Waiver Level of Care Eligibility Form signed and dated by a DMAS representative.

**4. MR Waiver
Level of Care
Eligibility Form**

Individuals screened and approved for the MR waiver will have the MR Waiver Level of Care Eligibility Form signed and dated by the *DBHDS* representative. The MR Waiver Level of Care Eligibility Form will include the individual's name, address and the date of *DBHDS* approval.

**5. DS Waiver Level
of Care
Eligibility Form**

Individuals screened and approved for the DS waiver will have the DS Waiver Level of Care Eligibility Form signed and dated by the *DBHDS* representative. The DS Waiver Level of Care Eligibility Form will include the individual's name, address and the date of *DBHDS* approval.

**6. DD Waiver
Level of Care
Eligibility Form**

Individuals screened and approved for the DD waiver will have the DD Waiver Level of Care Eligibility Form signed and dated by a DMAS Health Care Coordinator. The form letter will include the individual's name, address and the date of approval for waiver services.

**D. Authorization for
LTC Services**

If the form is not available when placement needs to be made, verbal assurance from a screener or DMAS that the form approving long-term care will be mailed or delivered is sufficient to determine Medicaid eligibility as an institutionalized individual. However, the appropriate form must be received prior to approval and enrollment in Medicaid as an institutionalized individual.



COMMONWEALTH of VIRGINIA

Department of
Behavioral Health and Developmental Services
Post Office Box 1797
Richmond, Virginia 23218-1797

JAMES REINHARD
COMMISSIONER

Telephone (804) 786-3921
Voice/TDD (804) 371-8977
www.dbhds.virginia.gov

MR Waiver Level of Care Eligibility Form

Name: _____

Address: _____

City: _____ VA. Zip Code: _____

Date of Approval by *DBHDS*: _____

This person has met the level of care requirements for Medicaid waiver services and needs a Medicaid eligibility determination completed. This person is authorized to have eligibility determined using the special institutional rules.

DBHDS Representative: _____

Date: _____

Phone: _____



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www.dbhds.virginia.gov

DS Waiver Level of Care Eligibility Form

Name: _____

Address: _____

City: _____ VA. Zip Code: _____

Date of Approval by *DBHDS*: _____

This person has met the level of care requirements for Medicaid waiver services and needs a Medicaid eligibility determination completed. This person is authorized to have eligibility determined using the special institutional rules.

DBHDS Representative: _____

Date: _____

Phone: _____

Confidentiality Statement: This document contains confidential health information that is legally privileged. This information is intended only for the use of the individuals or entities listed above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of this document is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of this document.

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M1430 Changes

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TN #93	01/01/2010	Appendix 1, page 1
Update (UP) #1	07/01/2009	Appendix 1, page 1

List Of IMDs In Virginia

Catawba Hospital
P.O. Box 200
Catawba, VA 24070-0200

Central State Hospital
P.O. Box 4030
Petersburg, VA 23803-0030

(NOTE: Hiram Davis Medical Center is not an IMD)

Eastern State Hospital
4601 Ironbound Road
Williamsburg, VA 23188-2652

Northern Virginia Mental Health Institute
3302 Gallows Road
Falls Church, VA 22042-3398

Piedmont Geriatric Hospital
P.O. Box 427
Burkeville, VA 23922-0427

Southern Virginia Mental Health Institute
382 Taylor Drive
Danville, VA 24541-4023

Southwestern VA Mental Health Institute
340 Bagley Circle
Marion, VA 24354-3126

Western State Hospital
1301 Richmond Avenue
Staunton, VA 24402-2500

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M1440 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/2010	pages 14, 16
TN #91	05/15/2009	Table of Contents page 12 pages 17-18c

All recommendations are submitted to *Department of Behavioral Health and Developmental Services (DBHDS)* or DMAS staff for final authorization.

1. CSB

The CSB case manager may only recommend waiver services if:

- the individual is found Medicaid eligible; and
- the individual is mentally retarded, or is under age 6 and at developmental risk; and
- the individual is not an inpatient of a nursing facility or hospital.

2. DRS

The DRS 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 AIDS WAIVER

A. General Description

The AIDS waiver provides services to individuals with HIV infection to prevent hospitalization or nursing facility placement.

B. Targeted Population

The waiver services are for individuals with HIV infection, who have been diagnosed and are experiencing the symptoms associated with AIDS (Acquired Immunodeficiency Syndrome) or who are HIV positive and are symptomatic, and for whom the services provided through the waiver are expected to prevent placement in a hospital or nursing facility.

C. Eligibility Rules

Patients receiving AIDS waiver services must meet the non-financial and financial Medicaid eligibility criteria applicable to the other Medicaid covered groups and must be Medicaid-eligible in a medical institution. These individuals are considered as if they were institutionalized for the purpose of applying institutional resource and income rules.

The income limit used for this waiver is 300% of the current SSI payment standard for one person, or the medically needy (MN) income limit and spenddown.

D. Services Available

Services available under the AIDS Waiver include:

- case management
- nutritional supplements
- private duty nursing
- personal care
- respite care.

E. Assessment and Service Authorization

Status as an AIDS individual in need of CBC shall be determined by the pre-admission screener.

- nutritional supplements
- medical supplies and equipment not otherwise available under the Medicaid State Plan.

E. Assessment and Service Authorization

The initial assessment and development of the plan of care is conducted by DMAS staff.

The following entities are authorized to screen for the Technology-Assisted Individuals Waiver:

- DMAS Health Care Coordinator.

M1440.105 DAY SUPPORT WAIVER

A. General Description

The Day Support (DS) Waiver is targeted to provide home and community-based services to individuals with mental retardation who have been determined to require the level of care provided in an ICF/MR. These individuals may reside in an ICF/MR or may be in the community at the time of the assessment for DS Waiver services.

B. Targeted Population

Only those individuals on the urgent and non-urgent waiting lists for the MR Waiver are considered for DS Waiver services. Individuals may remain on the MR Waiver waiting list while receiving DS Waiver Services.

C. 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.

D. Services Available

Services available under the DS Waiver include:

- day support
- prevocational services

E. Assessment and Service Authorization

The individual's need for CBC is determined by the CSB or *DBHDS* case manager after completion of a comprehensive assessment. All recommendations are submitted to *DBHDS* staff for final authorization.

M1450 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/2010	Table of Contents pages 3, 17-18, 29 Appendix 2, page 1
TN #91	05/15/2009	pages 41, 42

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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

M1450.520 PURCHASE OF ANNUITY BEFORE FEBRUARY 8, 2006**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

The following policy applies to annuities purchased before February 8, 2006. Determine if the annuity is a countable resource using the policy in M1140.260. If the expected return on the annuity is commensurate with a reasonable estimate of the beneficiary's life expectancy, the annuity is actuarially sound and its purchase is a transfer of assets for fair market value.

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).

2. **Example #2** **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 LTC services payment.
3. **Example #3** **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.

M1450.530 PURCHASE OF ANNUITY ON OR AFTER FEBRUARY 8, 2006

A. Introduction

The DRA established new policy for evaluating the purchase of an annuity as an asset transfer. The policy applies to annuities purchased on or after February 8, 2006. A significant change made under the DRA is that 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. **The policy in this section applies to actions taken on applications, renewals and changes on or after July 1, 2006 for transfers made on or after February 8, 2006.**

B. Policy

All annuities purchased by an applicant/recipient or his spouse on or after February 8, 2006, must be declared on the Medicaid application or renewal form. 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 On/After Feb. 8, 2006**

An annuity purchased by the institutionalized individual or 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 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 On/After Feb. 8, 2006**

An annuity purchased by the institutionalized individual on or after February 8, 2006, 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,

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.

$$\begin{array}{r}
 \$ 500 \\
 \underline{\times 12} \text{ months} \\
 \$6,000 \text{ yearly income} \\
 \underline{\times 15.52} \text{ life expectancy from table} \\
 \$93,120 \text{ value} \\
 \underline{- 0} \text{ compensation} \\
 \$93,120 \text{ uncompensated value}
 \end{array}$$

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.

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	<i>Life Expectancy MALE</i>	<i>Life Expectancy FEMALE</i>	AGE	<i>Life Expectancy MALE</i>	<i>Life Expectancy FEMALE</i>
0	73.26	79.26	74	10.12	12.74
10	64.03	69.93	75	9.58	12.09
20	54.41	60.13	76	9.06	11.46
30	45.14	50.43	77	8.56	10.85
40	35.94	40.86	78	8.07	10.25
50	27.13	31.61	79	7.61	9.67
60	19.07	22.99	80	7.16	9.11
61	18.33	22.18	81	6.72	8.57
62	17.60	21.38	82	6.31	8.04
63	16.89	20.60	83	5.92	7.54
64	16.19	19.82	84	5.55	7.05
65	15.52	19.06	85	5.20	6.59
66	14.86	18.31	86	4.86	6.15
67	14.23	17.58	87	4.55	5.74
68	13.61	16.85	88	4.26	5.34
69	13.00	16.14	89	3.98	4.97
70	12.41	15.44	90	3.73	4.63
71	11.82	14.85	95	2.71	3.26
72	11.24	14.06	100	2.05	2.39
73	10.67	13.40	110	1.14	1.22

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M1460 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/2010	pages 28, 35
TN #91	05/15/2009	pages 23, 24

- 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.

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. In 2009 *and* 2010, up to \$1,640 per month, but not more than \$6,600 in a calendar year, of the earned income of a blind or disabled student 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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M1470 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/2010	pages 9, 13, 19-20, 23, 43, 44
TN #91	05/15/2009	Table of Contents pages 1-56 Appendix 1

prescription drug plan (PDP) with a “benchmark” premium. However, the individual may elect enrollment in a basic plan with a premium above the benchmark or in an enhanced plan, which offers additional benefits.

Individuals who enroll in a higher-premium basic plan or an enhanced plan are responsible for that portion of the premium attributable above the benchmark rate. When a full-benefit Medicaid enrollee is enrolled in a higher-premium PDP, the portion of the premium that remains the individual’s responsibility is an allowable deduction from patient pay.

The benchmark *Medicare Part D* premium for Virginia for 2010 is \$34.15.

6. 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 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.

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

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

a. Elderly or Disabled with Consumer-Direction (EDCD) Waiver, Mental Retardation (MR) Waiver, Technology-Assisted Individuals Waiver, Individual and Family Developmental Disabilities Support (DD) Waiver and Day Support (DS) Waiver

Patients receiving Medicaid CBC under the following waivers are allowed a monthly basic PMA:

- EDCD Waiver,
- MR Waiver,
- Technology-Assisted Individuals Waiver
- DD Waiver, and
- DS Waiver

The PMA is:

- *January 1, 2010 through December 31, 2010: \$1,112 (no change for 2010)*
- January 1, 2009 through December 31, 2009: \$1,112.

Contact a Medical Assistance Program Consultant for the PMA in effect for years prior to 2009.

b. AIDS Waiver

Patients under the AIDS waiver are allowed a monthly basic PMA that equals 300% of the SSI payment limit for one person (see M0810.002 A. 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 for representative payee or "power of attorney" fees or expenses.

- 3. Special Earnings Allowance for Recipients in EDCD, DD, MR or DS 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:
- 1) for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (\$2,022 *in 2010*) per month.
 - 2) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI (\$1,348 *in 2010*) per month.

- 4. Example - Special Earnings Allowance (Using January 2009 figures)**
- A working patient receiving EDCD waiver services is employed 18 hours per week. His income is gross earnings of \$928.80 per month and SSA of \$300 monthly. His special earnings allowance is calculated by comparing his gross earned income (\$928.80) to the 200% of SSI maximum (\$1,348.00). His gross earned income is less than 200% of SSI; therefore, he is entitled to a special earnings allowance. His personal maintenance allowance is computed as follows:

\$ 1,112.00	CBC basic maintenance allowance
+ 928.80	special earnings allowance
\$ 2,040.80	PMA

Because the PMA may not exceed 300% of SSI, the PMA for the patient in this example must be reduced to \$2,022.00.

- 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 income limit for the number of the patient's dependent children in each home.
 - 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.

For cash assistance and QMB (either just QMB or dually-eligible) enrollees, 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.

Do not deduct Medicare premiums in retroactive and ongoing coverage periods for the following recipients:

- SSI recipients,
- AG recipients,
- ABD 80% FPL recipients,
- IV-E cash assistance recipients,
- QMB eligible recipients (either dually-eligible or just QMB).

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 CNNMP 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 CNNMP. 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 Part D Premiums

The federal government sets a yearly "benchmark" premium for Medicare Part D Prescription Drug Plans (PDP). An individual who is eligible for Medicare and Medicaid is entitled to premium-free enrollment in a Medicare Part D basic prescription drug plan (PDP) with a "benchmark" premium. However, the individual may elect enrollment in a basic plan with a premium above the benchmark or in an enhanced plan, which offers additional benefits.

Individuals who enroll in a higher-premium basic plan or an enhanced plan are responsible for that portion of the premium attributable above the benchmark rate. When a full benefit Medicaid enrollee is enrolled in a higher-premium PDP, the portion of the premium that remains the individual's responsibility is an allowable deduction from patient pay.

The benchmark *Medicare Part D* premium for Virginia for 2010 is \$34.15.

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 NOT pay any of the individual'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. Follow the instructions in M1470.610 for calculating spenddown and patient pay when spenddown liability is less than or equal to the PACE rate (minus the Medicare Part D premium).

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 and LTC providers to exchange information.

B. Purpose

The DMAS-225 is available on SPARK at: http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi. The form is used to:

- notify the LTC provider of a patient's Medicaid eligibility status;
- reflect changes in the patient's income, resources or deductions;
- *notify a new provider that the patient pay is available through the verification systems;*
- document admission, death 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 MMIS 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.

M1470.900 ADJUSTMENTS AND CHANGES

A. Policy

The Medicaid recipient or his 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 must be completed following the procedures in 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.

M1480 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/2010	Table of Contents, page ii pages 3, 8b, 18, 18c, 20a pages 21, 31,50, 51, 66, pages 69, 70, 93 Appendix 4 was removed.
Update (UP) #1	07/01/2009	page 66
TN # 91	05/15/2009	pages 67, 68 pages 76-93

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 Maintenance Standards & AllowancesM1480.410..... 66
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APPENDIX

Medicaid Resource Assessment Request..... Appendix 1 1
 Medicaid Resource Assessment..... Appendix 2 1
 Notice of Medicaid Resource Assessment Appendix 3 1

- an amount transferred to the community spouse by the institutionalized spouse pursuant to a court spousal support order; or
- an amount designated by a DMAS Hearing Officer

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 30 or more days absence from a medical institution or 30 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].

- is in a nursing facility, or
- is screened and approved 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 screened and approved to receive nursing facility or Medicaid CBC services or within the month of application for Medicaid, whichever is later.

The following table contains examples that indicate when an individual is treated as an institutionalized individual for the purposes of the resource assessment:

Screened and Approved 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 institutionalization	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.

The Medicaid Technicians in the *Department of Behavioral Health and Developmental Services (DBHDS)* facilities are responsible for processing a married patient's request for a resource assessment without a Medicaid application, and for processing the patient's Medicaid application.

3. The applicant has assigned to DMAS, to the full extent allowed by law, all claims he or she may have 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.

B. Procedures

1. Assisting the Applicant

The EW 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 file. Refer to Section B below.

If the applicant locates the separated spouse, the EW 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 file. Refer to Section 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 EW must document the record and deny the application due to failure to verify resources held at the beginning of institutionalization.

b. Undue hardship claimed:

If the applicant claims an undue hardship, he must provide a written statement requesting an undue hardship evaluation. The applicant or his representative must make an effort to locate and contact the estranged spouse or provide documentation as to why this is not possible. Contact or action to locate the estranged spouse by the EW alone is not sufficient to complete the undue hardship evaluation. When it is reported that the applicant has a medical condition that prevents participation in the process, then a physician's statement must be provided documenting the medical condition.

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 he reapplies as an institutionalized individual, use only the resources of the institutionalized spouse for his eligibility determination.

C. Institutionalized Spouse Resource Eligibility Worksheet Use the “Institutionalized Spouse Resource Eligibility Worksheet,” available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi, or the electronic Resource Assessment and Eligibility Workbook located at http://www.vcu.edu/vissta/bps/bps_resources/ltc_medicaid.htm to determine the institutionalized spouse’s resource eligibility.

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 \$21,912 *1-1-10 (no change for 2010)*
 \$21,912 1-1-09

C. Maximum Spousal Resource Standard \$109,560 *1-1-10 (no change for 2010)*
 \$109,560 1-1-09

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.

**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, 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.

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: (Use the “Institutionalized Spouse Resource Eligibility Worksheet,” available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi or the electronic Resource Assessment and Eligibility Workbook located at http://www.vcu.edu/vissta/bps/bps_resources/ltc_medicaid.htm).

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.

Step 2: $\$130,000 \div 2 = 65,000$. 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 (court-ordered spousal support resource amount or DMAS hearing decision 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).

a. Not Eligible In Initial Eligibility Determination Period

If the institutionalized spouse is NOT eligible after deducting the spousal PRA from the couple's total resources, DO NOT USE this section. Go to section M1480.250 below when resources exceed the limit.

b. Eligible In Initial Eligibility Determination Period

When the institutionalized spouse's countable resources (as calculated in section M1480.232 above) are within the Medicaid resource limit, calculate the CSRA using the policy and procedures in section M1480.241.

2. Subsequent Application

a. Medicaid Eligibility Never Established

If an individual has applied before but never established Medicaid eligibility as an institutionalized spouse and is NOT eligible in the initial eligibility determination period, DO NOT USE THIS SECTION. Go to section M1480.250 below.

b. Medicaid Eligibility Established Previously

Once an institutionalized spouse has established initial 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.

When determining the institutionalized spouse's eligibility based on any application made after having previously established Medicaid eligibility as an institutionalized individual, 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 in the application month and the application's retroactive month(s). **Do not calculate a CSRA; there is no protected period of eligibility. Go to section M1480.255 below.**

M1480.241 CSRA CALCULATION PROCEDURES

A. Worksheet

Use the "Institutionalized Spouse Resource Eligibility Worksheet," available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi or the electronic Resource Assessment and Eligibility Workbook located at http://www.vcu.edu/vissta/bps/bps_resources/lrc_medicaid.htm to determine countable resources and the CSRA.

B. 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.

C. Determine Institutionalized 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

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.

M1480.310 300% SSI AND ABD 80% FPL 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 300% SSI covered group. If the individual is ineligible in the 300% SSI covered group due to excess resources, determine the individual's eligibility in the ABD 80% FPL covered 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."

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.

M1480.315 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 Long-term Care, 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 on MMIS. The insurance policy type is "H" and the coverage type is "N." When entered in MMIS on the TPL system, MMIS 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 nursing facility. If the patient cannot do this, or the policy prohibits assignment, the 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 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

After eligibility is established, the usual reporting and notification processes apply. Send the “Notice of Action on Medicaid” for the month(s) during which the individual establishes Medicaid eligibility. *MMIS will generate the “Notice of Obligation for LTC Costs” and it will be sent to the individual or his authorized representative.*

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 LTC 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 Standard**

\$1,821.25	7-1-09	
\$1,750.00	7-1-08	
- C. Maximum Monthly Maintenance Needs Allowance**

\$2,739.00	<i>1-1-10 (no change for 2010)</i>	
\$2,739.00	1-1-09	
- D. Excess Shelter Standard**

\$546.38	7-1-09	
\$525.00	7-1-08	
- E. Utility Standard Deduction (SNAP)**

\$141	1 - 3 household members	10-1-09
\$381	4 or more household members	10-1-09
\$290	1 - 3 household members	10-1-08
\$365	4 or more household members	10-1-08

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 his patient pay (post-eligibility treatment of income).

\$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

Deduct the appropriate maintenance allowance for one person as follows:

- 1) For the Elderly or Disabled with Consumer Direction Waiver (EDCD Waiver), Mental Retardation (MR) Waiver, Technology-Assisted Individuals Waiver, Individual and Family Developmental Disabilities Support (DD) Waiver, Day Support (DS) Waiver or PACE:

- January 1, 2010 through December 31, 2010: \$1,112 (no change for 2010).
- January 1, 2009 through December 31, 2009: \$1,112.

Contact a Medical Assistance Program Consultant for the SSI amount in effect for years prior to 2009.

- 2) For the AIDS Waiver: the personal maintenance allowance is equal to 300% of the SSI limit for one person (\$2,022).

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.

NOTE: The guardianship filing fees CANNOT be deducted from the individual's income.

c. Special Earnings Allowance For EDCD, DD, DS and MR Waivers

[EXAMPLE #19 was deleted]

For EDCD, DD, DS and MR 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 (\$2,022 *in 2010*) per month.
- b) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI (\$1,348 *in 2010*) 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 MR 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

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. 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.

M1510 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/2010	page 6
Update (UP) #2	08/24/2009	page 11
TN #91	05/15/2009	page 14

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 a medically indigent Qualified Medicare Beneficiary (QMB) begins the first day of the month **following** the month in which the individual's QMB eligibility is determined.
3. **SLMB and QDWI** Ongoing entitlement for the Special Low Income Medicare Beneficiary (SLMB) and the Qualified Disabled and Working Individuals (QDWI) MI 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 21-64 Is Admitted To Ineligible Institution** An applicant who is age 21-64 years and who is admitted to an IMD or other ineligible institution (such as a jail) in a month is NOT eligible for Medicaid while he is a patient in the IMD (or is residing in the ineligible institution). If otherwise eligible for Medicaid in the application month, his entitlement to Medicaid begins the date he is discharged from the ineligible institution in the month.

EXAMPLE #6: Mr. A is a 50 year old man who applies for Medicaid at his local agency on October 1, 2006. He receives Social Security disability benefits. He was admitted to Central State Hospital (an IMD) on October 20, 2006, and was discharged on November 2, 2006, back to his home locality. The agency completes the Medicaid determination on November 5 and finds that he is eligible for Medicaid in October 2006 and ongoing, except for the period of time he was in Central State Hospital.

The worker enrolls him in Medicaid for a closed period of coverage beginning October 1, 2006, and ending October 20, 2006. The worker also enrolls him in an ongoing period of Medicaid coverage beginning November 2, 2006.

5. **Applications From CSBs For IMD Patients Ages 21-64 Years** A patient who is age 21 years or older but is less than 65 years and who is in an institution for treatment of mental diseases (IMD) is not eligible for Medicaid while in the IMD. Local agencies will take the **applications received from the CSBs** for *Department of Behavioral Health and Developmental Services (DBHDS)* IMD patients who will be discharged within 30 days and process the applications within the established time frames. 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.

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 #6a: Mr. A is a 50 year old patient at Central State Hospital (an IMD). He receives Social Security disability benefits. The CSB sends

M1520 Changes

Changed With	Effective Date	Pages Changed
TN #93	1/01/2010	pages 3, 4b, 5-6, 10, 15 pages 21, 22
Update (UP) #2	08/24/09	pages 1, 2, 13, 14, 17, 18
Update (UP) #1	07/01/09	page 3

**D. Covered Group
Changes**

1. Newborn Child

When a child is born to a Medicaid-eligible woman (**including an emergency services alien certified for Medicaid payment for labor and delivery**), the only information needed to enroll the child in Medicaid (Child Under One covered group) is the child's name, gender and date of birth.

This information may be reported through any reliable means, such as the hospital where the child was born, the medical practitioner, or the mother's managed care organization. The agency may **not** require that only the mother make the report.

An eligibility determination for a child born to a Medicaid eligible pregnant woman (including an emergency services alien certified for Medicaid payment for labor and delivery) is not required until the month in which the child turns one year old, unless there is an indication that the child no longer meets the Virginia residency requirements in M0230. If the child continues to reside in Virginia, an application and an eligibility determination must be completed prior to MMIS cut-off in the month the child turns one year old.

**2. Child Turns
Age 6**

When a child who is enrolled as an MI child turns age 6, the child's Aid Category (AC) in MMIS will automatically be changed to 092 or 094. No action is required when the child is enrolled as AC 092. If the child is enrolled as AC 094, a partial review must be completed to determine if the child has creditable health insurance coverage. If the child does not have creditable health insurance, no additional action is required. If the child has creditable health insurance, the eligibility worker must cancel the child's enrollment in AC 094 effective the end of the month and reinstate coverage in AC 092 effective the first day of the following month. **Do not use change transactions to move a child to or from AC 094.**

**3. SSI Medicaid
Enrollee
Becomes a
Qualified
Severely
Impaired
Individual
(QSII) –
1619(b)**

When an SSI Medicaid enrollee loses eligibility for an SSI money payment due to receipt of earned income, continued Medicaid eligibility under the Qualified Severely Impaired Individual (QSII) -1619(b) covered group may exist. A partial review to determine the individual's 1619(b) status via the State Verification Exchange System (SVES) must be completed. . *If SVES is not available or the worker requires immediate verification to expedite the case, the State Online Query-Internet system (SOLQ-I) can be used instead of SVES.*

To identify a 1619(b) individual, check the "Medicaid Test Indicator" field on the SOLQ-I or SVES screen. If there is a code of A, B, or F, the individual has 1619(b) status. The eligibility worker must change the AC to the appropriate AC.

complete them for another program under which he is receiving benefits.

These forms are available on the intranet at:

<http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.

**B. Renewal
Requirements and
Time Standard**

The agency must make all reasonable efforts to obtain relevant information from Medicaid files and other sources (subject to confidentiality requirements) in order to conduct eligibility renewals.

An evaluation of the information used to determine continued eligibility must be completed and included in the case record. The enrollee must be informed of the findings of the renewal and the action taken using the Notice of Action when continued eligibility exists. The Advanced Notice of Proposed Action must be used when there is a reduction of benefits or termination of eligibility. Renewals must be completed prior to cut-off in the 12th month of eligibility.

**1. Ex Parte
Renewal Process**

The agency must utilize on-line systems information verifications that are available to the agency without requiring verifications from the individual or family and make efforts to align renewal dates for all programs. The agency has ready access to *Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps)* and TANF records, some wage and payment information, information from SSA through the SVES, SDX and Bendex, and child support and child care files.

The enrollee is not required to complete and sign a renewal form when all information necessary to redetermine Medicaid eligibility can be obtained through an ex parte renewal process.

**2. Income
Verification
Required**

Income verification no older than 6 months old may be used unless the agency has reason to believe it is no longer accurate. It is not necessary to retain a copy of verifications of income in the case record. If a copy is not retained, the worker must document the date and method used to obtain the information (viewed, telephone call, etc.), the type of verification, the source and a description of the information.

When the enrollee has reported that he has no income (\$0 income), the enrollee must be given the opportunity to report income on a renewal form. Do not complete an ex parte renewal when the enrollee has reported \$0 income.

3. **Renewal For SSI Recipient** The renewal for an SSI recipient who has no countable real property can be completed by verifying continued receipt of SSI through SVES and documenting the case record. The ex parte process cannot be used for an SSI recipient who owns non-exempt real property. He is subject to a resource evaluation and the agency has no internal means to verify all his resources.

4. **Coordination With Other Benefit Programs** When an ongoing F&C Medicaid enrollee applies for *SNAP* or TANF, the income information obtained for the application can be used to complete an early Medicaid renewal and extend the Medicaid renewal to coincide with the Food Stamp certification period. However, failure to complete an early renewal must not cause ineligibility for Medicaid.

5. **Medicaid Renewal Form Required** When a Medicaid renewal form is required, the form must be sent to the enrollee no later than the 11th month of eligibility. The Medicaid Renewal form can be completed by the worker and sent to the enrollee to sign and return or can be mailed to the enrollee for completion. The eligibility worker must allow at least 10 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 verification must be documented.

If information necessary to redetermine eligibility is not available through on-line information systems available to the agency and the enrollee has been asked, but failed to provide the information, the renewal must be denied and the coverage cancelled due to the inability to determine continued eligibility.

6. **SSN Follow Up** If the enrollee's SSN has not been assigned by renewal, the worker must obtain the enrollee's assigned SSN at renewal in order for Medicaid coverage to continue. See subchapter M0240 for detailed procedures for obtaining the SSN.

C. Special Requirements for Certain Covered Groups

1. **Pregnant Woman** *Do not initiate a renewal of eligibility of an MI pregnant woman, or a pregnant woman in any other covered group, during her pregnancy. Eligibility in a pregnant woman covered group ends effective the last day of the month in which the 60th day following the end of her pregnancy occurs.*

When eligibility *in a pregnant woman covered group* ends, 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.

If the woman does not meet the definition and/or the income requirements for another full-benefit covered group, she may be eligible for the limited benefit family planning services covered group, Plan First. *If the worker manually cancels the pregnant woman's Medicaid coverage before cut-off in the 60th-day month, a Plan First Brochure or a Plan First Fact Sheet,*

available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>, must be included with the Advance Notice of Proposed Action. Eligibility for Plan First is not determined unless the woman submits a Plan First application.

Do not use change transactions to move an individual between full and limited coverage.

2. Plan First (FPS) Review Requirements

Effective January 1, 2008, a Plan First application/renewal form must be filed for individuals (men and women) who request Medicaid coverage for family planning services only (see M0320.302). The application/renewal form is available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.

The ex parte renewal process cannot be used for this covered group.

3. Newborn Child Turns Age 1

An application for a child enrolled as a Newborn Child Under Age 1 must be filed before MMIS cut-off in the last month in which the child meets the Newborn Child Under Age 1 covered group and must include:

- an application (see M0120.300)
- verification of citizenship and identity
- SSN or proof of application
- verification of income
- verification of resources for the MN child.

4. Child Under Age 19 (FAMIS Plus)

Eligibility of children in the MI Child Under Age 19 (FAMIS Plus) covered group must be renewed at least once every 12 months.

When an enrolled FAMIS Plus child no longer meets the MI income limits, evaluate the child for the Family Access to Medical Insurance Security Plan (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.

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 prior to sending an advance notice and canceling the child's Medicaid coverage.

5. 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. *If SVES is not available or the worker requires immediate verification to expedite the case, the State Online Query-Internet system (SOLQ-I) can be used instead of SVES.* If the child does not receive SSI, complete a referral to Disability Determination Services (DDS) following the procedures in M0310.112. The referral to DDS should be made at least 90 calendar days prior to the child's 19th birthday.

2. Death of Recipient

The eligibility worker must take the following action when it is determined that an enrollee is deceased:

- If the enrollee has an SSN, the worker must verify the date of death. The worker must run a SVES request to verify the date of death. SVES will display an “X” and the date of death in the “SSN VERIFICATION CODE” field on Screen 1. If the individual receives Social Security (Title II) payments or Supplemental Security Income, *and SVES is not available or the worker requires immediate verification to expedite the case, the State Online Query-Internet system (SOLQ-I) can be used instead of SVES.*
- If the recipient does not have an SSN, or if SOLQ-I or SVES does not return information showing that the recipient is deceased, contact the parent/caretaker relative or authorized representative to obtain the date of death. Information from a medical professional/facility is also acceptable.
- The worker must document the case file. 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 coverage in MMIS using cancel code “001.” The effective date of cancellation is the date of death.

3. 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.

M1520.402 CANCELLATION ACTION OR SERVICES REDUCTION

A. Introduction

1. MMIS Transaction

An enrollee’s coverage must be canceled in MMIS prior to the date of the proposed action. The change to the MMIS enrollee file must be made after system cut-off in the month the proposed action is to become effective. For example, if the Notice of Action specifies the intent to cancel coverage on October 31, a change to MMIS is made prior to cut-off in October.

In the event the proposed action is not taken, the enrollee’s coverage must be immediately reinstated. If the enrollee files an appeal prior to the proposed date of action, the DMAS Appeals Division will notify the agency if the enrollee’s coverage should be reinstated.

For family members who are not eligible for Medicaid or FAMIS-FAMIS MOMS, **send the Advance Notice of Proposed Action** and cancel Medicaid effective the last day of the twelfth month.

If any of the ineligible family members meet a medically needy covered group definition, send an Application for Benefits to the family giving them the opportunity to apply for spenddown.

M1520.600 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 applicant/recipient 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.
- B. DBHDS Facilities** The procedures for transfer of Medicaid cases of ABD patients admitted to or discharged from *Department of Behavioral Health and Developmental Services (DBHDS)* facilities are in subchapter M1550. F&C cases are not transferred to the *DBHDS* facilities.
- C. Cases From DMAS FAMIS Plus Unit FIPS 976** The Medicaid cases approved by the DMAS FAMIS Plus Unit, FIPS 976, must be transferred to the local department of social services (LDSS) where the recipient lives. Medicaid cases are **not** transferred from local agencies **to** the DMAS FAMIS Plus Unit (FIPS 976).
- 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 DMAS FAMIS Plus Unit.
 - 2. Review Eligibility** LDSS workers must review (partial review) the Medicaid eligibility determination for cases transferred from the DMAS FAMIS Plus Unit and must take any necessary corrective action.
 - 3. Corrective Action** If an eligibility error(s) is found or the case is overdue for renewal, do not send the case back to the DMAS FAMIS Plus Unit. 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 DMAS FAMIS Plus Unit supervisor.
 - 4. Eligible for FAMIS or FAMIS MOMS** If the LDSS re-evaluation of the case's Medicaid eligibility results in Medicaid ineligibility, but some or all case members are eligible for FAMIS or FAMIS MOMS, follow the case transfer procedures in Chapter M2140 E.

- E. 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) or the workers at Medical College of Virginia (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.
- F. 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. Case Renewal Cannot Be Overdue**

The sending locality must make certain the 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 annual renewal is due in the month the LDSS plans to transfer the case or the following month, the renewal must be completed before transferring the case.

Exception: When the Medicaid case is in ADAPT and *SNAP* is active in the ADAPT case, the *SNAP* case transfer rules override the Medicaid policy that the Medicaid renewal cannot be overdue. The ADAPT case must be transferred immediately to the new locality, even if the Medicaid renewal is overdue, due in the transfer month or due in the following month to comply with the *SNAP* case transfer rule.
 - b. When Renewal Must Be Completed Before Transferring**

If the sending LDSS must complete the renewal before transferring the case, the Sending LDSS must keep the case record to complete the renewal.

The sending locality must update the enrollees' MMIS records as follows to assure managed care continuity:

CHAPTER M15

ENTITLEMENT POLICY & PROCEDURES

SUBCHAPTER 50

***DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL
DISABILITIES (DBHDS) FACILITIES***

M1550 Transmittal Changes

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TN #93	01/01/2010	Title page Table of Contents pages 1-9 Appendix 1, page 1
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M1550.000 DBHDS FACILITIES

M1550.100 GENERAL PRINCIPLES

- A. Introduction** The Department of Social Services' Division of Benefit Programs has five eligibility workers, called Medicaid Technicians, located in four *Department of Behavioral Health and Developmental Services (DBHDS)* facilities to determine the patients' eligibility for Medicaid. The Medicaid Technicians function like a local department of social services (LDSS) agency. Medicaid cases may be transferred to and from the Medicaid Technicians.
- B. Procedures** This subchapter contains a list and a brief description of the *DBHDS* facilities (M1550.200), a directory of the Medicaid Technicians (M1550.300, and procedures for handling cases of Medicaid applicants/recipients admitted to or discharged from a *DBHDS* facility (M1550.400).

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. Training Centers** Training centers are medical facilities for patients diagnosed as mentally retarded (institutions for the mentally retarded). Training centers provide either or both intermediate and skilled nursing care. Some patients receiving intermediate care may be employed and have earned income.
- Normally, patients in the training centers are disabled, but some are children who have not been determined disabled. Patients of any age in a training center may be Medicaid eligible if they meet all nonfinancial and financial Medicaid eligibility requirements.
- The State training centers and locations are:
- Central Virginia Training Center (CVTC) – Madison Heights
 - Southside Virginia Training Center (SSVTC) – Petersburg
 - Northern Virginia Training Center (NVTC)– Fairfax
 - Southeastern Virginia Training Center (SEVTC) – Chesapeake
 - Southwestern Virginia Training Center (SWVTC) – Hillsville
- 2. Psychiatric Hospitals** Psychiatric hospitals are medical facilities – institutions for the treatment of mental diseases – 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.

Patients in psychiatric hospitals may be Medicaid eligible only if 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.

The following are psychiatric hospitals, offering differing levels of care:

- a. Eastern State Hospital – Williamsburg
- b. 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.

M1550.300 MEDICAID TECHNICIANS

The Medicaid Technicians share responsibilities for the *DBHDS* facilities assigned to their caseloads. See M1550, Appendix 1, for the chart listing the Medicaid Technicians, their supervisor, addresses, telephone numbers and caseload assignment.

M1550.400 CASE HANDLING PROCEDURES

- A. Introduction** Effective July, 1994, the Aged, Blind or Disabled (ABD) Medicaid cases handled by local departments of social services and cases of patients in *DBHDS* facilities will be transferred between the facility and the local DSS agency when the individual leaves a community to enter a *DBHDS* facility or leaves the *DBHDS* facility to live in a community. Case transfer policy in M1520.600 is applicable.

NOTE: Transfer procedures are applicable only to individuals who are eligible in an ABD covered group. The Medicaid case of a child eligible in a Families and Children (F&C) covered group who is a patient in a *DBHDS* facility is the responsibility of the local department of social services (LDSS) in which the child last resided. If the child is not currently a Medicaid recipient, an application for Medicaid may be made with the LDSS in the locality in which the child last resided.

Persons between the ages of 21 (or 22 if treatment began before age 21) and 65 are not eligible for Medicaid while they are patients in an institution for treatment of mental diseases (IMD) or tuberculosis.

- B. Procedures** Use the policy and procedures contained in the subchapters below when an individual is:

- admitted to a *DBHDS* facility (M1550.401),
- discharged from a *DBHDS* facility to a community living arrangement (M1550.402),
- discharged from a *DBHDS* facility to an assisted living facility (ALF) (M1550.403), and
- discharged from a *DBHDS* facility to a nursing facility or Medicaid Community-based Care (CBC) waiver services (M1550.404).

M1550.401 ADMISSION TO *DBHDS* FACILITIES

- A. Introduction** When a Medicaid recipient is admitted to a *DBHDS* facility from a community living arrangement, follow the procedures in this section. The procedures for an ABD recipient differ from those for an F&C recipient

B. Local Social Services

- 1. ABD Recipient** When an ABD recipient has been admitted to a *DBHDS* facility, the eligibility worker must determine if it is appropriate to transfer the case. Do not transfer the Medicaid case of an individual between the ages of 21 and 65 if the individual is admitted to an IMD since he or she cannot be Medicaid eligible while in the institution. The Medicaid case of such an individual must be closed.

- 1. Pending Case in MEDPEND**

If a pending case is found in MEDPEND, contact the local agency shown holding the case. Advise them that the recipient is now a patient in the facility and request that the pending case be transferred immediately, since an eligibility determination must be made within 45/90 days. When a determination is completed, notify the agency according to policy. Send the Notification of Action on Medicaid to the Reimbursement office and a copy of the notice to the patient's authorized representative.
- 2. Active Case in MMIS**

If an active case is found in MMIS, follow-up 30 days from the date the patient entered the facility. Contact Medical Records to determine if the patient is still in the facility.

 - a. If so, ask the EW in the LDSS holding the case to transfer the case.
 - b. If the patient has left the facility at the time of the 30 day follow-up, advise the EW of that information; return the DMAS-225 to Reimbursement indicating that patient's eligibility must be determined by the local agency because the patient was not in the facility for 30 days.
- 3. Transfer Case Received**

When an active case is received in transfer, a full redetermination must be done in order to determine if the patient continues to be eligible for Medicaid based on his or her current status using policy for institutionalized ABD individuals. After the redetermination is completed, update the MMIS and send appropriate notification according to policy. Send appropriate notice to Reimbursement office and a copy to the patient's authorized representative.
- 4. No Pending or Active Case**

If neither a pending application nor an active Medicaid case is found, open a case using a completed Application for Benefits submitted by the Reimbursement Office on behalf of the patient.

 - a. If a case number is found in MEDPEND or MMIS, use that case number to establish the hospital case.
 - b. If no case number is found in MEDPEND or MMIS, but there is an inactive case in the facility, use the facility case number.
 - c. Send all notification required by policy to Reimbursement with a copy to the authorized representative for the patient.
- 5. Patient Discharged**

If the patient is discharged before spending 30 days in the facility and the application is received after discharge, immediately forward the case to the appropriate local DSS agency for processing.

M1550.402 PATIENTS DISCHARGED FROM *DBHDS* FACILITIES

A. Introduction

When a Medicaid recipient in a *DBHDS* facility will be discharged from the facility, follow the procedures in the following sections:

- for patients discharged to a community living arrangement, see this section M1550.402;
- for patients discharged to an assisted living facility (ALF), see section M1550.403;
- for patients discharged to a nursing facility, see section M1550.404.

B. *DBHDS* Discharge Planner/Social Worker/Reimbursement

For Medicaid patients who do not receive SSI, contact the Social Security Administration (SSA) within 15 days of discharge to apply for SSI. If a patient's SSI has been decreased while in the institution, advise SSI of the patient's discharge so that, if appropriate, his or her SSI may be increased.

Medicaid cases of patients discharged to a living arrangement which is not an assisted living facility (ALF) or nursing facility will be transferred to the LDSS in which he or she will be living.

C. Reimbursement Office

Send the DMAS-225 to the Medicaid Technician and DMAS to advise of the date the patient will leave the facility.

D. Medicaid Technician

The Medicaid case of a Medicaid enrollee discharged to a living arrangement which is not an ALF or nursing facility will be transferred to the LDSS in the locality where he or she will be living.

Do a desk review of all cases to be transferred to an LDSS, **but do NOT determine if the recipient will be eligible in the locality.**

Update the MMIS. Enter the new city/county code on the case, new address, and change worker number to M0000.

Forward the case containing all original Medicaid information, any verification provided by discharge planner and/or Reimbursement office, and the DMAS-225, via certified mail to the appropriate LDSS.

E. Eligibility Worker in LDSS

When the case is received, do a full redetermination to determine the recipient's continued eligibility for Medicaid in his or her new circumstances.

Send the Case Record Transfer Form to the Medicaid Technician to notify the Technician of disposition of the transfer.

M1550.403 PATIENTS DISCHARGED TO ALF

- A. Introduction** When a patient in a *DBHDS* facility will be discharged to an assisted living facility (ALF), follow the procedures in this section.
- B. *DBHDS* Discharge Planner/Social Worker/Reimbursement**
- 1. Medicaid Patient Discharge to ALF**
- For patients being discharged to an ALF who are Medicaid eligible in the *DBHDS* facility, complete an Application For Benefits to apply for Auxiliary Grants (AG) and a Uniform Assessment Instrument. Attach copies of any verifications, a copy of the Community Placement Plan, the DMAS-225 and the DMAS-96. Send the completed forms to the LDSS immediately.
- The Discharge Planner should not request information from the Medicaid case, but should complete the Application For Benefits providing the latest information available on the patient. The Medicaid Technician should also be given a copy of the Community Placement Plan and the DMAS-225 for the Medicaid case.
- The Medicaid Technician will transfer the Medicaid case to the LDSS. However, the AG application form should be sent immediately to the appropriate LDSS in order to expedite processing, with a note that the patient's Medicaid case is being transferred to them. **The application must be received by the LDSS in the month of the patient's entry to the ALF in order for an AG payment to be made for that month, if eligible; no retroactive payments are made for AG.**
- 2. Patient Not On Medicaid, Discharged to ALF**
- For patients being discharged to an ALF who are not Medicaid eligible in the *DBHDS* facility, but for whom a AG/Medicaid application needs to be pursued, complete an Application For Benefits providing the latest known information on the patient, and a UAI. Attach copies of any verifications available, a copy of the Community Placement Plan, the DMAS-225 and the DMAS-96.
- Applications for patients being discharged to an ALF must be sent to the LDSS in the locality in which the patient last resided prior to entering the *DBHDS* facility. If admission to the *DBHDS* facility was from the out of state but the patient intends to remain in Virginia, the application must be sent to the LDSS in the Virginia locality in which the ALF is located. **Do not send any information to the Medicaid Technician located in the *DBHDS* facility.**
- The application must be received by the LDSS in the month of the patient's entry to the ALF in order for payment to be made for that month, if eligible; there are no retroactive payments made for AG.**

C. Medicaid Technician

Do a desk review of all cases to be transferred to a LDSS, **but do NOT determine if case will be eligible in the locality.** Update the MMIS. Enter new city/county code, new address, and change worker number to M0000.

Forward the case containing all original Medicaid information, any verifications provided by discharge planner/Reimbursement office, and DMAS-225, via certified mail to the appropriate LDSS.

D. Eligibility Worker in LDSS

When the case is received, do a full redetermination to determine the recipient's continued eligibility for Medicaid and, if appropriate, eligibility for Auxiliary Grants, in his or her new circumstances. Send the Case Record Transfer Form to the Medicaid Technician to notify the Technician that the case was received by the agency.

M1550.404 PATIENTS DISCHARGED TO NURSING FACILITY/CBC

A. Introduction

When a patient in a *DBHDS* facility will be discharged to a nursing facility or to a community living arrangement with Medicaid CBC waiver services, follow the procedures in this section.

B. DBHDS Discharge Planner/ Social Worker/ Reimbursement

1. Patient Not On Medicaid

If the patient was not Medicaid-eligible in the *DBHDS* facility but Medicaid eligibility in the patient's new circumstances needs to be determined, the Discharge Planner, Social Worker, Reimbursement, patient or the patient's authorized representative may complete an Application For Benefits and send it to the appropriate LDSS.

Applicants for patients being discharged to a nursing facility must be sent to the LDSS in the locality in which the patient last resided prior to entering the *DBHDS* facility. If admission to the *DBHDS* facility was from out of state but the patient intends to remain in Virginia, the application form must be sent to the Virginia locality in which the nursing facility is located.

Applications for patients being discharged to a community living arrangement with Medicaid CBC waiver services must be sent to the locality in which the patient will reside.

2. Medicaid Patient

If the patient was Medicaid eligible in the facility, provide the Medicaid Technician a copy of the Community Placement Plan, the DMAS-225 and any other information necessary to transfer the Medicaid case record.

C. Reimbursement Office

Send the DMAS-225 to the Medicaid Technician and DMAS to advise them of the date the patient will leave the facility.

D. Medicaid Technician

The Medicaid case of an eligible individual discharged to a nursing facility or CBC will be transferred to the LDSS in the locality in which he or she last resided outside of an institution.

Do a desk review of the case to be transferred to the LDSS. Update the MMIS with the new city/county code, new address, and change the worker number to M0000.

Forward the case containing all original Medicaid information, any verification provided by the discharge planner and/or Reimbursement office, and the DMAS-225, via certified mail to the appropriate LDSS. Note on the Case Transfer Form that this case is a nursing facility or CBC waiver case so that the receiving agency will be alerted to take immediate action.

E. Eligibility Worker in LDSS

When the case is received, do a full redetermination to determine the recipient's continued eligibility for Medicaid in his or her new circumstances.

Send the Case Record Transfer Form copy to the Medicaid Technician to notify the Technician that the case was received by the agency.

**DBHDS Facilities
Medicaid Technicians**

NAME	LOCATION	WORK TELEPHONE	CASELOAD
Brenda Wolhfert, Supervisor (T006)	Central Virginia Training Center Medicaid Office Madison Heights, VA Mail to: P. O. Box 1098 Lynchburg, VA 24505	434-947-2754 cell 434-906-0024	CVTC-caseload-A-H
Mary Lou Spiggle (T003)	Central Virginia Training Center Medicaid Office Madison Heights, VA Mail to: P. O. Box 1098 Lynchburg, VA 24505	434-947-6256	CVTC-caseload-I-Z PGH-caseload-all WSH-caseload-all NVMHI-caseload-all SVMHI-caseload-all
Debra J. Quesenberry (T002)	Catawba Hospital Medicaid Office P. O. Box 200 Catawba, VA 24070	540-375-4350	Catawba-caseload-all NVTC-caseload-all Hiram Davis-caseload-all
Frances Jones (T004)	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0841	SWVTC-caseload-all ESH-caseload-A-J SSVTC-caseload-A-J
Vickie C. Simmons (T005)	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0842	SEVTC-caseload-all ESH-caseload-K-Z SSVTC-caseload-K-Z SWVMHI-caseload-all

NOTE: Because the Medicaid Technicians handle various hospitals in their caseloads, LDSS staff should send transferred case records directly to the Medicaid Technician who requested the case record. In the case record transfer request, the Medicaid Technician will give specific instructions about where to send the case record.

DBHDS Facilities:

FIPS	Facility Initials and Full Name
997	Catawba – Catawba Hospital
990	CVTC – Central Virginia Training Center
994	ESH – Eastern State Hospital
988	NVMHI – Northern Virginia Mental Health Institute
986	NVTC – Northern Virginia Training Center
993	PGH – Piedmont Geriatric Hospital
985	SEVTC – Southeastern Virginia Training Center
989	SSVTC – Southside Virginia Training Center
983	SVMHI – Southern Virginia Mental Health Institute
992	SWVMHI – Southwestern Virginia Mental Health Institute
984	SWVTC – Southwestern Virginia Training Center
991	WSH – Western State Hospital
996	Hiram Davis Medical Center

M17 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/2010	page 3

3. Suspected Fraud Involving Recipients of Public Assistance **a. Temporary Assistance for Needy Families (TANF) and Auxiliary Grant (AG) Cases**

Cases of suspected fraud involving ineligibility for a TANF or AG payment are the responsibility of the local department of social services. The local agency determines the period of ineligibility for Medicaid, and the DMAS Recipient Audit Unit provides the amount of Medicaid payments made. The amount of misspent Medicaid funds must be included in the TANF or AG fraud cases, whether the action results in prosecution or in voluntary restitution. The final disposition on all money payment fraud cases must be communicated to the Recipient Audit Unit, DMAS, no later than 5 business days after disposition for inclusion in federal reporting.

b. SNAP, General Relief (GR), Fuel, etc.

For suspected fraud involving *the Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps)*, GR, Fuel, or other such assistance which does not directly relate to the provision of Medicaid, the local agency must notify the Recipient Audit Unit of the agency's action on the other assistance case so that Medicaid can take concurrent action if necessary.

C. Medicaid Ineligibility Following Fraud Conviction

1. Period of Eligibility

When an individual has been convicted of Medicaid fraud by a court, that individual will be ineligible for Medicaid for a period of 12 months beginning with the month of fraud conviction. Action to cancel the individual's Medicaid coverage must 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

In a TANF or F&C Medicaid case, only the parent/caretaker will be ineligible for Medicaid when the parent/caretaker has been convicted of Medicaid fraud. The TANF payment for the caretaker may 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.

3. 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.

M18 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/2010	pages 4, 5
TN #91	05/15/2009	page 2 pages 5, 6 page 8

- Qualified Medicare Beneficiaries (QMB), dually-eligible recipients, Special Low-income Medicare Beneficiaries (SLMB), Qualified Individuals, and Qualified Disabled and Working Individuals (QDWI);
- recipients with other comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents, and any insurance purchased through the Health Insurance Premium Payment Program;
- women enrolled in the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) covered group;
- individuals enrolled in the Plan First (family planning services) covered group;
- recipients who receive hospice services in accordance with DMAS criteria;
- refugees; and
- recipients on a spenddown.

MEDALLION

The following recipients are excluded from participating in MEDALLION:

- recipients who are not accepted to the caseload of any participating PCP, and
- recipients whose enrollment in the caseload of the assigned PCP has been terminated and whose enrollment has been declined by other PCPs.

Medallion II

The following recipients are excluded from participating in Medallion II:

- recipients, other than students, who permanently live outside their area of residence for greater than sixty (60) consecutive days, except those placed there for medically necessary services funded by the MCO;

- newly eligible Medallion II enrollees who are in their third trimester of pregnancy and who request exclusion by the 15th of the month in which their MCO enrollment becomes effective. Exclusion may be granted only if the member's obstetrical provider (physician or hospital) does not participate with any of the state-contracted MCOs. The enrollee, MCO, or obstetrical provider can make exclusion requests. Following end of pregnancy, these individuals shall be required to enroll in Medallion II to the extent they remain eligible for full Medicaid benefits.
- recipients who have been pre-assigned to the MCO but have not yet been enrolled, who have been diagnosed with a terminal condition, and whose physician certifies a life expectancy of six (6) months or less may request exclusion from Medallion II. Requests must be made during the pre-assignment period.
- recipients who are inpatients in hospitals, other than those listed above, at the scheduled time of enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge.
- Certain children between birth and age three certified by the *Department of Behavioral Health and Developmental Services (DBHDS)* as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (IDEA) and who meet DMAS review.

**1. Foster Care/
Adoption
Assistance
Children**

All Foster Care and Adoption Assistance children enrolled in MMIS with an Aid Category (AC) of 072, 074, 076, or 086 or enrolled through ADAPT are automatically excluded from participating in managed care. Foster Care/Adoption Assistance children who are enrolled outside ADAPT under any other AC can be exempted from Medicaid managed care programs. If a worker finds that a Foster Care/Adoption Assistance child is enrolled in a managed care program, the worker may request that the child be removed from managed care and placed in fee-for-service Medicaid through the following process:

- Complete the Foster Care Child-Exemption from Managed Care form available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>. The custody order, emergency removal order, or a statement on agency letterhead signed by the director or foster care supervisor verifying the child is in the agency's custody and the date the agency received custody must be attached to the form in order to have the child exempted from managed care.
- Fax the form to (804) 786-5799.

M20 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/2010	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

Extra Help Income and *Resource Limits & Medicare Savings Programs (MSPs) Resource Limits* Appendix 3 1

Calculation Tables Appendix 4 1

Notice of Approval on Your Application for Appendix 5 1
Extra Help with Medicare Part D Costs (Form #032-03-703)

Notice of Denial on Your Application for Appendix 6 1
Extra Help with Medicare Part D Costs (Form #032-03-704)

Notice of Termination of Your Appendix 7 1
Extra Help with Medicare Part D Costs (Form #032-03-705)

Notice of Change in the Amount of Appendix 8 1
Extra Help with Medicare Part D Costs (Form #032-03-706)

Precedence of Extra Help Decisions..... Appendix 9 1

**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 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 listed in M20, Appendix 3*, 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.

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);

- 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 listed in M20, Appendix 3. Resources at or below \$6,600 for an individual and \$9,910 for a married couple and income at or below 135% FPL entitles the applicant(s) to the full subsidy.

Note: The SSA *Low Income* Subsidy application (SSA-1020) lists *higher* resource limits *that include* 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, do not give the burial fund exclusion.

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;
- *all* life insurance owned by an individual (and spouse, if any);
- 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;

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, *other than contributed food and/or shelter*, 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.

In-kind earned income in the form of contributed food and shelter is not counted.

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. *In-kind support and maintenance is not counted as income.*

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.

- 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 is equal to or exceeds 150% FPL;
 - resources exceed *the current resource limit listed in M20, Appendix 3 (include the actual resource limit amount in the notice)*;
 - 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 is equal to or exceeds 150% FPL;
 - resources exceed *the current resource limit listed in M20, Appendix 3 (include the actual resource limit amount in the notice)*;
 - not a resident of the State;
 - not a resident of U.S./incarcerated.

Screening Script for Help with Medicare Costs
Effective 1/1/10

“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 \$1,353.75 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 \$11,010 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 \$1,821.25 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 \$22,010 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 \$1,219 for one person or \$1,640 for a couple and your resources are less than \$6,600 for one person or \$9,910 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
Effective 1/1/10

- 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	\$1,219	\$1,640	< \$1,353.75	< \$1,821.25	< \$2,288.75	< \$2,756.25
Resources	\$6,600	\$9,910	\$11,010	\$22,010 (C)	\$11,010 (S) \$22,010 (C)	\$11,010 (S) \$21,010 (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 1/23/09 MONTHLY GUIDELINES					
FAMILY SIZE	PERCENT OF FEDERAL POVERTY LEVEL (FPL)				
	100%	135%	140%	145%	150%
1	\$902.50	\$1,218.38	\$1,263.50	\$1,308.63	\$1,353.75
2	1,214.17	1,639.13	1,699.83	1,760.54	1,821.25
3	1,525.83	2,059.88	2,136.17	2,212.46	2,288.75
4	1,837.50	2,480.63	2,572.50	2,664.38	2,756.25
5	2,149.17	2,901.38	3,008.83	3,116.29	3,223.75
6	2,460.83	3,322.13	3,445.17	3,568.21	3,691.25
7	2,772.50	3,742.88	3,881.50	4,020.13	4,158.75
8	3,084.17	4,163.63	4,317.83	4,472.04	4,626.25

For family units of more than 8 members, contact a Medical Assistance Program Consultant.

**MEDICARE SAVINGS PROGRAMS (MSPs)
RESOURCE LIMITS – EFFECTIVE 1/1/10**

	<i>Qualified Medicare Beneficiary (QMB), Special Low Income Medicare Beneficiary (SLMB), Qualified Individual (QI) and Qualified Disabled Working Individual (QDWI)</i>	
	<i>*Use Resource Policy in S11 and S11 Appendices*</i>	
	1	2
<i>Resource Limit</i>	\$6,600	\$9,910

EXTRA HELP RESOURCE LIMITS – EFFECTIVE 1/1/10

	<i>Extra Help</i>			
	<i>*Use Resource Policy in M20*</i>			
	1	2	3	4
<i>Income</i>	< \$1,353.75	< \$1,821.25	< \$2,288.75	< \$2,756.25
<i>Resource Limit</i>	\$11,010	\$22,010 (C)	\$11,010 (S) \$22,010 (C)	\$11,010 (S) \$21,010 (C)

CALCULATION TABLES
Effective 1/1/10

Subsidy Calculation for One Person

Countable Resources in \$	≤135% FPL	> 135% to ≤140% FPL	> 140% to ≤ 145% FPL	> 145% to < 150% FPL	≥ 150%
≤ \$6,600	A	C	D	E	F
> \$6,600 to ≤ \$11,010	B	C	D	E	F
> \$11,010	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%
≤ \$9,910	A	C	D	E	F
> \$9,910 to ≤ \$22,010	B	C	D	E	F
> \$22,010	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	\$2.50/\$6.30	N	\$0
B	100%	\$60	15%	N	\$2.50/\$6.30
C	75%	\$60	15%	N	\$2.50/\$6.30
D	50%	\$60	15%	N	\$2.50/\$6.30
E	25%	\$60	15%	N	\$2.50/\$6.30
F (No subsidy)	0%	\$310	25%	Y	@5%

M21 Changes

Changed With	Effective Date	Pages Changed
TN #93	1/01/10	page 2-4, 8
Update (UP) #2	08/24/09	page 4

- he is uninsured;
- he is **not** a member of a family eligible for health benefits coverage under the State Employee Health Insurance Plan on the basis of a family member's employment with a State agency (see Appendix 2 to this chapter);
- he is **not** a member of a family who has dropped health insurance coverage on him within 4 months of the application without good cause;
- he is **not** an inmate of a public institution;
- he is **not** an inpatient in an institution for mental diseases;
- he meets the Medicaid Nonfinancial Eligibility Requirements in Chapter M02 with certain exceptions; and
- he has gross family income less than or equal to 200% FPL.

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 Medicaid Nonfinancial Eligibility Requirements in Chapter M02 that must be met are:

- citizenship and alienage requirements, including Afghan and Iraqi special immigrants in M0220.313 A, with the exceptions noted in M2120.100 C.1. below;
- Virginia residency requirements;
- institutional status requirements regarding inmates of a public institution.

C. M02 Exceptions

The exceptions to the Medicaid Nonfinancial Eligibility Requirements in Chapter M02 are:

1. *Citizenship & Identity Verification Required*

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 mandates that, effective January 1, 2010, all applicants for and recipients of coverage in a Title XXI program must provide verification of citizenship and identity. If the child is a United States (U.S.) citizen, the child must meet the U.S citizenship requirements in M0220.001.

Verification of citizenship is required; declaration of the child's U.S. citizenship is no longer accepted. However, like Medicaid, a reasonable

opportunity period must be given to the applicant. The citizenship and identity verification requirements in M0220.100 apply to FAMIS. If the child is not a U.S. citizen, the child must meet the FAMIS alienage requirements.

2. Alienage Requirements

Alien status must be verified. Refer to sections M0220.200, M0220.201 and M0220.202 for information about verifying alien status.

FAMIS alienage requirements are different from the Medicaid alienage requirements. Qualified aliens who entered the U.S. before August 22, 1996 meet the alienage requirements and are not subject to time limitations.

a. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **without regard to time limitations**:

- refugees or Cuban-Haitian Entrants (see M0220.310 A. 2 and 7),
- asylees (see M0220.310 A. 4),
- veteran or active military (see M0220.311),
- deportation withheld (see M0220.310 A. 6), and
- victims of a severe form of trafficking (see M0220.313 A.52).

b. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **after five years of residence in the United States**:

- lawful permanent residents (LPR),
- conditional entrants-aliens admitted pursuant to 8 U.S.C.1153(a)(7),
- aliens, other than Cuban-Haitian Entrants, paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA, and
- battered aliens, alien parents of battered children, alien children of battered parents.

3. Legal Immigrant Children < 19 Not Applicable

The legal immigrant children policy in M0220.314 does NOT apply to the FAMIS program.

4. No Emergency Services Only For Unqualified Aliens

Unqualified aliens, including illegal and non-immigrant aliens, do not meet the alienage requirements and are not eligible for FAMIS.

5. Alien Eligibility Chart

Appendix 3, FAMIS Alien Eligibility Chart, lists alien groups that meet or do not meet the alienage requirements.

6. **SSN** A Social Security number (SSN) or proof of application for an SSN (M0240) is **not** a requirement for FAMIS.
7. **Assignment of Rights** Assignment of rights to payment for medical care from any liable third party is a condition of eligibility for the child.
- 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. **State Employee Prohibition** A child is ineligible for FAMIS if he is a member of a family eligible for health insurance coverage under any Virginia State Employee Health Insurance Plan on the basis of the family member's employment with a State agency.
4. **IMD Prohibition** The child cannot be an inpatient in an institution for mental diseases (IMD).

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 creditable health insurance coverage is dropped within 4 months of the application for FAMIS unless good cause for discontinuing the insurance is demonstrated, or the child is pregnant.
- 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;
 - a public health plan; and

- ii If monthly premiums are more than 10% of this gross monthly income, good cause is met and there is no waiting period for FAMIS.

M2120.300 NO CHILD SUPPORT REQUIREMENTS

A. Policy There are no child support requirements for FAMIS.

M2130.100 FINANCIAL ELIGIBILITY

A. Financial Eligibility

1. FAMIS Assistance Unit

The FAMIS assistance unit consists of:

- the child applicant under age 19;
- the parent(s) and stepparent who live in the home with the child; and
- any siblings, half-siblings, and stepsiblings under age 19 who live in the home with the child.

NOTE: Medicaid family/budget unit rules do not apply to FAMIS. A child who is pregnant is counted as 1 individual; DO NOT COUNT the unborn child.

2. Asset Transfer

Asset transfer rules do not apply to FAMIS.

3. Resources

Resources are not evaluated for FAMIS.

4. Income

a. Countable Income

The source and amount of all income other than Workforce Investment Act, *Supplemental Security Income (SSI)* and student income must be verified and counted. FAMIS uses the same income types and methods for estimating income as FAMIS Plus (see chapter M07). There are no income disregards and no budget units in FAMIS.

b. 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.

c. 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.

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M22 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/10	pages 2-10
Update (UP) #2	08/24/09	page 3
Update (UP) #1	07/01/09	pages 1, 2, 7 Appendix 1, page 1

- she is **not** an inpatient in an institution for mental diseases; and
- she has countable family income less than or equal to 200% FPL.

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;
 - Virginia residency requirements;
 - assignment of rights;
 - application for other benefits;
 - institutional status requirements regarding inmates of a public institution.
- C. FAMIS Nonfinancial Requirements** The FAMIS nonfinancial eligibility requirements are:
- 1. Citizenship & Identity Verification Required** *The Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2009 mandates that, effective January 1, 2010, all applicants for and recipients of coverage in a Title XXI program must provide verification of citizenship and identity. If the pregnant woman is a United States (U.S.) citizen, the pregnant woman must meet the United States (US) citizenship requirements in M0220.001. Verification is required; declaration of the woman’s US citizenship is **no longer** accepted. However, like Medicaid, the applicant must be given a reasonable opportunity period to provide verification.*
- The citizenship and identity verification requirements in M0220.100 apply to FAMIS MOMS. If not a US citizen, the pregnant woman must meet the alienage requirements.
- 2. Alienage Requirements** FAMIS MOMS alienage requirements are the same as the FAMIS alienage requirements.
- a. Citizens and qualified aliens who entered the U.S. before August 22, 1996 meet the citizenship/alienage requirements.
 - b. The following qualified aliens who entered the U.S. on or after August 22, 1996 meet the alienage requirements **without any time limitations**:

- refugees (see M0220.310 A. 2),
 - asylees (see M0220.310 A. 4),
 - veteran or active military (see M0220.311),
 - deportation withheld (see M0220.310 A. 6), and
 - victims of a severe form of trafficking (see M0220.313 A. 5).
- c. The following qualified aliens who entered the U.S. on or after August 22, 1996 meet the alienage requirements **after 5 years of residence in the United States:**
- lawful permanent residents (LPRs),
 - conditional entrants-aliens admitted pursuant to 8 U.S.C.1153(a)(7),
 - aliens paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA, and
 - battered aliens, alien parents of battered children, alien children of battered parents.
- d. Afghan and Iraqi special immigrants who meet all other eligibility requirements for FAMIS MOMS are eligible for a limited period of time from the date they enter the U.S. or the date their immigrant status is converted to Special Immigrant Visa (SIV) status. See section M0220.313 A and Appendix 3 to Chapter M21 for the limited time periods and details about these special immigrants. When the limited time period (6 or 8 months, beginning with the month of entry or status conversion to SIV) is over, these special immigrants are no longer eligible for FAMIS MOMS because of their lawful permanent resident (LPR) status. LPRs are not eligible for FAMIS MOMS for the first 5 years they reside in the U.S.
- e. Appendix 3 to Chapter M21 contains a FAMIS Alien Eligibility Chart that lists the alien groups that meet or do not meet the FAMIS MOMS alienage requirements.
3. **Legal Immigrant Children < 19 Not Applicable** *The legal immigrant children policy in M0220.314 does NOT apply to the FAMIS program.*
4. **No Emergency Services for Unqualified Aliens** Unqualified aliens, including illegal and non-immigrant aliens do not meet the alienage requirements. FAMIS MOMS does not provide any emergency services eligibility for unqualified aliens.
5. **SSN not Required** The applicant is not required to provide an SSN or proof of an application for an SSN.

**D. FAMIS MOMS
Covered Group
Requirements**

- 1. Verification of Pregnancy** Verification of pregnancy, including the expected delivery date, must be provided. Acceptable verification is a written or verbal statement from a physician, public health nurse or similar medical practitioner.

Documentation of how the pregnancy was verified must be included in the case record.
- 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.
- 3. IMD Prohibition** The pregnant woman cannot be an inpatient in an institution for mental diseases (IMD).
- 4. State Employee Health Benefits Prohibition** A pregnant woman is ineligible for FAMIS MOMS if she is eligible for health insurance coverage under any Virginia State Employee Health Insurance Plan on the basis of her or a family member's employment with a State agency. A woman who cannot be enrolled until an open enrollment period is not prohibited from FAMIS MOMS coverage.

See Appendix 2 to Chapter M21 for a list of state government agencies.

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;
 - 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. Family Member** ONLY when determining whether the pregnant woman is eligible for coverage under a State Employee Health Insurance Plan, “family member” means the pregnant woman’s spouse with whom she lives, or her parent(s) with whom she lives when the pregnant woman is unmarried and is under age 23. “Family member” includes the pregnant woman’s stepparent with whom she is living if the pregnant woman is under age 21 and her stepparent claims the pregnant woman as a dependent on his federal tax return. State employee health benefits are available to the state employee’s unmarried **dependent** child or stepchild under age 23 years.
- 4. 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:
- Medicare, Medicaid 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.
- 5. 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.
- 6. 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.

Medicaid F&C income disregards, other than the \$30 plus 1/3 earnings disregard in LIFC, apply when determining countable income for FAMIS MOMS (see chapter M07).

b. Available Gross Income

For the 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. There is no retroactive coverage in FAMIS MOMS.

c. Income Limits

The FAMIS MOMS income limit is 200% of the FPL (see Appendix 1 to this chapter) for the number of individuals in the FAMIS MOMS family unit, or budget unit (if applicable).

5. 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 and she must be given the opportunity to have a medically needy (MN) Medicaid evaluation.

M2240.100 APPLICATION and CASE PROCEDURES

A. Application Requirements

The following forms are acceptable application forms for FAMIS MOMS:

- Health Insurance for Children and Pregnant Women application,
- Medicaid Application for Medically Indigent Pregnant Women
- Application for Benefits, and
- ADAPT Statement of Facts.

Applications can be mailed to the LDSS or the FAMIS Central Processing Unit (CPU). A face-to-face interview is not required.

The date of the application is the date the signed application is received at the LDSS, including DSS outstationed sites, or at the FAMIS CPU.

For applicants under the age of 18, the parent, legal guardian, authorized representative, or an adult relative with whom the child lives must sign the application. The adult relative must be related by blood or marriage.

Documentation of the relationship is not required. The child's parent or legal guardian may designate in writing an authorized representative to complete and sign the application.

For applicants age 18 or older, the applicant, family substitute relative, authorized representative or the guardian can sign the application.

**B. Eligibility
Determination**

**1. Pregnant
Teenager Under
Age 19**

When an application is received for a pregnant teenager who is under age 19, is not eligible for Medicaid and has income in excess of the Medicaid limits, process her eligibility in the following order:

- a. first, process eligibility as a Medicaid MI child under age 19; if not eligible because of excess income, go to item b.
- b. second, process eligibility as a Medicaid MI pregnant woman; if not eligible because of excess income, go to item c.
- c. third, process eligibility as a FAMIS child under age 19; if not eligible because of excess income, go to item d.
- d. fourth, process eligibility as a FAMIS MOMS pregnant woman. In order to complete the eligibility determination, the FAMIS MOMS nonfinancial requirements in M2220.100 and the financial requirements in M2230.100 must be met. If she is not eligible for FAMIS MOMS because of excess income, she must be given the opportunity to have a medically needy evaluation completed.

**2. 10-day
Processing**

Applications for pregnant women must be processed as soon as possible, but no later than 10 working 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 10 working days in order to determine eligibility. If all verifications are not received within 10 working days, a Notice of Action on Medicaid and FAMIS Programs (NOA), form #032-03-008 (see subchapter M0130, Appendix 1) must be sent to the applicant. The NOA 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**

Because Medicaid and FAMIS MOMS are separate programs, Medicaid eligible individuals and FAMIS MOMS eligible individuals cannot share the same base case number in the Virginia Medicaid Management Information System (MMIS). Only individuals eligible for the same program (Medicaid or FAMIS/FAMIS MOMS) can share the same base case number in the MMIS.

When an individual is determined eligible for FAMIS MOMS and the individual has family members enrolled in Medicaid, the FAMIS MOMS individual must be given a new MMIS base case number when enrolled.

The local DSS worker cannot change the FIPS code or make any other change to the case after the case has been transferred to the FAMIS CPU in MMIS.

D. Entitlement and Enrollment

- 1. Begin Date of Coverage** Pregnant women determined eligible for FAMIS MOMS are enrolled for benefits in the Virginia Medicaid Management Information System (MMIS) 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 MOMS program.
- 3. Aid Category** The FAMIS MOMS aid category (AC) is “005.”

E. Notification Requirements

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.

If the pregnant woman is eligible for FAMIS MOMS, the notice must inform the pregnant woman that the case has been transferred to the FAMIS CPU and that further information on the program will come from the FAMIS CPU.

If the pregnant woman is ineligible for both Medicaid and FAMIS MOMS due to excess income, she must be sent a notice that she is not eligible for either program and must be given the opportunity to have a Medicaid medically needy evaluation completed. Send the notice and an Application for Benefits to the pregnant woman and advise her that if the signed application is returned within 10 days the original application date will be honored.

NOTE: The ADAPT NOA meets the notification requirements. When a NOA is generated by ADAPT, do not send the NOA form #032-03-008.

F. Transfer Case to FAMIS CPU

Once the enrolled FAMIS MOMS case is transferred in MMIS and the notice is sent to the family, the case must be transferred to the FAMIS CPU for ongoing case maintenance.

See chapter M21, section M2140.100 E for the procedures to use when transferring a FAMIS MOMS case to the FAMIS CPU.

**G. Transitions Between
Medicaid And
FAMIS MOMS
(Changes and
Renewals)**

See chapter M21, sections M2140.100 F through J for the procedures to use when an enrollee transitions between Medicaid and FAMIS MOMS.

**H. Application
Required for
Newborn**

The newborn child born to a FAMIS MOMS enrollee is not deemed eligible for FAMIS or Medicaid. The newborn's parent, guardian or authorized representative must file an application for medical assistance for the newborn to have the newborn's eligibility determined for Medicaid and/or FAMIS.

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.