



COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

October 1, 2011

MEDICAID ELIGIBILITY MANUAL – VOLUME XIII

TRANSMITTAL #96

The following acronyms are used in this transmittal:

- ABD – Aged, Blind or Disabled
- ACP – Address Confidentiality Program
- BRVS – Birth Record Verification System
- CBC – Community-Based Care
- CMS – Centers for Medicare and Medicaid Services
- DMAS – Department of Medical Assistance Services
- FAMIS – Family Access to Medical Insurance Security
- FPL – Federal Poverty Level
- HIPP – Health Insurance Premium Payment
- LDSS – Local Departments of Social Services
- LIFC – Low Income Families with Children
- LIS – Low Income Subsidy
- LTC – Long-term Care
- MMIS – Medicaid Management Information System
- MSP – Medicare Savings Program
- PACE – Program of All-inclusive Care for the Elderly
- QI – Qualified Individual
- SPARK – Services Programs Answers Resources Knowledge
- SSA - Social Security Administration
- SSI – Supplemental Security Income
- SSN – Social Security Number
- TPL – Third Party Liability
- U.S. – United States
- USCIS - United States Citizenship and Immigration Services
- VDSS – Virginia Department of Social Services
- VIEW – Virginia Initiative for Employment not Welfare

This transmittal includes new, revised, clarified and updated Medicaid eligibility policy and procedures effective October 1, 2011, unless otherwise indicated.

New Policy

Information and policy regarding the Address Confidentiality Program (ACP) was added in Transmittal #96. The ACP is administered by the Office of the Attorney General to help victims of domestic violence who have recently moved to a new location that is unknown to their abusers. Individuals who participate in the program are given a secure Post Office box mailing address in Richmond, and their mail is routed to their residence address by staff with the Office of the Attorney General. Information about the ACP was originally posted in Broadcast 6976.

TN #96 contains new policy on FAMIS MOMS eligibility for certain pregnant qualified aliens whose income is within the Medicaid limit. If an MI pregnant woman is ineligible for Medicaid because she does not meet the alien status requirements for full-benefit Medicaid, the woman is to be enrolled in FAMIS MOMS as long as she (1) meets the FAMIS MOMS alien status requirements and all other FAMIS MOMS non-financial eligibility requirements, and (2) has income less than or equal to 200% FPL. This policy does NOT apply to unqualified aliens, including illegal and non-immigrant aliens, because they do not meet the alien status requirements for FAMIS MOMS. Information about the new policy was originally posted in Broadcast 6900.

This transmittal also contains policy introduced in Broadcast 6798 regarding the treatment of federal income tax refunds or advance payments received after December 31, 2009 but before January 1, 2013. Income tax refunds and advance payments are not counted as income or as an available resource for a period of 12 months following the month of receipt of the payment. Income tax refunds or advance payments received during this time period are also exempt from asset transfer provisions.

Revised Policy

The procedures for referring an individual to apply for an SSN have been revised. If an individual does not have an SSN and cannot provide proof of application for an SSN, the individual is to be instructed to submit the SS-5, the Application for Social Security Number, to the SSA and to obtain a receipt from SSA verifying that the application was submitted. The Enumeration Referral Form, previously referenced in subchapter M0240, is obsolete.

The procedures for assigning a pseudo SSN to an eligible applicant were revised according to the information originally posted in Broadcast 6977. In ADAPT, LDSS must use APP as the prefix (the first three (3) digits of the SSN) plus the person's date of birth (MMDDYY) or date of application for an SSN, in the remaining fields when assigning a pseudo SSN. When enrolling a member directly in MMIS, LDSS staff must use "999" as the first 3 digits of the pseudo SSN. ADAPT translates the "APP" prefix to "999" when sending the member's enrollment to MMIS.

In subchapter M0310, the Sample Cover Letter for expedited DDS referrals has been revised to include a physician's statement that the individual meets the criteria for an expedited disability determination. The revision was first announced in Broadcast 6873.

Effective October 1, 2011, Plan First is no longer a waiver program and is a Medicaid covered group. A separate Plan First application is not required; any Medicaid application form will be valid for Plan First because Medicaid eligibility will be determined for the limited-coverage Plan First covered group if the individual is not eligible in any other full or limited-benefit Medicaid covered group, FAMIS or FAMIS MOMS. Retroactive eligibility is available, but retroactive eligibility can begin no earlier than October 1, 2011. Certain eligibility requirements have changed with the implementation of the Plan First covered group. Eligible individuals can be of any age, can have health insurance coverage and may have had a

sterilization procedure. The income limit for Plan First has increased to 200% FPL. Covered Services are still limited to family planning services, but now transportation to receive family planning services is also covered.

In the appendices to subchapter S1130, procedures for determining the countable value of non-home real property were added. The procedures for determining the countable value of home property were similarly revised for clarity.

Several policies were removed from the Medicaid Eligibility Manual because they are no longer relevant. In S1120.210, the requirement to apply for periodic retirement benefit payments was removed. In S1140.240, the information about purchasing limits for U.S. Savings Bonds was removed because these limits are set by the Treasury Department and do not impact Medicaid policy. In M1460.530, the instructions for referring an alleged adult disabled child to DDS for a disability determination were removed because the individual must previously have been determined disabled for the home property exclusion to apply. Disability determinations cannot be completed for individuals who are not applicants for or recipients of Medicaid. The policies in M1450 regarding asset transfers made prior to February 8, 2006, were also removed because they now fall beyond the 60-month look-back period for evaluating asset transfers.

In subchapter M1520, the policies on completing partial reviews and renewals were significantly revised. The policies on completing ex parte renewals were revised with an emphasis on using ex parte renewals whenever policy allows. A policy for allowing telephone interviews for renewals was also added. Information in this section, including the procedures for the transfer of cases, was also reorganized and expanded for improved clarity.

The majority of Chapter M20 on determining eligibility for the Extra Help LIS has been removed; key information regarding the LIS remains. Although the requirement that LDSS be able to determine eligibility for the Extra Help LIS is still in effect, the SSA has been determining LIS eligibility in nearly all cases since the implementation of the program. In the unlikely event that the LDSS should be required to determine eligibility for the Extra Help LIS, a Medical Assistance Program Consultant should be contacted. **LDSS are to continue processing LIS-generated Medicaid applications as usual.**

Clarified Policy

The use of the BRVS was clarified in subchapter M0220. BRVS allowable use by LDSS continues despite changes in Medicaid policies and procedures that have greatly reduced the need for its use. BRVS is to be used to obtain birth record verification **only for the purposes of Medicaid eligibility** when (1) the SSA citizenship status data match is unsuccessful, (2) the individual was born in Virginia **and** (3) the individual requests assistance with obtaining documentation of U.S. citizenship.

The policy and procedures in subchapter M220 for requesting emergency services certification from DMAS have been clarified and include more explicit instructions regarding the information required by DMAS to process the certification request.

Clarifications to the following policies are also contained in this transmittal:

- accepting any valid application form,
- the begin date of eligibility for an individual released from an ineligible institution,
- the application policy for QI individuals,
- the inapplicability of SSN follow-up requirements to newborns and undocumented aliens,

- the former home property exclusion for individuals receiving Medicaid CBC in another person’s home,
- how to determine the value of life and remainder interest in real property,
- when home equity is evaluated for LTC eligibility determinations,
- patient pay allowances for guardianship fees when the guardian is affiliated with a publicly funded entity and for Medicare Advantage premiums,
- eligibility criteria for Extended Medicaid coverage,
- CBC patients enrolled in managed care and transportation authorizations for managed care enrollees, and
- the parent of a half-sibling in the FAMIS assistance unit.

Updated Policy

The following information was updated in TN #96:

- In subchapter M0130, a new public e-mail address for HIPP was added. Applicants and other clients with questions about HIPP should be given this dedicated e-mail address.
- In subchapter M0220, and Chapter M21, the references to legal immigrant children were updated to the CMS-approved term, lawfully residing non-citizen children.
- The 2010 MSP resource limits were added to S1110 for reference purposes.
- The utility standard deduction amounts were updated for 2011-2012 in M1480.
- In subchapter M1550, the Medicaid Technician’s caseload assignments were updated.

Electronic Version

Transmittal #96 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 With Significant Changes	Changes
Subchapter M0110 page 6	On page 6, added information about the ACP.
Subchapter M0120 pages 10, 12, 15-17	On page 10, clarified the treatment of an application submitted by someone not in the covered group for which the application was intended. On page 12, revised the Plan First application policy. On pages 15 and 16, added policy regarding the begin date of eligibility for an individual released from an ineligible institution. On page 17, clarified the application policy for individuals in the QI covered group.
Subchapter M0130 pages 6, 8	On page 6, revised the instructions for referring an applicant to the SSA. On page 8, added a new e-mail address for HIPP Program inquiries for use by the public.
Subchapter M0220 pages 3, 18-19, 22-22a	On page 3, clarified when it is appropriate to use the BRVS. On pages 18 and 19, added policy on FAMIS MOMS coverage for pregnant

Pages With Significant Changes	Changes
	qualified aliens who do not meet the requirements for full Medicaid coverage. On pages 22-22a, revised the policy on requesting emergency services certifications from DMAS. Throughout the subchapter, references to legal immigrant children were changed to lawfully residing non-citizen children to conform with CMS guidance.
Subchapter M0240 pages 2-4	On page 2, revised the instructions for referring an applicant to the SSA. On page 3, clarified that SSN follow-up procedures do not apply to newborns or emergency services aliens because they are not required to provide an SSN. On pages 3 and 4, changed the pseudo SSN digits.
Subchapter M0310 Appendix 4	Revised the Sample Cover Letter for expedited DDS referrals to include a physician's certification.
Subchapter M0320 pages 46f, 49, 50	On page 46f, added policy on FAMIS MOMS coverage for pregnant qualified aliens who do not meet the requirements for full Medicaid coverage. On pages 49 and 50, revised the Plan First eligibility policy.
Subchapter M0710 Appendix 6, page 1	Added the 200% FPL monthly income limit for the Plan First covered group.
Subchapter S1110 page 2	On page 2, added the 2010 resource limits for the MSPs for reference purposes.
Subchapter S1120 page 25	On page 25, removed the requirement to apply for periodic payments.
Subchapter S1130 pages 4, 73, 74 Appendix 1, pages 1-7 Appendix 2 Appendix 4, pages 1-7	On page 4, clarified that the former home property exclusion applies when the individual is receiving CBC in someone else's home. On pages 73 and 74, added policy on excluding income tax refunds and advance payments as a resource. Revised Appendices 1 and 2 for added clarity. Added Appendix 4, Determining the Countable Value of Non-Home Real Property.
Subchapter S1140 pages 12, 12a, 24	On pages 12 and 12a, clarified how to determine the value of life and remainder interest. On page 24, removed the information about the limits imposed on the purchase of U.S. Savings Bonds by the Treasury Department because they do not impact Medicaid.
Subchapter M1350 pages 7, 8	On pages 7 and 8, corrected an error in the example.
Subchapter M1410 pages 11, 12	On page 11, revised the policy on the necessary actions when an SSI recipient enrolled in Medicaid enters LTC. On page 12, removed

Pages With Significant Changes	Changes
	financial information from the list of information to report on a DMAS-225 because this information is not shared with the provider.
Subchapter M1450 page 15	On page 15, added policy on the treatment of transfers of income tax refunds and advance payments. The policy on asset transfers made before February 8, 2006 found throughout the subchapter was removed because it now falls outside the 60 month look-back period for asset transfer evaluations.
Subchapter M1460 pages 3, 20	On page 3, clarified that the amount of home equity must be evaluated at the time of entry into LTC and at each renewal. On page 20, removed the instructions to refer alleged disabled adult children for a disability determination because the individual must already have been determined disabled for the home property exclusion to apply.
Subchapter M1470 pages 3, 4, 8, 19, 23, 24	On page 3, clarified that benefit withholdings are income unless an exception in S0830.110 is met. On pages 4 and 19, clarified that the guardianship allowance from patient pay is not given when the guardian is affiliated with a publicly-funded agency. On pages 8 and 23, added policy on patient pay allowances for Medicare Advantage premiums. On page 24, removed financial information from the list of information to report on a DMAS-225 because this information is not shared with the provider.
Subchapter M1480 pages 7, 14, 66, 71	On page 7, clarified that the amount of home equity must be evaluated at the time of entry into LTC and at each renewal. On page 14, clarified how to request resource information when the first continuous period of institutionalization began prior to the application's retroactive period. On page 66, the utility standard deduction amounts were updated for 2011-2012. On page 71, clarified the process for appealing the community spouse monthly income allowance amount.
Subchapter M1510 Page 8a	On page 8a, corrected the policy on spenddown for individuals who receive a disability determination upon an appeal to match the policy in M0310.112.
Subchapter M1520 pages 1-7g pages 13, 24	On pages 1-7g, revised, reorganized and clarified the policies on partial review and renewal. On page 13, clarified the 12-months Extended Medicaid policy to note that months during which the family received Extended Medicaid are not considered months in which the family received LIFC Medicaid. On page 24, added a transfer case management procedure for identifying transferred Medicaid cases.
Subchapter M1550 Appendix 1	Updated the Medicaid Technicians' caseload assignments.

Pages With Significant Changes	Changes
Chapter M18 pages 3, 4, 16	On pages 3 and 4, clarified that most individuals enrolled in managed care remain in managed care if they begin receiving CBC. On page 16, clarified the information regarding transportation to non-emergency medical services.
Chapter M20 pages 1, 2	In Chapter M20, the bulk of policy and procedures for determining eligibility for the Extra Help LIS was removed to streamline the Medicaid Eligibility Manual. Pages 1 and 2 remain and contain general information about the LIS and the LIS Medicaid application process.
Chapter M21 pages 3, 8	On page 3, references to legal immigrant children were changed to lawfully residing non-citizen children to conform with CMS guidance. On page 8, clarified that a parent of an applicant's half sibling is in the FAMIS assistance unit with an applicant when that parent lives in the home, whether or not that parent is married to the applicant's parent.
Chapter M22 pages 3, 3a	On pages 3 and 3a, added policy on FAMIS MOMS coverage for pregnant qualified aliens who do not meet the requirements for full Medicaid coverage.

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.

Martin D. Brown
Commissioner

Electronic Attachment

M0110 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/01/11	Table of Contents pages 2-6a
TN #95	03/01/11	pages 2-4a
TN #94	09/01/10	pages 2, 3
TN #93	01/01/10	pages 1, 6

TABLE OF CONTENTS

M01 APPLICATION FOR MEDICAL ASSISTANCE

M0110.000 GENERAL INFORMATION

	Section	Page
Legal Base and Agency Responsibilities.....	M0110.100	1
<i>Confidentiality</i>	M0110.110	2
<i>Address Confidentiality Program</i>	M0110.120	6
Definitions.....	M0110.200	6a
Availability of Information.....	M0110.300	7
Retention of Case Information	M0110.400	10

- the processing of claims and making payments to medical providers, and
- the recovery of Medicaid expenditures in appropriate cases. Suspected applicant fraud is a combined responsibility of both DMAS and DSS.

2. DSS

The responsibilities of DSS are:

- the determination of initial and continuing eligibility for Medicaid and
- the enrollment of eligible persons in the Medicaid program.

M0110.110 Confidentiality

A. Confidentiality

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

B. Release of Client Information

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

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

C. Use of System Searches

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

D. Release of Information to Medical Providers

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

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

Provider contractors, such as application assistance companies, operate under the authority of the provider. A patient's consent is not required for the agency to provide the contractor with information related to reimbursement for services rendered or medical treatment. Provider contractors **are not** entitled to receive detailed financial or income information contained in an applicant's or recipient's case record without the person's consent to release the information.

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

**E. Release to
Authorized
Representatives**

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

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

**F. Safeguarding Client
Information**

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

- name, address, and all types of identification numbers assigned to the client;
- medical services provided to the client;

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

G. Ownership of Records

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

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

H. Release of Client Information with Consent

As part of the application process for Medicaid, the client shall be informed of the need to consent to the release of information necessary for verifying eligibility. Whenever a person, agency or organization that is not performing one or more of the functions described in 3.a above requests client information, the agency must obtain written permission to release the information from the client or the personal legally responsible for the client whenever possible. A release for information obtained from the client by the requesting agency also satisfies this requirement.

I. Release of Client Information without Consent

Information from the applicant/recipient's case record may not be released to other agencies, such as public housing agencies, legal services, private organizations, the U.S. Citizenship and Immigration Services (USCIS), Virginia Employment Commission (VEC), school lunch programs, health departments or elected officials without the client's consent. An exception applies to agencies with which there is an agreement for specific types of sharing of information, such as wage information from the VEC, Systematic Alien Verification for Entitlements (SAVE) with USCIS, the State Verification Exchange System (SVES) with the Social Security Administration, etc.

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

I. Social Services Employees

to employees of state and local departments of social services for the purpose of program administration;

2. ***Program Staff in Other States*** to program staff in other states when a client moves or when there is a question of dual participation, or to verify the status of assistance in Virginia for applicants in another state;
 3. ***DMAS & LDSS Staff*** between state/local department of social services staff and DMAS for the purpose of supervision and reporting;
 4. ***Auditors*** to federal, state and local employees for the purposes of auditing, monitoring, and evaluation; and
 5. ***For Recovery Purposes*** for the purpose of recovery of monies for which third parties are liable for payment of claims.
- J. Client's Right of Access to Information** Any client has the right to obtain personal information held by the agency. Upon written or verbal request, the client shall be permitted to review or obtain a copy of the information in his record with the following exceptions:
- Information that the agency is required to keep confidential from the client pursuant to §2.2-3704 and §2.2-3705, Code of Virginia, Virginia Freedom of Information Act, Public Records to be open to Inspection; and
 - Information that would breach another individual's right to confidentiality
1. ***Freedom of Information Act (FOIA)*** Consistent with the Virginia Freedom of Information Act, §2.2-3704 and §2.2-3705, Code of Virginia, the agency shall provide access within five working days after the receipt of the request. The agency shall make disclosures to applicants and recipients during normal business hours. Copies of the requested documents shall be provided to the client or a representative at reasonable standard charges for document search and duplication.
 2. ***Client May Be Accompanied*** The client shall be permitted to be accompanied by a person or persons of the client's choice and may grant permission verbally or in writing to the agency to discuss the client's file in such person's presence. Upon request and proper identification of any client or agent of the client, the agency shall grant to the client or agent the right to review the following:
 - All personal information about the client except as provided in §2.2-3704 and §2.2-3705,
 - The identity of all individuals and organizations not having regular access authority that request access to the client's personal information.
 3. ***Client May Contest Information*** Pursuant to the Code of Virginia §2.2-3800, a client may contest the accuracy, completeness or relevancy of the information in his record. Correction of the contested information, but not the deletion of the original information if it is required to support receipt of state or federal financial

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

M0110.120 Address Confidentiality Program (ACP)

- A. Purpose** *The Virginia Attorney General's Office's ACP was created to help a victim of domestic violence who has recently moved to a new location that is unknown to the abuser. The victim wants to keep the new address confidential. Effective July 1, 2011, this program was made available statewide.*
- B. All Mail Goes to Richmond P.O. Box Address** *The ACP offers a substitute mailing address for the individual in a high risk situation. An individual participating in the ACP will have an ACP authorization card that can be used to verify participation in the program; a participant will use a post office box address in Richmond as his address. This address is to be accepted as a mailing address. No locality, FIPS code, or other geographic identification is included on the ACP authorization card.*
- The actual physical address of the participant **MUST NOT** be entered in into any of the VDSS automated systems. Only the mailing address (which is P.O. Box 1133, Richmond, Virginia, 23218) is entered into the computer systems as the participant's residence address; no separate mailing address is entered.*
- C. Accept Participant's Verbal Statement of Residency** *Virginia state residency and locality residency is established by the participant's verbal statement that he is residing in the locality where he is applying for assistance.*
- D. Refer to Local Domestic Violence Program** *Please refer any victims of domestic violence to the local Domestic Violence Program for consideration of the ACP, for safety planning, and other services. Local domestic violence advocates are currently receiving training about the ACP. In most localities, the applications for the ACP program will be completed with the DV advocates as a part of in depth safety planning.*

M0110.200 Definitions

- A. Adult Relative** means an individual who is age 18 or older, who is not a parent, but who is related to a child by blood or marriage and who lives with and assumes responsibility for day-to-day care of the child in a place of residence maintained as his or their own home.
- B. Applicant** means an individual who has directly or through his authorized representative made written application for Medicaid at the local social services department serving the locality in which he is a resident, or if institutionalized, the locality in which he last resided outside an institution.
- C. Application for Medical Assistance** means an official form prescribed by DMAS for requesting medical assistance that is used for initial eligibility determinations and redeterminations. An application for medical assistance is an application for the Medicaid, 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.

M0120 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/01/11	Table of Contents pages 6-18
TN #95	03/01/11	pages 1, 8, 8a, 14
TN #94	09/01/10	pages 8, 8a
TN #93	01/01/10	pages 1, 7, 9-16
Update (UP) #1	07/01/09	page 8
TN #91	05/15/09	page 10

TABLE OF CONTENTS

M01 APPLICATION FOR MEDICAL ASSISTANCE

M0120.000 MEDICAL ASSISTANCE APPLICATION

	Section	Page
Right to Apply.....	M0120.100.....	1
Who Can Sign the Application.....	M0120.200.....	1
Application Forms.....	M0120.300.....	8
Place of Application	M0120.400.....	12
Receipt of Application.....	M0120.500.....	17
When an Application Is Required	M0120.600.....	17

Appendices

Sample Letter Requesting Signature.....	Appendix 1.....	1
The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application, form #032-03-384.....	Appendix 2.....	1
Interstate Compact on Adoption and Medical Assistance (ICAMA) Member States and Reciprocity.....	Appendix 3.....	1

c. Action Not Initiated – Refer to Child Welfare Services

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

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

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

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

2. Minor Parent Applying for His Child

A parent under age 18 years may apply for Medicaid for his own child because he is the parent of the child.

3. Foster Care Child

a. IV-E

The Title IV-E Foster Care & Medicaid Application/Redetermination form, *posted on SPARK at*

<http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi> is used for the IV-E Foster Care eligibility determination. A separate Medicaid application is **not** required for a child who has been determined eligible for Title IV-E Foster Care. However, if there is a non-custodial agreement for the IV-E eligible child, the parent or legal guardian must sign a Medicaid application for the child.

b. Non-IV-E

The Title IV-E Foster Care & Medicaid Application/Redetermination form, *posted on SPARK at*

<http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi> is also used for the **non-IV-E** Foster Care eligibility determination. The Medicaid application for a non-IV-E child who is in foster care must be signed by an authorized employee of the public or private agency that has custody of the child. If there is a non-custodial agreement, a Medicaid application form (Application for Benefits or Health Insurance for Children and Pregnant Women form) must be filed and the parent or legal guardian must sign the Medicaid application.

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

a. IV-E

A separate Medicaid application is not required for a child who has been determined eligible for Title IV-E Adoption Assistance, regardless of which state has the adoption assistance agreement with the adoptive parents. IV-E Adoption Assistance children who have been placed for adoption through the Interstate Compact for Adoption and Medical Assistance (ICAMA) should have an ICAMA form 6.01 which verifies their Title IV-E eligibility for Medicaid. The ICAMA form 6.01 serves as the 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,
- attorney-in-fact,
- executor or administrator of his estate
- his surviving spouse, or
- his surviving family member, in this order of preference: adult child, parent, adult brother or sister, adult niece or nephew, or aunt or uncle.

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

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

E. Unsigned Application

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

F. Invalid Signature

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

G. Enrollee Turns 18

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

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

M0120.300 Medical Assistance Application Forms

A. General Principle – Application Required

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

- IV-E Foster Care/Adoption Assistance children
- Auxiliary Grant (AG) applicants
- Newborn children under age 1 born to a Medicaid-eligible mother.

**1. Exception for
Certain
Newborns**

EXCEPTION: A child born to a mother who was Medicaid eligible at the time of the child's birth (including a child born to an emergency-services-only alien mother) is deemed to have applied and been found eligible for Medicaid on the date of the child's birth (see M0320.301). An application for the child is not required. The child remains eligible for Medicaid to age 1 year.

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

**2. Forms That
Protect the
Application Date**

a. ADAPT Request for Assistance

The Request for Assistance – ADAPT, form #032-03-875 available at: <http://localagency.dss.virginia.gov/divisions/bp/files/fs/forms/general/032-03-0875-08-eng.pdf> may be used to establish and preserve the application date for 30 calendar days, but a signed application must be submitted within 30 calendar days in order for eligibility to be determined.

b. Model Application for Medicare Premium Assistance Form

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

Should a local department of social services (LDSS) receive a model application form, the agency is to send a Virginia Application for Adult Medical Assistance (form # 032-03-0022), or an Application for Benefits (form #032-03-0824), to the applicant with a request that it be completed, signed, and returned to the agency within 30 calendar days. The date of application on the model Application for Medicare Premium Assistance is to be preserved as the application date for purposes of Medicaid entitlement.

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

The model application form may be viewed on the SSA web site at:
<http://www.socialsecurity.gov/prescriptionhelp/MSP-Model-Application-ENG.pdf>.

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.

1. Forms for Specific Covered Groups

There are specialized forms intended for use with certain covered groups, including pregnant women, children, SSI recipients, *Plan First* 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.

2. Applicant Use of Incorrect Form

*Applicants may not know for which covered group they should apply, so they may apply using an incorrect application form. Another application form is **not** to be requested of the applicant if the incorrect form is used.*

If additional information is required to determine an applicant's eligibility in another covered group, send the applicant the appropriate pages from the Application for Benefits or the other application form that asks for the information and give the applicant at least 10 business days to return the pages and the required verifications to the agency.

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

3. 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.

4. 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.

5. 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.

- 6. 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.
- 7. 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).
- 8. 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.
- 9. 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.

10. 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 the online

Application 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.

11. Auxiliary Grant (AG)

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

12. Plan First Application Form

Individuals who wish to apply for *Plan First* family planning services *may apply on the Application for Benefits or the 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. The Plan First Application form is available on SPARK at:
<http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.

For applicants who are determined not eligible for full-benefit Medicaid in any other covered group, it is appropriate to process the applicant's eligibility in the Plan First family planning services covered group. If eligible for Plan First, enroll the applicant in Plan First and send the Notice of Action indicating that he has been enrolled in Plan First coverage for family planning services only. On the notice, state that if he does not wish to remain covered by Plan First, to contact the eligibility worker and request that the Plan First coverage be cancelled. Include a Plan First Fact Sheet, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>, with the notice of action.

13. 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.

1. **Locality of Residence** Medical assistance applications that are completed and filed online are sent to the LDSS in the applicant's locality of residence.
2. **Joint Custody Situations** A child whose residence is divided between two custodial parents living in different localities is considered to reside in the locality in which he attends school. If the child is not enrolled in school, the parents must decide which locality is the child's residence for 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. Coverage Begin Date

The eligible individual's coverage Begin Date cannot be earlier than the date of discharge from the DBHDS institution.

**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.

If the individual did not reside in Virginia prior to becoming incarcerated, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in which correctional facility is located.

1. 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.

2. 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.

3. Coverage Begin Date

The eligible individual's coverage Begin Date cannot be earlier than the date of discharge from the correctional facility.

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. *New applications for QI coverage for an upcoming year may not be taken until January 1 of that year (see M0320.208).*

If the initial QI application is processed in November or December, the QI coverage may be renewed for the following year without obtaining a separate renewal form. See section M1520.200 C.11.

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 #96	10/1/11	pages 6-8
TN #95	3/1/11	page 8
TN #94	9/1/10	pages 2-6, 8
TN #93	1/1/10	pages 4-6, 8
Update (UP) #2	8/24/09	pages 8, 9

1. **SSN Verification** SVES or SOLQ-I may be used to verify the individual's SSN. However, to verify the SSA record of the individual's name at the initial Medicaid application, SVES must be used because SVES verifies the spelling, etc., of the individual's name in the SSA records.

 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). *Instruct the applicant to submit form SS-5, the Application for Social Security Number, to the SSA and to obtain a receipt from the SSA verifying that the application was submitted. The SS-5 is available online at: <http://www.socialsecurity.gov/ssnumber/ss5.htm>.* 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 MMIS or MedPend, use the date the individual applied for an SSN, or the individual's date of birth, preceded by "999" as the individual's SSN. For example, an individual applied for an SSN on October 13, 2006, enter "999101306" as the individual's SSN. *In ADAPT, use "APP" as the first 3 digits and the individual's DOB or date of SSN application as the final 6 digits.*
- 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.

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

2. Documents That Demonstrate Legal Presence

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

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

3. Failure to Provide Proof of Legal Presence

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

- a period of 90 days or until it is determined that he is not legally present in the U.S., whichever is earlier; or
- indefinitely if the applicant provides a copy of a completed application for a birth certificate that has been filed and is pending and being actively pursued in accordance with federal or state law. Such extension shall terminate upon the applicant's receipt of a birth certificate or determination that a birth certificate does not exist because the applicant is not a U.S. citizen.

The affidavit form is on the intranet at:

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

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

4. Relationship to Other Medicaid Requirements

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

F. Third Party Liability (TPL)

Applicants must be asked to provide information about any health insurance they may have. The eligibility worker must enter that information into the Medicaid Management Information System (MMIS) TPL file. Verification of health insurance information is not required.

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

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

**G. Health Insurance
Premium
Payment (HIPP)
Program**

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

The local DSS agency must give each applicant or enrollee who reports that he or someone in his family is employed more than 30 hours each week and is eligible for health insurance coverage under an employer's group health plan must be given a HIPP Fact Sheet, which provides a brief description of the program and the contact information for the HIPP Unit at DMAS. The HIPP Fact Sheet is available on-line at: <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>. *Enrollees and other members of the public may contact the HIPP Unit for additional information at hippcustomerservice@dmass.virginia.gov.*

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

**H. Verification of
Financial
Eligibility
Requirements**

The eligibility worker must verify the following financial eligibility requirements:

- the value of all countable, non-excluded resources;
- 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 SVES or SOLQ-I is not available.

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

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 Changes

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

TABLE OF CONTENTS

M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS

	Section	Page
General Principles	M0220.001	1
Citizenship and Naturalization.....	M0220.100	2
Alien Immigration Status.....	M0220.200	4
Immigration Status Verification	M0220.201	4
Systematic Alien Verification for Entitlements (SAVE)	M0220.202	5
Full Benefit Aliens	M0220.300	7
Aliens Receiving SSI.....	M0220.305	8
Certain American Indians	M0220.306	9
Qualified Aliens Defined	M0220.310	9
Veteran & Active Military Aliens	M0220.311	12
Qualified Aliens Who Entered U.S. Before 8-22-96.....	M0220.312	14
Qualified Aliens Who Entered U.S. On/After 8-22-96	M0220.313	14a
<i>Lawfully Residing Non-citizen Children Under Age 19</i>	M0220.314	14d
Emergency Services Aliens	M0220.400	17
Emergency-Services-Only Qualified Aliens		
Who Entered U.S. On/After 8-22-96	M0220.410	17
Unqualified Aliens	M0220.411	19
Aliens Eligibility Requirements.....	M0220.500	20
Full Benefit Aliens Entitlement & Enrollment	M0220.600	22a
Emergency Services Aliens Entitlement & Enrollment	M0220.700	23

Appendices

Citizenship & Identity Procedures and Documentation Charts	Appendix 1.....	1
Sample Letters of Certification/Eligibility for Victims of a Severe Form of Trafficking.....	Appendix 2.....	1
SSA Quarters of Coverage Verification Procedures for Lawful Permanent Residents	Appendix 3.....	1
Emergency Medical Certification (Form 032-03-628).....	Appendix 4.....	1
Alien Codes Chart	Appendix 5.....	1
Proof of U.S. Citizenship and Identity for Medicaid.....	Appendix 6.....	1

M0220.100 CITIZENSHIP AND NATURALIZATION

A. Introduction

A citizen or naturalized citizen of the United States meets the citizenship requirement for Medicaid eligibility, and is eligible for all Medicaid services if he meets all other Medicaid eligibility requirements.

B. Citizenship Determination

1. Individual Born in the United States

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

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

2. Individual Born Outside the U.S.

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

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

b. Individual Born to Naturalized Parents

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

c. Naturalized Individual

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

C. Verification

1. Requirements

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

2. Exceptions to Verification Requirements

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

- a. All foster care children and IV-E Adoption Assistance children;
- b. Individuals born to mothers who were eligible for Medicaid in any state on the date of the individuals' birth;
- c. Individuals entitled to or enrolled in Medicare, individuals receiving Social Security benefits on the basis of a disability and SSI recipients currently entitled to SSI payments. Former SSI recipients are not included in the exemption. The local department of social services (LDSS) must have verification from the Social Security Administration (such as a SVES response) of an individual's Medicare enrollment, benefits entitlement or current SSI recipient status.

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

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

**3. Verification
Required One
Time**

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

**4. Enroll Under
Good Faith
Effort**

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

If the applicant meets all other Medicaid eligibility requirements:

- Approve the application and enroll the applicant in Medicaid, *AND*
- Specify on the Notice of Action that the individual may have to provide documentation of C&I if it cannot be obtained by other means, *OR*
- Include the Reasonable Opportunity Insert, available on SPARK at: <http://spark.dss.virginia.gov/divisions/bp/me/citizenship/index.cgi>, with the Notice of Action.

Do NOT verify citizenship using the Birth Record Verification System (BRVS) unless it is known that the SSA data match is not successful. The BRVS should be used only when (1) citizenship cannot be verified by SSA and (2) the individual was born in Virginia and requests assistance with obtaining birth record verification.

The individual remains eligible for Medicaid while the agency attempts to verify C&I through the data matching process described in M0220.100 D below, or if necessary, requests verification from the individual. The same good faith effort requirements apply should an individual lose his exemption from providing C&I verification.

**D. Procedures for
Documenting C&I**

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

M0220.300 FULL BENEFIT ALIENS**A. Policy**

A “full benefit” alien is

- an alien who receives SSI (M0220.305);
- an American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (INA) apply, or a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)) (M0220.306);
- a “qualified” alien (defined in M0220.310 below) who entered the U.S. before 8-22-96;
- a qualified alien refugee; asylee; deportee; Amerasian; Cuban or Haitian entrant; victim of a severe form of trafficking; or a qualified Afghan or Iraqi immigrant admitted to the U.S. on a Special Immigrant Visa; 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 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 *lawfully residing non-citizen* 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 *lawfully residing non-citizen* child under age 19. Section M0220.314 defines a legal immigrant child under age 19.
- If the alien is NOT a *lawfully residing non-citizen* under age 19, go to Step 5.
- If the alien is a *lawfully residing non-citizen* 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.
- an alien who was blind or disabled on August 22, 1996, and who is residing legally in the U.S. may receive SSI in the future if he/she meets all other SSI eligibility requirements.
- a legal alien who is receiving SSI for months after July 1996 on the basis of an SSI application filed before January 1, 1979, is exempted from the SSI legal alien requirements, and is eligible for SSI if he/she meets all other SSI eligibility requirements

M0220.314 LAWFULLY RESIDING NON-CITIZEN 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 *lawfully residing non-citizen* 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 *lawfully residing* 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.

- | | |
|---|--|
| 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. |
| 5. Afghan and Iraqi Special Immigrants | Medicaid coverage for Afghan and Iraqi Special Immigrants who are eligible in a Medicaid covered group cannot begin earlier than December 26, 2007. After 7 years of residence in the U.S., Afghan and Iraqi Special Immigrants are no longer eligible for full Medicaid benefits and become “emergency services” aliens.

After the applicable limited time period expires, individuals become “emergency services” aliens unless the requirements in M0220.313 B or M0220.314 are met. |
| D. Services Available To Eligibles | An emergency services alien who meets all Medicaid eligibility requirements is eligible for Medicaid coverage of emergency services only. |
| E. Entitlement & Enrollment of Eligibles | The Medicaid entitlement policy and enrollment procedures for emergency services aliens are found in section M0220.700 below. |
| F. Certain Pregnant Qualified Aliens | <i>If a pregnant woman is ineligible for full-benefit Medicaid because she does not meet the alien status requirements for full-benefit Medicaid, the woman is to be enrolled in FAMIS MOMS as long as she (1) meets the FAMIS MOMS alien</i> |

status requirements and all other FAMIS MOMS non-financial eligibility requirements and (2) has income less than or equal to 200% FPL. See M2220.100 for additional information.

The table below lists the differences between the qualified alien status policies for full Medicaid coverage and FAMIS MOMS coverage for individuals who entered the U.S. on or after August 22, 1996:

Qualified Alien Group	Meets Medicaid alien status requirement for full coverage	Meets FAMIS MOMS alien status requirement (see M2220.100)
<i>veterans or active military</i>	<i>yes, with no time limit</i>	<i>yes, with no time limit</i>
<i>refugees; asylees; deportation withheld; Cuban/Haitian entrants; victims of a severe form of trafficking; and Iraqi and Afghan Special Immigrants</i>	<i>yes, for first 7 years U.S. only</i>	<i>yes, with no time limit</i>
<i>lawful permanent residents (LPRs),</i>	<i>yes, only after 5 years in U.S. and with 40 qualifying work quarters</i>	<i>yes, only after 5 years in U.S., no work requirement</i>
<i>conditional entrants; aliens paroled in the U.S.; and battered aliens, alien parents of battered children, alien children of battered parents</i>	<i>No</i>	<i>yes, only after 5 years in U.S.</i>

M0220.411 UNQUALIFIED ALIENS

A. Unqualified Aliens

Aliens who do not meet the qualified alien definition M0220.310 above and who are **NOT** *lawfully residing non-citizen* children under age 19 (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;
3. **Travel Status** aliens in travel status while traveling directly through the U.S.;
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.

If an individual who signed a statement indicating that he does not intend to remain subsequently changes his mind, eligibility cannot begin prior to the date of the original statement.

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.

- | | |
|---|--|
| 3. Assignment of Rights and Pursuit of Support from Absent Parents | the assignment of rights to medical benefits requirements (M0250); |
| 4. Application for Other Benefits | the requirements regarding application for other benefits (M0270); |
| 5. Institutional Status | the institutional status requirements (M0280); |
| 6. Covered Group | the covered group requirements (chapter M03); |
| 7 Financial Eligibility | the asset transfer requirements (see subchapter M1450) apply. |

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

Income must be within the income limit appropriate to the individual's covered group. (Chapter M07 for F&C covered groups; Chapter S08 for ABD covered groups). Spenddown provisions apply to these individuals. All medical expenses count toward meeting the spenddown, but once an entitlement date is determined after the individual meets the spenddown, only emergency services rendered on or after the entitlement date and which are within the period of coverage on the Emergency Medical Certification form are covered for emergency services aliens.

B. Emergency Services Certification--Not Applicable to Full Benefit Aliens

Certification that the service provided was an emergency service is an additional eligibility requirement for emergency services aliens (not applicable to full benefit aliens). LDSS can certify emergency services coverage for pregnancy-related labor and delivery services for limited, specified periods of time. DMAS must certify emergency services coverage for all other requests and determine the period of coverage.

1. LDSS Certification for Pregnancy-Related Labor and Delivery Services

LDSS can certify emergency services payment for pregnancy-related labor and delivery services, including inpatient hospitalizations that did not exceed:

- 3 days for a vaginal delivery, or
- 5 days for a cesarean delivery.

To determine the length of stay, count the day of admission, but not the day of discharge. If the length of stay exceeded 3 days for a vaginal delivery or 5 days for a cesarean delivery, DMAS must approve the coverage following the procedures in M0220.500 B.2 below. Note that the enrollment period for the emergency service(s) includes the day of discharge even though it is not counted to determine the length of stay (see M0220.700).

For LDSS certifications, verification of the labor and delivery services must be obtained from the physician or hospital and include the following information:

- patient name, address and date of birth,
- facility name and address where the delivery took place
- type of delivery (vaginal or cesarean), and
- inpatient hospital admission and discharge dates.

The verification must be documented in the record.

NOTE: A child born to an emergency-services-only alien mother who was eligible for Medicaid on the date of the child's birth is entitled to Medicaid as a newborn child (see M320.301).

**2. DMAS
Certification for
Emergency
Services
Required**

When DMAS certification for emergency services is required, *send a written request for the evidence of emergency treatment listed below to the applicant or authorized representative. Request that the applicant/authorized representative provide the following information from the hospital or treating physician, as applicable to the emergency service provided, for each period of service:*

- *On the Emergency Medical Certification Form, specify the exact dates of service requested. Ask for a phone number where the person can be reached .*
- *emergency room record, admission (admit) orders, history and physical, MD notes, discharge summary, operative notes;*
- *operative consent form;*
- *pre operative evaluation;*
- *labor and delivery notes, if pregnancy related; and*
- *dates of service – admission date/discharge date.*

If the applicant/authorized representative is unlikely to be able to obtain the above information without assistance (e.g. due to a language barrier), obtain a signed release of information. If necessary, use the release to request evidence of emergency treatment from the hospital and/or treating physician

If the hospital or treating physician is *unsure* of the information *that* is needed, refer the hospital's staff, physician or physician's staff to the Virginia Medicaid Hospital Provider Manual, Chapter VI "Documentation Guidelines."

Using the Emergency Medical Certification, form #032-03-628 (see M0220, Appendix 4) as a cover letter, send the medical evidence to:

Division of Program Operations
Department of Medical Assistance Services (DMAS)
600 E. Broad Street, Suite 1300
Richmond, VA 23219

for a determination of medical emergency and the duration of the emergency services certification period.

If more than one period of service is requested, the records must be separated, and a separate certification form must be attached for each period of service.

If a request is received with one certification form and the records contain multiple dates of service, and/or DMAS is unable to make a determination with the medical records received, the entire request will be returned to the eligibility worker with a note specifying the information needed.

Do not include application forms for disability, FAMIS, etc. These forms contain protected health information that is not needed for the determination of medical necessity.

Do **not** take action to approve or enroll an emergency services alien until you receive the completed Emergency Medical Certification form back from DMAS. If approved, DMAS will provide the certification for Medicaid payment for emergency services and coverage begin and end dates.

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. Country

In this field, Country, enter the code of the alien's country of origin.

2. Cit Status

In this field, Citizenship Status, enter the MMIS Citizenship code that applies to the alien. Below, next to the MMIS code, is the corresponding Alien Code from the Alien Code Chart in Appendix 5 to this subchapter. Eligible alien codes are:

R = refugee (Alien Chart codes F1, F2, G1, G2); also used for Afghan and Iraqi Special Immigrants (Alien Chart Code Z1).

E = entrant (Alien Chart code D1).

P = full benefit qualified aliens (Alien Chart codes A1, A2, A3, B1, B3, C1, 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. **Appl Dt** In this field, Application Date, enter the date of the alien's Medicaid application upon which the eligibility coverage period is based.
5. **Coverage Begin Date** In this field, Coverage Begin Date, enter the date the alien's Medicaid entitlement begins.
6. **Coverage End Date** Enter data in this field only if eligibility is a closed period of eligibility in the past. Enter the date the alien's Medicaid entitlement ended.
7. **AC** Enter the AC code applicable to the alien's covered group.

M0220.700 EMERGENCY SERVICES ALIENS ENTITLEMENT & ENROLLMENT

- A. Policy** Unqualified aliens, and qualified aliens eligible for emergency services only are eligible for Medicaid coverage of emergency medical care only. This care must be provided in a hospital emergency room or as an inpatient in a hospital.
- B. Entitlement-Enrollment Period** If the applicant is found eligible and is certified for emergency services, eligibility exists only for the period of coverage certified by the LDSS or DMAS staff on the Emergency Medical Certification form, # 032-03-628 (M0220, Appendix 4).

Once an eligibility period is established, additional requests for coverage of emergency services within 6 months will not require a new Medicaid application. However, each request for Medicaid coverage of an emergency service or treatment requires a new, separate certification and a review of the alien's income and resources and any change in situation that the alien reports.

An emergency services alien must file a new Medicaid application after the 6-month eligibility period is over if the individual receives an emergency service and wants Medicaid coverage for that service.

- C. Enrollment Procedures** Once an emergency services alien is found eligible for coverage of emergency services, the individual must be enrolled in MMIS using the following data:

1. **Country** In this field, Country of Origin, enter the code of the alien's country of origin.

2. **Cit Status** In this field, Citizenship Status code, enter :

A = Emergency services alien (Alien Chart codes B2, C2, C3, D2, D3, E2, E3, F3, G3, H3, I2, I3, codes J3 through V3, Z2) other than dialysis patient.

D = Emergency services alien who receives dialysis.

V = Visitor, non-immigrant alien (Alien Chart codes W1, W2, W3).

The Alien Codes Chart is found in Appendix 5 to this subchapter.

NOTE: Foreign visitors are not usually eligible for Medicaid because usually they do not meet the Medicaid Virginia state residency requirement.

	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, diplomas, 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
LAWFULLY RESIDING NON-CITIZEN CHILDREN UNDER AGE 19				
Y	Non-citizen (alien) children under the age of 19 lawfully residing in the U.S. who meet the requirements in M0220.314.	N/A	Full Benefits	Full Benefits

	AFGHAN AND IRAQI SPECIAL IMMIGRANTS	First 7 Years after Entry into U.S.	After 7 Years
Z	Afghan and Iraqi Special Immigrants admitted on a Special Immigrant Visa (SIV), including the spouse and children under age 21 living in the home with the principal visa holder. [I-551 or passport/ I-94 indicating categories SI1, SI2, SI3, QQ1, SQ2, or SQ3 and bearing Department of Homeland Security stamp or notation]	Full Benefits Z1	Emergency Only Z2

M0240 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	pages 2-4
TN #94	9/1/10	pages 1-6
TN #93	1/1/10	pages 1-4
Update (UP) #1	7/1/09	pages 1, 2
TN #91	5/15/09	pages 1, 2

Management Information System (MMIS) sends the enrollee information to SSA for the Medicare Buy-in or the citizenship and identity match, the enrollee can be matched to SSA records.

At the time of the initial Medicaid application, the State Verification Exchange System (SVES) must be used to verify the SSA record of the individual's name because SVES verifies the spelling, etc., of the individual's name in the SSA records. For subsequent reapplications, the State Online Query-Internet system (SOLQ-I) may be used.

1. SSN The individual's SSN must be verified. The worker may use the SOLQ-I or SVES to verify an individual's SSN.

2. Verification Systems - SVES & SOLQ-I SVES verifies the individual's SSN, name spelling, entitlement to SSA benefits and the amount of the benefit, entitlement to SSI and the amount, and entitlement to Medicare & the Medicare premium amounts. SVES tells the worker what is wrong with the name, if the name is incorrectly spelled.

The SOLQ-I verifies the individual's SSN, entitlement to SSA benefits and the amount of the benefit, entitlement to SSI and the amount, and entitlement to Medicare & the Medicare premium amounts. SOLQ-I does not verify the individual's name according to the SSA records.

Workers may use either the SOLQ-I or SVES to verify the individual's SSN and entitlement to Social Security benefits and Medicare. However, to verify the SSA record of the individual's name at the initial application, SVES must be used.

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). *Instruct the applicant to submit form SS-5, the Application for Social Security Number, to the SSA and to obtain a receipt from SSA verifying that the application was submitted. The SS-5 is available online at:*
<http://www.socialsecurity.gov/ssnumber/ss5.htm>.

The 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.
 3. **Retroactive Eligibility** An individual who provides proof of application for an SSN after he applies for medical assistance, meets the application for SSN requirement in the three months retroactive to his medical assistance application.
- 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 APPLICATION

- A. Applicant Applied for SSN** When an applicant who has applied for an SSN is determined eligible for medical assistance, he is enrolled with a pseudo-SSN. The worker must obtain the enrollee’s SSN when it is assigned and enter it into the enrollee’s records.
- B. Follow-Up Procedures** *The follow-up procedures below do not apply to individuals listed in M0240.100 B.*
1. **Documentation** If the applicant does not have an SSN, the agency must document in the record the date he applied for an SSN.
 2. **Entering Computer Systems** When entering the individual in MMIS or MedPend, use the date the individual applied for an SSN, or the individual’s date of birth, preceded by “999” as the individual’s SSN. *In ADAPT, use “APP” as the first 3 digits and the individual’s DOB or date of SSN application as the final 6 digits.*

For example, an individual applied for an SSN on October 13, 2006. Enter “999101306” as the individual’s SSN *in MMIS and MedPend*; *in ADAPT, enter “APP101306.”*
 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 “999” 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 "999" 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?

Virginia DSS, Volume XIII

M0250 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/01/11	Page 3
TN #94	09/01/2010	Pages 3-5

- take any other reasonable steps to assist the state in pursuing any liable third party.

Should DMAS or the local agency request information from the individual, including information about third party liability, or otherwise require cooperation with the pursuit of medical support and/or third party liability as outlined in M0250.200 C. above, the individual must cooperate with the pursuit of medical support in order for the individual's eligibility to continue.

1. Waiver of Cooperation

A waiver of the cooperation requirement in identifying and providing liable third party information is allowed if the agency finds that cooperation is against the best interests of the individual, or other person for whom he/she can assign rights, because the agency anticipates that cooperation will result in reprisal against or cause physical or emotional harm to the individual or other person.

2. Documentation

Document the case record with the reason(s) the individual refuses to cooperate in identifying and providing liable third party information and the reason(s) the agency finds that cooperation is against the best interests of the individual or other person for whom he/she can assign rights.

M0250.300 PURSUIT OF MEDICAL SUPPORT FROM THE ABSENT PARENT

A. Policy

To be eligible for Medicaid, an individual applicant or recipient must cooperate with the agency in obtaining medical support and payments from, or derived from, the absent parent(s) of a child for whom the individual is applying, unless the individual establishes good cause for not cooperating. The individual's non-cooperation does NOT affect the individual's *Plan First eligibility, nor the individual's child(ren)'s Medicaid eligibility.*

A pregnant woman is not required to cooperate with DCSE when requesting assistance for herself and her child(ren) born out of wedlock. If she is or was married, she is required to cooperate in pursuing medical support for her legitimate child(ren) from the legitimate child(ren)'s absent father.

A married pregnant woman who meets the medical assistance support requirement **cannot be denied** medical assistance for failure to cooperate in pursuing support even when ineligible for another program because of failure to cooperate with pursuit of support.

B. Definition of Cooperation

1. Application

By signing the application for Medicaid, the individual meets the eligibility requirement to cooperate in pursuing support from the absent parent(s) of the child for whom the individual is applying. No further action by the applicant is required at the time of application.

M0310 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	Appendix 4
TN #95	3/1/11	Pages 30, 30a
TN #94	9/1/10	pages 21-27c, 28
TN #93	1/1/10	page 35 Appendix 5, page 1
Update (UP) #2	8/24/09	Table of Contents page 39
TN #91	5/15/09	pages 23-25 Appendix 4, page 1 Appendix 5, page 1

SAMPLE

Cover Sheet for Expedited Referral to DDS and DSS

This is an example of a cover sheet that is used when a Medicaid Disability Determination is required to transition a hospitalized patient to a rehabilitation facility. The address, phone number and fax number for the appropriate Regional DDS Office will be included in the cover letter. *Expedite procedures do not apply if the person will be discharged home, to long term care, or to hospice.*

Patient: _____ SSN: _____

DISABILITY is defined as:

The inability to do any substantial gainful work, because of a severe, medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or is expected to last for a continuous period of not less than 12 months.

All of these conditions must be met for a Medicaid claim to qualify as an Expedite.

1. *The patient is hospitalized.*
2. *The patient is able to participate in rehabilitative activities, requires transitioning to a rehabilitation facility, and cannot be discharged without a determination of Medicaid eligibility.*
3. *The patient's impairment is so severe it can be expected to prevent all work activity for at least one year.*
4. *The hospital has provided sufficient evidence to document an impairment that is expected to prevent work activity for at least one year.*

Physician's Signature: _____ *Date:* _____

The Medicaid application has been faxed/sent to this Dept. of Social Services (DSS):

DSS Name: _____ Address: _____

FAX Number: _____ Date Faxed: _____

The information checked below is being faxed *or sent overnight* to DDS:

DDS Address : _____ FAX Number: _____

_____ Form SSA-3368 Disability Report Form

_____ SSA-827 Authorizations to Disclose Information

_____ Medical Reports

_____ Medical History & Physical, including consultations

_____ Clinical Findings (such as physical/mental status examination findings)

_____ Laboratory findings (such as latest x-rays, scans, pathology reports.)

_____ Diagnosis.

_____ *Signed Expedite Cover Sheet with physician's certification that the claim meets the conditions necessary to be treated as an Expedite.*

Name of Hospital: _____ Date Completed: _____

Your Name Printed: _____ Your Signature: _____

Your Telephone: (_____) _____ Your Fax: (_____) _____

M0320 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	Table of Contents pages 46f-50b page 50c deleted
TN #95	3/1/10	pages 11, 12, 42c, 42d, 50, 53, 69 pages 70, 71 page 72 added.
TN #94	9/1/10	pages 49-50b
UP #3	3/1/10	pages 34, 35, 38, 40, 42a, pages 42b, 42f
TN #93	1/1/10	pages 11-12, 18, 34-35, 38 pages 40, 42a-42d, 42f-44, 49 pages 50c, 69-71
UP #2	8/24/09	pages 26, 28, 32, 61, 63, 66
Update (UP) #1	7/1/09	pages 46f-48
TN #91	5/15/09	pages 31-34 pages 65-68

TABLE OF CONTENTS

M03 MEDICAID COVERED GROUPS

M0320.000 CATEGORICALLY NEEDY GROUPS

	Section	Page
General Policy Principles	M0320.001.....	1
Protected Covered Groups	M0320.100.....	2
Former Money Payment Recipients		
August 1972.....	M0320.101.....	2
Conversion Cases.....	M0320.102.....	4
Former SSI/AG Recipients.....	M0320.103.....	8
Protected Widows or Widowers	M0320.104.....	13
Qualified Severely Impaired Individuals (QSII)-1619(b).....	M0320.105.....	18
Protected Adult Disabled Children	M0320.106.....	20
Protected SSI Disabled Children	M0320.107.....	22
ABD Categorically Needy Groups.....	M0320.200.....	22b
SSI Recipients	M0320.201.....	23
AG Recipients	M0320.202.....	25
ABD In Medical Institution, Income ≤ 300% SSI	M0320.203.....	26
ABD Receiving Waiver Services (CBC)	M0320.204.....	28
ABD Hospice	M0320.205.....	31
QMB (Qualified Medicare Beneficiary).....	M0320.206.....	34
SLMB (Special Low-income Medicare Beneficiary).....	M0320.207.....	38
QI (Qualified Individuals)	M0320.208.....	42
QDWI (Qualified Disabled & Working Individual)	M0320.209.....	42e
ABD With Income ≤ 80% FPL	M0320.210.....	44
MEDICAID WORKS	M0320.211.....	45
Families & Children Categorically Needy Groups	M0320.300.....	46e
MI Pregnant Women & Newborn Children	M0320.301.....	46f
Plan First - Family Planning Services	M0320.302.....	49
MI Child Under Age 19 (FAMIS Plus).....	M0320.303.....	50
Low Income Families With Children (LIFC)	M0320.304.....	51
IV-E Foster Care & IV-E Adoption Assistance.....	M0320.305.....	52
Individuals Under Age 21	M0320.307.....	54
Special Medical Needs Adoption Assistance	M0320.308.....	57
F&C In Medical Institution, Income ≤ 300% SSI.....	M0320.309.....	60
F&C Receiving Waiver Services (CBC).....	M0320.310.....	63
F&C Hospice	M0320.311.....	66
Breast and Cervical Cancer Prevention Treatment Act (BCCPTA).....	M0320.312.....	69

- M0320.301 MI Pregnant Women & Newborn Children;
- M0320.302 Plan First--Family Planning Services (FPS);
- M0320.303 MI Child Under Age 19 (FAMIS Plus);
- M0320.304 Low Income Families With Children (LIFC);
- M0320.305 IV-E Foster Care & IV-E Adoption Assistance;
- M0320.307 Individuals Under Age 21;
- M0320.308 Special Medical Needs Adoption Assistance;
- M0320.309 F&C In Medical Institution, Income \leq 300% SSI;
- M0320.310 F&C Receiving Waiver Services (CBC);
- M0320.311 F&C Hospice;
- M0320.312 Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA).

M0320.301 MI PREGNANT WOMEN & NEWBORN CHILDREN

A. Policy

The federal Medicaid law requires the Medicaid State Plan to cover pregnant women and newborn children whose family income is within 133% of the federal poverty level (FPL). The law allows the State Plan to cover these pregnant women and newborns regardless of their resources; Virginia has chosen to waive the resource eligibility requirements for this covered group.

B. Nonfinancial Eligibility

1. Pregnant Woman

42 CFR 435.170 - The woman must meet the pregnant woman definition in M0310.124.

The MI pregnant woman must meet all the nonfinancial eligibility requirements in chapter M02.

a. Emergency services alien pregnant woman

If a pregnant woman is not eligible for full-benefit Medicaid because the woman does not meet the Medicaid alien status requirements for full-benefit Medicaid coverage, the woman may be enrolled in FAMIS MOMS if she (1) meets the FAMIS MOMS alien status requirements and all other FAMIS MOMS non-financial eligibility requirements, and (2) has income less than or equal to 200% FPL.

b. Does NOT apply to unqualified aliens

This policy does NOT apply to Unqualified aliens, including illegal and non-immigrant aliens, because they do not meet the alien status requirements for FAMIS MOMS. FAMIS MOMS does not allow emergency services only eligibility for unqualified aliens.

2. Newborn Child

42 CFR 435.117 - A child born to a woman who was eligible for Medicaid at the time the child was born (including a newborn child born to an alien eligible for Medicaid payment of emergency services only) is eligible as a newborn child under age 1 year.

a. Eligible To Age 1

A child no longer meets this covered group effective the end of the month in which the child reaches age 1, provided he was under age 1 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 1.

Any child born a Medicaid-eligible woman will continue to be eligible up to age 1. If the child's mother was covered by Medicaid as a categorically needy individual in a state other than Virginia at the time of the child's birth, verification of the mother's Medicaid coverage must be provided by the parent or authorized representative.

b. No Other Nonfinancial Eligibility Requirements

No other nonfinancial or financial eligibility requirements need to be met by the newborn child.

C. Financial Eligibility

1. Assistance Unit

Use the assistance unit policy in chapter M05 to determine the pregnant woman's financial eligibility. If a pregnant woman also applies for other family unit members living with her who do not meet the pregnant woman, newborn child or child under age 19 years covered group requirements, separate financial eligibility calculations must be completed for the unit. One is the MI pregnant woman determination; the other is based on the other members' covered group(s).

2. Asset Transfer

The asset transfer rules in subchapter M1450 apply to institutionalized MI individuals.

3. Resources

There is no resource limit.

4. Income

The income requirements in chapter M07 must be met by a pregnant woman. The income limits are 133% of the federal poverty level and are found in subchapter M710, Appendix 6.

5. Income Changes After Eligibility Established

a. Pregnant Woman

Once eligibility is established as a pregnant woman, changes in income do not affect her eligibility as long as she meets the pregnant definition and the other nonfinancial Medicaid eligibility requirements. This also includes situations where eligibility is established in the retroactive period.

For example, a married pregnant woman applies for Medicaid on October 10. She received a medical service in the retroactive period. Her expected delivery date is January 15. She and her husband have been unemployed since June 23. Her husband began earning \$3,000 a month on October 9; she remains unemployed. Since they had no income during the retroactive period, she is found eligible for retroactive coverage effective July 1.

Because her available income (from her husband) changed after she established eligibility on July 1, the change in income does not affect her eligibility and she remains eligible for Medicaid in October and subsequent months until she no longer meets the pregnant woman definition or other nonfinancial requirements.

b. Newborn

Income changes do NOT affect the certain newborn's eligibility for the first year of the child's enrollment as a certain newborn.

The mother's failure to complete a renewal of her own eligibility and/or the eligibility of other children in the household does NOT affect the eligibility of the certain newborn.

6. Income Exceeds MI Limit

A pregnant woman whose income exceeds the MI income limit may be eligible for Virginia's Title XXI program, FAMIS MOMS. The income limit for FAMIS MOMS is 200% FPL. See chapter M22 to determine FAMIS MOMS eligibility.

Spendedown does not apply to the medically indigent. If the pregnant woman's income exceeds the medically indigent limit, 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 pregnant women are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group if pregnancy is verified as existing in the retroactive month(s).

The newborn's Medicaid coverage begins the date of the child's birth. A Medicaid application for the newborn child is not required until the month in which the child turns age 1.

Eligible medically indigent pregnant women and newborns are entitled to all Medicaid covered services as described in chapter M18.

After her eligibility is established as a medically indigent pregnant woman, the woman's Medicaid entitlement continues through her pregnancy and the 60-day period following the end of her pregnancy. Medicaid coverage ends the last day of the month in which the 60th day occurs.

E. Enrollment

The aid category (AC) for MI pregnant women is "091." The AC for newborns born to women who were enrolled in Medicaid as categorically needy or MI is "093."

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

Effective October 1, 2011, Plan First, Virginia's family planning services health program covers individuals whose income is less than or equal to 200% FPL for their family size and who are not eligible for another full or limited-benefit Medicaid covered group, FAMIS or FAMIS MOMS. This optional covered group is available to individuals regardless of their age, gender, disability status, insured status or if they previously had a sterilization procedure. While there are no age limits for enrollment in this group, an unemancipated child under age 18 should not be enrolled for family planning coverage without first obtaining the child's parent's or guardian's consent.

Plan First covers only family planning services, including transportation to receive family planning services.

1. Application Forms

Eligibility for Plan First can be determined using any valid application form. An individual does not need to request Plan First for his eligibility to be determined. The Plan First and Application for Benefits forms allow individuals to specifically request a Plan First eligibility determination on the forms. If an individual indicates on the application or to the agency that he does not want his eligibility for Plan First determined, do not do so.

2. Determine Eligibility in Other Medicaid Covered Groups, FAMIS or FAMIS MOMS First

*If the information contained in the application indicates **potential** eligibility in a full-benefit Medicaid covered group (e.g., the applicant has a child under 18 in the home or alleges disability), in another limited benefit covered group (e.g., the individual has Medicare), or in FAMIS or FAMIS MOMS, the worker must determine whether eligibility exists in another covered group before the individual(s) can be determined eligible for Plan First.*

If additional information is needed to complete the eligibility determination in another Medicaid covered group, the applicant must be given the opportunity to provide the additional information needed. If the additional information is not provided by the deadline, determine the applicant's eligibility for Plan First only.

If the applicant is not eligible for Medicaid in another covered group, FAMIS or FAMIS MOMS, but is eligible for Plan First, enrollment in Plan First must be made directly in the MMIS.

B. Nonfinancial Requirements

Individuals in this covered group must meet the following Medicaid nonfinancial requirements in chapter M02.

DCSE services are available to all Medicaid recipients, but cooperation with DCSE is not a condition of eligibility for this covered group.

C. Financial Eligibility

1. **Assistance Unit** Use the assistance unit policy in chapter M05 to determine financial eligibility.
2. **Resources** There is no resource limit.
3. **Income** The income requirements in chapter M07 must be met for this covered group. The income limits are 200% FPL and are found in subchapter M0710, Appendix 6.
4. **Spenddown** Spenddown does not apply to this covered group.

D. Entitlement and Enrollment

1. **Begin Date** Eligibility in the Plan First covered group begins the first day of the month in which the application is filed, if all eligibility factors are met in the month.
2. **Retroactive Coverage** *Individuals in this covered group are entitled to retroactive coverage if they meet all the requirements in the retroactive period. If eligible for retroactive coverage, however, coverage can begin no earlier than October 1, 2011.*
3. **Enrollment** The AC for Plan First enrollees is “080.”

M0320.303 MI CHILD UNDER AGE 19 (FAMIS PLUS)**A. Policy**

Section 1902(a)(10)(A)(i)(VI) and 1902 (1)(1)(C) of the Act - The federal Medicaid law requires the Medicaid State Plan to cover children from birth to age 6 years whose countable income is less than or equal to 133% of the federal poverty limit (FPL). Section 1902(a)(10)(A)(i)(VII) and 1902 (1)(1)(D) of the Act - The federal Medicaid law requires the Medicaid State Plan to cover children who have attained age 6 years but are under age 19 years whose countable income is less than or equal to 100% of the FPL and allows states to cover children at higher income limits.

Virginia has elected to cover children from age 6 to age 19 with countable income less than or equal to 133% of the FPL. The federal law allows the State Plan to cover these children regardless of their families' resources; Virginia has chosen to waive the resource eligibility requirements for these children. Coverage under the MI Child Under Age 19 covered group is also referred to as FAMIS Plus.

B. Nonfinancial Eligibility

The child must meet the nonfinancial eligibility requirements in chapter M02.

The child must be under age 19 years. The child's date of birth must be provided, but birth verification is not required. Any child under age 19 years can be eligible in this covered group regardless of the child's living arrangements or the child's mother's Medicaid eligibility.

A child no longer meets this covered group effective the end of the month in which the child reaches age 19 years, provided he was under age 19 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 19.

NOTE: a child who does not meet a Medicaid non-financial eligibility criterion AND who has excess income for Medicaid may be evaluated for FAMIS eligibility.

C. Financial Eligibility

1. **Assistance Unit** Use the assistance unit policy in chapter M05 to determine the child's financial eligibility.
2. **Asset Transfer** The asset transfer rules in subchapter M1450 apply to institutionalized MI individuals.
3. **Resources** There is no resource limit.
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 MI children are:

AC	Meaning:
090	<ul style="list-style-type: none"> • MI child under age 6; income greater than 100% FPL, but less than or equal to 133% FPL
091	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 HIPP program.

Virginia DSS, Volume XIII

M0710 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/01/11	Appendix 6, page 1
UP #5	7/1/11	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1
TN #95	3/1/11	Appendix 6, pages 1, 2 Appendix 7
Update (UP) #1	7/1/09	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1

MEDICALLY INDIGENT CHILD UNDER AGE 19 (FAMIS PLUS) AND PLAN FIRST INCOME LIMITS FEDERAL POVERTY LEVEL (FPL) EFFECTIVE 1-20-11* ALL LOCALITIES			
# of persons in Family/Budget Unit	100% FPL Monthly Limit	133% FPL Monthly Limit	200% FPL Monthly Limit*
1	\$908	\$1,207	\$1,815
2	1,226	1,631	2,452
3	1,545	2,054	3,089
4	1,863	2,478	3,725
5	2,181	2,901	4,362
6	2,500	3,324	4,999
7	2,818	3,748	5,635
8	3,136	4,171	6,272
Each additional person add	319	424	637

AC 091 - MI Child under age 6 with income less than or equal to 100% FPL

AC 092 - MI Child age 6 to 19 with income less than or equal to 100% FPL

AC 090 - MI Child under age 6 with income greater than 100% FPL and less than or equal to 133% FPL

AC 092 - **Insured** MI Child age 6 to 19 with income greater than 100% FPL and less than or equal to 133% FPL

AC 094 - **Uninsured** MI Child age 6 to 19 with income greater than 100% FPL and less than or equal to 133% FPL

*AC 080 – Plan First for men and women with income less than or equal to 200% FPL (*effective 10-01-2011*).

S1110 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	page 2
TN #95	3/1/11	page 2
Update (UP) #3	3/2/10	Table of Contents page 2
TN #93	1/1/10	page 2
TN #91	5/15/09	pages 14-16

M1110.003 RESOURCE LIMITS

A. Introduction

The resource limit is the maximum dollar amount of countable assets an individual, couple, or family may own and still meet the established criteria for Medical Assistance in an ABD category. These amounts are established by law.

B. Policy Principles

1. Resource Ineligibility

An individual (or couple) with countable resources in excess of the applicable limit is not eligible for Medicaid.

2. Resource Limits

ABD Eligible Group	One Person	Two People
Categorically Needy Cat-Needy Non-money Payment Medically Needy	\$2,000	\$3,000
ABD With Income \leq 80% FPL	\$2,000	\$3,000
QDWI	\$4,000	\$6,000
QMB SLMB QI	<i>Calendar Year</i> <i>2011</i> \$6,680 <i>2010</i> \$6,600	<i>Calendar Year</i> <i>2011</i> \$10,020 <i>2010</i> \$9,910

3. Change in Marital Status

A change in marital status can result in a change to the applicable resource limit. The resource limit change is effective with the month that we begin treating both members of a couple as individuals. For example, separation from an ineligible spouse can change the limit from \$3,000 to \$2,000. See M1110.530 B.

4. Reduction of Excess Resources

Month of Application

Excess resources throughout the month of application causes ineligibility for the application month. Reduction of excess resources within the application month can cause resource eligibility for that month.

Virginia DSS, Volume XIII

S1120 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	Table of Contents pages 24-26
TN #93	1/1/2010	page 22

TABLE OF CONTENTS

S1120.000 IDENTIFYING RESOURCES

	Section	Page
OVERVIEW		
Purpose of Subchapter.....	S1120.001	1
Distinguishing Resources from Income.....	S1120.005	1
Factors That Make Property a Resource.....	S1120.010	2
Transactions Involving Agents.....	S1120.020	5
Conserved Funds When Formally Designated		
Agent Changes.....	S1120.022	7

ASSETS THAT ARE NOT RESOURCES

Home Energy Assistance/Support and Maintenance Assistance	S1120.100	8
Certain Cash to Purchase Medical or Social Services	S1120.110	8
Retroactive In-Home Supportive Services Payments to Ineligible Spouses and Parents.....	S1120.112	9
Death Benefits for last Illness and Burial Expenses.....	S1120.115	10
Gifts of Domestic Travel Tickets	S1120.150	11

PROPERTY THAT MAY OR MAY NOT BE A RESOURCE

Trust Property	M1120.200	12
Trusts Established on or after August 11, 1993.....	M1120.201	20
Trusts Established for Disabled Individuals		
On or After August 11, 1993	M1120.202	22
Uniform Gifts to Minors Act.....	S1120.205	23
Retirement Funds.....	M1120.210	24
Inheritance and Unprobated Estates.....	S1120.215	26
Loans, Promissory Notes, and Property Agreements	S1120.220	27
Reverse Mortgages	M1120.225	29

B. Policy Principles

1. UGMA and Resources

a. General

Since a custodian of UGMA assets cannot legally use any of the funds for his or her own personal benefit, they are not his or her resources. Similarly, once there is a gift under UGMA, additions to or earnings on the principal are not income to the custodian who has no right to use them for his/her own support and maintenance. (Additions to the principal may be income to the donor prior to becoming part of the UGMA principal.) For example, if the donor is a devisor who receives rental income and adds it to a child's UGMA funds, we would have to consider the rental income as income for deeming purposes.

b. While Donee Remains a Minor

- UGMA property, including any additions or earnings, is not income to the **minor**;
- the custodian's UGMA disbursements to the minor **are income to the minor**;
- the custodian's UGMA disbursements on behalf of the minor may be income to the latter if used to make certain third party-vendor payments.

c. When Donee Reaches Majority

All UGMA property becomes available to the donee and subject to evaluation as income in the month of attainment of majority.

M1120.210 RETIREMENT FUNDS

A. Definitions

1. Retirement Funds

Retirement funds are annuities or work-related plans for providing income when employment ends (e.g., pension, disability, or retirement plans administered by an employer or union). Other examples are funds held in an individual retirement account (IRA) and plans for self-employed individuals, sometimes referred to as Keogh plans. Also, depending on the requirements established by the employer, some profit sharing plans may qualify as retirement funds.

2. Periodic Retirement Benefits

Periodic retirement benefits are payments made to an individual at some regular interval (e.g., monthly) and which result from entitlement under a retirement fund.

3. Value of a Retirement Fund

The value of a retirement fund is the amount of money that an individual can currently withdraw from the fund. If there is a penalty for early withdrawal, the fund's value is the amount available to an individual after penalty deduction. However, any taxes due are not deductible in determining the fund's value.

B. Policy Principle

A retirement fund owned by an eligible individual is a resource if he/she has the option of withdrawing a lump sum even though he/she is not eligible for periodic payments. However, if the individual is eligible for periodic payments, the fund may not be a countable resource.

A previously unavailable retirement fund is not income to its recipient when the fund becomes available. The fund is subject to resources counting rules in the month following the month in which it first becomes available.

C. Operating Policies

1. Termination of Employment

A retirement fund is not a resource if an individual must terminate employment in order to obtain any payment.

2. Fund Not Immediately Available

A resources determination for the month following that in which a retirement fund becomes available for withdrawal must include the fund's value. A delay in payment for reasons beyond the individual's control (e.g., an organization's processing time) does not mean that the fund is not a resource since the individual is legally able to obtain the money. It is a nonliquid resource.

3. Claim of Periodic Payment Denied

If an individual receives a denial on a claim for periodic retirement payments but can withdraw the funds in a lump sum, include the fund's lump sum value in the resources determination for the month following that in which the individual receives the denial notice.

D. Development and Documentation

1. Evidence

If an individual has a retirement fund, obtain evidence of the availability of payments from the retirement fund. Determine if the individual is eligible for lump sum or periodic payments.

2. Determination

If the individual can withdraw a lump sum, the retirement fund is a resource in the amount that is currently available.

E. Related Policies

1. Nonliquid Resource

Absent evidence to the contrary, assume that resources in the form of retirement funds are nonliquid (S1110.300 B.).

2. Deeming Exclusion

If an ineligible spouse, or parent, owns a retirement fund, we exclude it from the deeming process. See S0830.500 regarding the treatment of interest income.

NOTE: If the individual is a married institutionalized individual with a community spouse, the retirement funds are evaluated as resources in the resource assessment and the eligibility determination (see M1480).

F. Example

- 1. Situation** Jeff Grant currently works 3 days a week for a company where he has been employed full-time for 20 years. Under his employer's pension plan, Mr. Grant has a \$4,000 retirement fund. The EW confirms that Mr. Grant could withdraw the funds now, but there would be a penalty for early withdrawal and he would forfeit eligibility for an annuity when he stopped working.
- 2. Analysis** Since Mr. Grant can withdraw the retirement funds without terminating employment, they are a resource in the amount available after penalty deduction. This is true despite the fact Mr. Grant forfeits eligibility for periodic annuity payments in the future. All sources of available support (unless otherwise excluded) are considered in determining eligibility.

M1120.215 INHERITANCES AND UNPROBATED ESTATES

A. Introduction

Property in the form of an interest in an undivided estate is to be regarded as an asset when the value of the interest plus all other resources exceed the applicable resource limit, unless it is considered unsalable for reasons other than being an undivided estate. An heir can initiate a court action to partition.

If a partition suit is necessary (because at least one other owner of or heir to the property will not agree to sell the property) in order for the individual to liquidate the interest, estimated partition costs may be deducted from the property's value. However, if such an action would not result in the applicant/recipient securing title to property having value substantially in excess of the cost of the court action, the property would not be regarded as an asset. An ownership interest in an unprobated estate may be a resource if an individual:

- is an heir or relative of the deceased; or
- receives any income from the property; or
- under State intestacy laws, has acquired rights in the property due to the death of the deceased.

The procedure for determining the countable value of an unprobated or undivided estate is found in Appendix 1 to subchapter S1130.

B. For QDWI, QMB, SLMB, QI and ABD 80%FPL

The policy for treatment of an unprobated or undivided estate for the QDWI covered group is in Appendix 1 to chapter S11. The policy for treatment of an unprobated or undivided estate for the QMB, SLMB, QI and ABD 80% FPL covered groups is in Appendix 2 to chapter S11.

C. Operating Policies

1. When to Develop

We develop for this type of resource only if:

- the property in question is not excludable under any of the provisions in S1110.210 B.; and
- counting the property's value would result in excess resources.

Virginia DSS, Volume XIII

S1130 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	Table of Contents, page ii pages 4, 73, 74 Appendix 1, pages 1-14 Appendix 2, page 1 Appendix 4, pages 1-8 added
TN #95	3/1/11	pages 28, 29, 33
TN #94	9/1/10	pages 20, 20a, 28-29a
TN #93	1/1/10	pages 63-65 pages 70, 74, 75
TN #91	5/15/09	page 13

S1130.000 ABD RESOURCES EXCLUSIONS

	Section	Page
RETAINED CASH AND IN-KIND PAYMENTS		
Retroactive SSI and RSDI Payments.....	S1130.600	62
Netherlands WUV Payments to Victims of Persecution	S1130.605	63
German Reparations Payments.....	S1130.610	64
Austrian Social Insurance Payments	S1130.615	65
Disaster Assistance	S1130.620	66
Cash and In-Kind Items Received for the Repair or Replacement of Lost, Damaged, or Stolen Excluded Resources.....	S1130.630	67
Benefits Excluded from Both Income and Resources by a Federal Statute Other Than Title XVI	S1130.640	70
Agent Orange Settlement Payments	S1130.660	70
Victim's Compensation Payments.....	S1130.665	71
State or Local Relocation Assistance Payments.....	S1130.670	72
Tax Advances and Refunds Related to Earned Income Tax Credits <i>And The Tax Relief, Unemployment Insurance Reauthorization And Job Creation Act Of 2010</i>	M1130.675	73
Radiation Exposure Compensation Trust Fund Payments	S1130.680	74
<u>Walker v. Bayer</u> Settlement Payments	M1130.685	75

COMMINGLED FUNDS

Identifying Excluded Funds That Have Been Commingled With Non-excluded Funds	S1130.700	76
---	-----------	----

Appendix

Determining the Countable Value of <i>Home & Contiguous</i> Property	Appendix 1	1
ABD Home Property Evaluation Worksheet	Appendix 2	1
Burial Fund Designation	Appendix 3	1
<i>Determining the Countable Value of Non-Home Real Property</i>	Appendix 4	1

The six-month home exclusion allowed for an institutionalized individual's former home also applies to the home owned by an individual receiving Medicaid community-based care (CBC) services in another person's home, providing the individual resided in the home prior to receipt of Medicaid CBC. See M1460.530 for additional information.

3. Extended Exclusion for Institutionalized Individual

An institutionalized individual's home property continues to be excluded if it is occupied by his:

- spouse;
- minor dependent child under age 18;
- dependent child, **under** age 19, **who attends** school or vocational training; or
- parent or adult child who is disabled (per Medicaid disability definition) and was living in the home with the person for at least one year prior to person's institutionalization, and who is dependent upon the person for his shelter needs.

E. Development and Documentation-- Initial Applications

1. Ownership

a. Verify Ownership

Verify an individual's allegation of home ownership. Have the individual submit one of the items of evidence listed in b.- d. below.

b. Evidence of real property ownership;

- tax assessment notice;
- recent tax bill;
- current mortgage statement;
- deed;
- report of title search;
- evidence of heirship in an unprobated estate (e.g., receipt of income from the property, a will, or evidence of relationship recognizable under State intestate distribution laws in cases where the home is unprobated property).

c. Evidence of personal property ownership (e.g., a mobile home):

- title,
- current registration.

d. Evidence of life estate or similar property rights:

- a deed,
- a will,
- other legal document.

C. Procedure -- Initial Applications and Posteligibility

- 1. When to Develop** When an individual would otherwise be ineligible due to excess resources, determine if applying this exclusion would permit eligibility. If the exclusion would permit eligibility, develop per 2. below.

NOTE: If the individual is resources-eligible even without the application of this exclusion, it is not necessary to develop under this section.

- 2. Development and Documentation** If an individual alleges that his/her resources include unspent relocation assistance payments:
- follow the procedures in S0830.655D.;
 - document the date(s), type(s) and amount(s) of such payments(s); and
 - obtain a statement as to the date(s) and amount(s) of any account deposits corresponding to the payments.

- D. References** Commingled funds, S1130.700.

M1130.675 TAX ADVANCES AND REFUNDS RELATED TO EARNED INCOME TAX CREDITS AND THE TAX RELIEF, UNEMPLOYMENT INSURANCE REAUTHORIZATION AND JOB CREATION ACT OF 2010

A. Policy

- 1. EITC Related Refunds** Effective with resource determinations made for the month of January 1991, an unspent Federal tax refund or payment made by an employer related to Earned Income Tax Credits (EITC's) is excluded from resources **only for the month following the month** the refund or payment is received.

Interest earned on unspent tax refunds related to EITC's is **not** excluded from income or resources by this provision (S0830.500).

- 2. Tax Relief...Act of 2010 Related Refunds and Advance Payments** *Federal tax refunds or advance payments received after December 31, 2009 are **not** to be counted as resources for **12 months following the month** of receipt according to Section 728 of the Tax Relief, Unemployment Insurance Reauthorization and Job Creation Act of 2010 (P.L. 111-312). This provision applies to tax refunds or advance payments received after December 31, 2009 but before January 1, 2013.*

*Interest earned on unspent tax refunds related to the Tax Relief Act is **not** excluded from income or resources by this provision (S0830.500).*

B. Procedure--Initial Claims and Post-Eligibility

- 1. When to Develop** Develop *these* exclusions only when an individual alleges the receipt of assistance excludable under this provision and the exclusion would permit eligibility.

2. Development and Documentation

If an individual alleges that his or her resources include unspent EITC and/or *Tax Relief Act related* refunds or payments:

- verify the source, date(s), and amount(s) of such refund(s) or payment(s) in accordance with S0820.400, and
- obtain a statement as to the date(s) and amount(s) of any account deposits corresponding to the EITC *and/or Tax Relief Act* 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.

DETERMINING THE COUNTABLE VALUE OF *HOME & CONTIGUOUS* PROPERTY

Definitions

1. “Assessed value” means the tax assessed value that a tax assessor’s office places on real property for tax purposes; the tax assessed value is the current fair market value (FMV) of real property. In Virginia, all real property is assessed at 100% of its current FMV, so the assessed value of real property is the current FMV of the property.
2. “Equity value” means the property’s assessed value minus the balance due on the lien (a mortgage or a court-ordered judgment) against the property, **when the lien is in the Medicaid applicant’s name, when the Medicaid applicant is one of the individuals listed on the lien, or when the Medicaid applicant is one of the owners subject to the lien, meaning that he is responsible for paying the lien. If the Medicaid applicant is not subject to the lien, the balance due on the lien is not subtracted from the value of the property. If the Medicaid applicant is one of two or more individuals subject to the lien, then **ONLY** the Medicaid applicant’s fractional share of the lien balance is deducted from the applicant’s share of the property’s value.**
3. “Home property exclusion” means an exclusion for the plot of land on which the home is located. The excluded home lot size may vary according to the locality's building requirements. For localities with a set minimum building lot size, use the lesser of:
 - the plat;
 - the survey; or
 - the locality's minimum size for a building lot.

For localities with no minimum building lot requirements, use the lesser of:

- the plat;
- the survey; or
- one acre.

If the equity value of countable contiguous property causes resources to exceed the maximum limit, re-evaluate the home property applying the definition of the home used in the State Plan for Medical Assistance in Virginia in effect on January 1, 1972. At that time, a “home” meant the house and lot used as the individual’s principal residence and all contiguous property **essential to the operation of the home regardless of value (M1130.100 B.2)**.

4. “Life estate interest” is a limited type of ownership in real property. A life estate conveys to the individual to whom it is given certain property rights for the duration of his or her life, or someone else's life. In some cases, it may be conditional: e.g., for life or until remarriage. The owner of a life estate can sell the life estate interest but does not have title to the property and normally cannot sell the property or pass it on as an inheritance.
5. “Remainderman” is the term used when an individual has an ownership interest in the real property, but does not have the right to possess and use the property until termination of the life estate interest.

A. Procedure #1: Property Owned by One Owner

Step 1 - Determine the *whole* property’s assessed value, the assessed value of the excluded house and homesite, and *determine* the balance due on all liens against the property *if the Medicaid applicant is subject to the lien(s)*.

Step 2 - Assessed value of excluded house and homesite
 + \$5,000 Exclusion
 Excluded property value

Step 3 - Whole property assessed value
 - Excluded property value
 Contiguous property assessed value

Step 4 - Contiguous property assessed value
 ÷ Whole property assessed value
 Portion of whole property value represented by the contiguous property
 x Balance due on the lien(s) in applicant's name
 Contiguous property lien amount

Step 5 - Contiguous property assessed value
 - Contiguous property lien amount
 Contiguous property equity value = Contiguous property countable value

Step 6 – If the contiguous property’s countable value causes excess resources, determine if the contiguous property can be excluded for another reason, such as income-producing. Re-evaluate the home property applying the definition of the home used in the State Plan for Medical Assistance in Virginia in effect on January 1, 1972. At that time, a “home” meant the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value.

EXAMPLE #1 (one-owner property, not re-evaluated):

Example #1, Step 1:

Whole property assessed value = \$81,500
 Assessed value of homesite (the excluded house, homesite, buildings, etc.) = \$64,000
 Balance due on property's mortgage (applicant is the only owner subject to the lien) = \$72,000

Example #1, Step 2:

\$64,000 Assessed value of house & homesite
 + 5,000 Exclusion
 69,000 Excluded property value

Example #1, Step 3:

\$81,500 Whole property assessed value
 - 69,000 Excluded property value
 \$12,500 Contiguous property assessed value

Example #1, Step 4:

\$ 12,500.00 Contiguous property assessed value
 ÷ 81,500.00 Total property assessed value
 .1533 Portion of whole property value represented by the contiguous property
 x 72,000.00 Balance due on lien
 11,037.60 Contiguous property lien amount

Example #1, Step 5:

\$12,500.00 Contiguous property *assessed* value
- 11,037.60 Contiguous property lien amount
 \$ 1,462.40 Contiguous property equity value

Example #1, Step 6:

The property does not produce any income and is not used to produce goods or services that are essential to the operation of the home.

\$ 1,462.40 contiguous property countable value

B. Procedure #2: Joint Ownership, Undivided Estate or Unprobated Estate, one owner subject to lien

Step 1 - Determine the *whole* property’s assessed value, the assessed value of the excluded house and homesite, and *determine* the balance due on all liens against the property *if the Medicaid applicant is subject to the lien(s)*.

Step 2 - **When a partition suit is necessary to liquidate the property because at least one owner does not agree to sell the contiguous property:** Determine the shared partition costs for liquidating the property. Use the average cost of partitioning in the locality where the property is located, based on the **assessed** (not equity) value of the *whole* property.

If a partition suit is NOT necessary to liquidate the property (all the owners agree to sell it), **do not** subtract any partition costs or attorneys' fees; insert zeros in the formula in place of partition costs and attorney’s fees.

Step 3 - Assessed value homesite property
+ \$5,000 Exclusion
 Excluded property value

Step 4 - *Whole* property assessed value
 - Shared partition costs
 Countable assessed value
 - Excluded property value
 Contiguous property *assessed* value

Step 5 - Contiguous property *assessed* value
 ÷ Whole property assessed value
 Portion of *whole* property value represented by the contiguous property
 x Balance due on the lien(s)
 Contiguous property lien amount
 ÷ Number of owners subject to lien
 Applicant’s share of contiguous property lien amount

Step 6 - Contiguous property *assessed* value
 ÷ Applicant’s ownership share
 Applicant’s share of contiguous property assessed value
 - Applicant’s share of contiguous property lien amount
 Applicant’s share contiguous property equity value
 - Applicant's attorney fees
 Contiguous property countable value

Step 7 – If the contiguous property’s countable value causes excess resources, determine if the contiguous property can be excluded for another reason, such as income-producing. Re-evaluate the home property applying the definition of the home used in the State Plan for Medical Assistance in Virginia in effect on January 1, 1972. At that time, a “home” meant the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value.

EXAMPLE #2 (undivided joint ownership, one owner subject to lien, not re-evaluated):

An applicant owns a 1/3 interest in his home, lot, and 4 acres of contiguous property. There is a lien on this property with a balance due of \$10,000. *The applicant is the only owner subject to the lien.* The assessed value of the house and homesite lot is \$40,000 and the 4 acres of contiguous property has an assessed value of \$60,000 (\$100,000 is the whole property’s assessed value). *One owner, not the applicant, does not agree to sell the contiguous property.* The estimated shared cost of partitioning is \$2,000 and the applicant's attorney's fees will be \$1,000.

Example #2, Step 1:

Whole property’s assessed value = \$100,000
 Assessed value of homesite (the excluded house, homesite, buildings, etc.) = \$40,000
 Contiguous property (4 acres) = \$60,000
 Balance due on whole property's mortgage = \$10,000

Example #2, Step 2:

Shared partition costs = \$2,000
 Applicant's attorney's fees = \$1,000

Example #2, Step 3:

\$ 40,000 Assessed value of homesite
 + 5,000 Exclusion
 45,000 Excluded property value

Example #2, Step 4:

\$100,000 Whole property assessed value
 - 2,000 Shared partition costs
 98,000 Countable assessed value
 - 45,000 Excluded property value
 53,000 Contiguous property assessed value

Example #2, Step 5:

\$ 53,000 Contiguous property assessed value
 ÷ 100,000 Whole property assessed value
 .53 Portion of whole property value represented by the contiguous property
 x 10,000 Balance due on the lien(s)
 5,300 Contiguous property lien amount
 ÷ 1 Number of owners subject to lien
 5,300 Applicant’s share of contiguous property lien amount

Example #2, Step 6:

$$\begin{array}{r} \$ 53,000.00 \text{ Contiguous property assessed value} \\ \div \quad \quad 3 \text{ Applicant's ownership share} \\ \hline 17,666.67 \text{ Applicant's share of contiguous property assessed value} \\ - \quad 5,300.00 \text{ Applicant's share of contiguous property lien amount} \\ \hline 12,366.67 \text{ Applicant's share contiguous property equity value} \\ - \quad 1,000.00 \text{ Applicant's attorney fees} \\ \hline \mathbf{\$11,366.67 \text{ Contiguous property equity value}} \end{array}$$

Example #2, Step 7:

The property does not produce any income and is not used to produce goods or services that are essential to the operation of the home.

\$11,366.67 contiguous property countable value

C. Procedure #3: Re-evaluated homesite, partition required, multiple owners subject to lien

Step 1 - Determine the *whole* property's assessed value, the assessed value of the excluded house and homesite, and *determine* the balance due on all liens against the property *if the Medicaid applicant is subject to the lien(s)*. *If another owner is subject to the lien, calculate the applicant's share of the lien balance by dividing the lien balance by the number of owners subject to the lien. The formula will calculate the applicant's share of the lien balance that is against the contiguous property.*

Step 2 - **When a partition suit is necessary to liquidate the property:** Determine the shared partition costs for liquidating the property. Use the average cost of partitioning in the locality where the property is located, based on the **assessed** (not equity) value of the *whole* property.

If a partition suit is NOT necessary to liquidate the property (all the owners agree to sell it), do not subtract any partition costs or attorney's fees; insert zeros in the formula in place of partition costs and attorney's fees.

Step 3 - Assessed value *house & homesite* property
+ \$5,000 exclusion
Excluded property value

Step 4 - Total property assessed value
- Shared partition costs
Countable assessed value
- Excluded property value
Contiguous property *assessed* value

Step 5 - Contiguous property *assessed* value
÷ Whole property assessed value
Portion of *whole* property value represented by the contiguous property
x Balance due on the lien(s)
Contiguous property lien amount
÷ Number of owners subject to lien
Applicant's share of contiguous property lien amount

Step 6 - Contiguous property *assessed* value

$$\begin{array}{r} \div \text{Applicant's ownership share} \\ \text{Applicant's share of contiguous property assessed value} \\ - \text{Applicant's share of contiguous property lien amount} \\ \text{Applicant's share contiguous property equity value} \\ - \text{Applicant's attorney fees} \\ \hline \text{Contiguous property countable value} \end{array}$$

Step 7 – If the applicant's countable equity in the contiguous property causes excess resources, re-evaluate the property using the 1972 definition of homesite to determine if the use of the contiguous land would mean more property excluded as the homesite. The \$5,000 exclusion is NOT applied when the homesite is re-evaluated using the 1972 definition of home and homesite.

Determine how much of the contiguous property is actually used by the household as part of the homesite.

Step 8 - Assessed value of house and homesite

$$\begin{array}{r} + \text{Value of additional contiguous property used for homesite} \\ \hline \text{Excluded property value} \end{array}$$

Step 9 - Whole property assessed value

$$\begin{array}{r} - \text{Excluded property value} \\ \hline \text{Contiguous property assessed value} \end{array}$$

Step 10 - Contiguous property *assessed* value

$$\begin{array}{r} \div \text{Whole property assessed value} \\ \text{Portion of whole property value represented by the contiguous property} \\ \times \text{Balance due on the lien(s)} \\ \hline \text{Contiguous property lien amount} \\ \div \text{Number of owners subject to lien} \\ \hline \text{Applicant's share of contiguous property lien amount} \end{array}$$

Step 11 – Contiguous property *assessed* value

$$\begin{array}{r} \div \text{Applicant's ownership share} \\ \text{Applicant's share of contiguous property assessed value} \\ - \text{Applicant's share of contiguous property lien amount} \\ \text{Applicant's share contiguous property equity value} \\ - \text{Applicant's attorney fees} \\ \hline \text{Re-evaluated contiguous property countable value} \end{array}$$

Use the lesser of the Contiguous Property Countable Value and the Re-evaluated Contiguous Property Countable Value.

Step 12: If the individual still has excess resources, evaluate the contiguous property to determine if it can be excluded for another reason or a disregard applied, such as the exclusion or disregard applicable to income-producing property.

EXAMPLE #3 (re-evaluated homesite, partition required, multiple owners subject to lien):

Example #3, Step 1:

Applicant owns a 1/3 undivided share in his house, homesite and 10 contiguous acres; the *whole* property is assessed at \$100,000. A partition suit is necessary to liquidate the contiguous property because one

owner does not agree to sell the property. The lien on the property is in the 3 owners' names, so the 3 owners are subject to the lien. The property does not produce any income to the applicant.

Assessed value of *whole* property = \$100,000
Assessed value of homesite (the excluded house, homesite, buildings, etc.) = \$40,000
Contiguous property assessed value = \$60,000
Balance due on entire property's mortgage = \$12,000

Example #3, Step 2:

Shared partition costs = \$2,000
Applicant's attorney's fees = \$1,000

Example #3, Step 3:

\$ 40,000 Assessed value of homesite
+ 5,000 Exclusion
45,000 Excluded property value

Example #3, Step 4:

\$100,000 *Whole* property assessed value
- 2,000 Shared partition costs
98,000 Countable assessed value
- 45,000 Excluded property value
53,000 *Contiguous property assessed value*

Example #3, Step 5:

\$ 53,000 *Contiguous property assessed value*
÷ 100,000 *Whole property assessed value*
.53 *Portion of whole property value represented by the contiguous property*
x 12,000 *Balance due on the lien(s)*
\$ 6,360 *Contiguous property lien amount*
÷ 3 *Number of owners subject to lien*
2,120 *Applicant's share of contiguous property lien amount*

Example #3, Step 6:

\$53,000.00 *Contiguous property assessed value*
÷ 1/3 *Applicant's ownership share*
17,666.67 *Applicant's share of contiguous property assessed value*
- 2,120.00 *Applicant's share of contiguous property lien amount*
15,546.67 *Applicant's share contiguous property equity value*
- 1,000.00 *Applicant's attorney fees*
14,546.67 *Contiguous property countable value*

\$14,546.67 causes the applicant to have excess resources, so the homesite is re-evaluated for actual use *using the 1972 definition of homesite.*

Example #3, Step 7:

The applicant says that of the contiguous 10 acres, 1 is used for a garden to grow produce used by the household, 1 acre is used for the livestock raised for home consumption, ½ acre is used for the family cemetery, and 1 acre is used for the septic system; a total of 3.5 additional acres are used as the homesite. *The property does not produce any income.*

Assessed value of *whole* property = \$100,000
 Assessed value of homesite (the excluded house, homesite, buildings, etc.) = \$40,000
 Assessed value 10 contiguous acres = \$60,000 ÷ 10 = 6,000 per acre
 \$6,000 value per acre x 3.5 acres = \$21,000 additional property value excluded *as homesite*

Example #3, Step 8:

\$ 40,000 Assessed value of homesite
+ 21,000 Value of additional property excluded as homesite
 \$ 61,000 Excluded property value

Example #3, Step 9:

\$100,000 *Whole* property assessed value
- 2,000 Shared partition costs
 98,000 Countable assessed value
- 61,000 Excluded property value
 37,000 Contiguous property *assessed* value

Example #3, Step 10:

\$ 37,000.00 Contiguous property *assessed* value
÷ 100,000.00 Whole property assessed value
 .37 Portion of property value represented by the contiguous property
x 12,000.00 Balance due on the lien(s)
 \$ 4,440.00 Contiguous property lien amount
÷ 3 Number of owners subject to lien
 1,480.00 Applicant's share of contiguous property lien amount

Example #3, Step 11:

\$ 37,000.00 Contiguous property *assessed* value
÷ 1/3 Applicant's ownership share
 12,333.33 Applicant's share of contiguous property assessed value
- 1,480.00 Applicant's share of contiguous property lien amount
 10,853.33 Applicant's share contiguous property equity value
- 1,000.00 Applicant's attorney fees
 9,853.33 Re-evaluated contiguous property countable value

Because *the \$9,853.33 re-evaluated value* is less than *the \$14,546.67 value first determined*, the countable value of the applicant's contiguous property is \$9,853.33. The applicant has excess resources and is not eligible for ABD Medicaid.

D. Procedure #4: One Owner (Remainderman), One Life Interest Owner, Lien

Step 1 – When the Medicaid applicant is a remainderman and lives on the property in which he owns a remainder interest, determine the age of the life interest owner, determine the whole property’s assessed value, the assessed value of the excluded house and homesite, and determine the balance due on all liens against the property if the Medicaid applicant is subject to the lien(s). No estimated costs of selling the remainder interest are deducted from the countable value.

Step 2 – Calculate the assessed value of the contiguous property:

*Assessed value of excluded house and homesite
+ \$5,000 Exclusion
Excluded property value*

*Whole property assessed value
- Excluded property value
Contiguous property assessed value*

Step 3 – The applicant is the remainderman on this property – determine the value of the remainder interest in the contiguous property which will be countable EVEN IF the life interest holder does NOT agree to sell the life interest.

*Contiguous property assessed value
X Remainder interest factor based on life interest owner’s age (from table in M1140.120)
Remainder interest value*

Step 4 – Calculate the contiguous property lien amount – the portion of the lien that is against the contiguous property:

*Contiguous property assessed value
÷ Whole property assessed value
Portion of whole property value represented by the contiguous property
x Balance due on the lien(s) to which applicant is subject
Contiguous property lien amount*

Step 5 – Calculate the countable value of the remainder interest in contiguous property:

*Remainder interest value
- Contiguous property lien amount
Countable value of remainder interest in contiguous property*

Step 6 - If the contiguous property’s countable value causes excess resources, determine if the contiguous property can be excluded for another reason, such as income-producing. Re-evaluate the home property applying the definition of the home used in the State Plan for Medical Assistance in Virginia in effect on January 1, 1972. At that time, a “home” meant the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value.

Example #4 - One Owner (Remainderman), One Life Estate Owner, Lien:

Example #4, Step 1:

Whole property assessed value = \$81,500
Assessed value of homesite (the excluded house, homesite, buildings, etc.) = \$64,000
Balance due on property's lien (applicant is the only owner subject to the lien) = \$10,000
Life interest owner is 71 years old

Example #4, Step 2:

\$64,000 Assessed value of excluded house and homesite
+ 5,000 Exclusion
\$69,000 Excluded property value

\$81,500 Whole property assessed value
- 69,000 Excluded property value
\$12,500 Contiguous property assessed value

Example #4, Step 3:

The life interest owner is 71 years old.

\$ 12,500.00 Contiguous property assessed value
X .41086 Remainder interest factor based on life interest owner's age (from table in M1140.120)
\$ 5,135.75 Remainder interest value

Example #4, Step 4:

\$ 12,500 Contiguous property assessed value
÷ 81,500 Whole property assessed value
.1534 Portion of whole property value represented by the contiguous property
X 10,000 Balance due on the lien(s)
\$ 1,534 Contiguous property lien amount

Example #4, Step 5:

\$5,135.75 Remainder interest value
- 1,534.00 Contiguous property lien amount
\$3,601.75 Countable value of remainder interest in contiguous property

Example #4, Step 6:

The contiguous property's countable value of \$3,601.75 causes excess resources. The contiguous property does not produce any income. The home property is re-evaluated for actual use using the 1972 definition of home property.

The applicant says that of the contiguous 5 acres, 1 acre is used for a garden to grow produce used by the household and 1 acre is used for the septic system; a total of 2 additional acres are used as the homesite.

Assessed value of whole property = \$81,500
Assessed value of homesite (the excluded house, homesite, buildings, etc.) = \$64,000
Assessed value 5 contiguous acres = \$17,500 ÷ 5 = \$3,500 per acre
\$3,500 value per acre x 2 acres = \$7,000 additional property value excluded as essential to homesite

\$64,000 Assessed value of home & homesite
+ 7,000 Value of additional property excluded as homesite
\$ 71,000 Excluded home property value

\$81,500 Assessed value of whole property
-71,000 Excluded home property value
10,500 Contiguous property assessed value

The life interest owner is 71 years old.

\$ 10,500.00 Contiguous property assessed value
X .41086 Remainder Interest Factor Based on Life Interest Owner's Age (from table in M1140.120)
\$4,314.03 Remainder interest value

\$ 10,500 Contiguous property assessed value
÷ 81,500 Whole property assessed value
.1288 Portion of whole property value represented by the contiguous property
X 10,000 Balance due on the lien(s)
\$ 1,288 Contiguous property lien amount

\$4,314.03 Remainder interest value
-1,288.00 Contiguous property lien amount
\$3,026.03 Re-evaluated countable value of remainder interest in contiguous property

Because \$3,026.03 is less than \$3,601.75, the re-evaluated countable value of the applicant's remainder interest in the contiguous property is used for the contiguous property countable value, and is added to all other resources to determine eligibility.

\$3,026.03 contiguous property countable value.

E. Procedure #5: Joint Owners (Remaindermen), One Life Estate Owner, Lien

This is home and contiguous real property that is owned jointly (undivided estate) and is subject to a life interest owner; the Medicaid applicant is one of the owners (remaindermen). The Medicaid applicant lives on the property in which he owns a remainder interest. Because there is a life interest owner of this property and life estate property cannot be divided, **no** estimated partition costs & attorney's fees are deducted from the value of the Medicaid applicant's remainder share.

Step 1 - Determine the total property assessed value, the assessed value of the excluded house and homesite, the balance due on all liens against the property if the applicant is subject to the lien, and the age of the life interest owner.

Step 2 – Calculate the assessed value of the contiguous property:

Assessed value of excluded house and homesite
+ \$5,000 Exclusion
Excluded property value

Whole property assessed value
- Excluded property value
Contiguous property assessed value

Step 3 – The applicant is one of the remaindermen owners of this property – determine the value of the remainder interest in the contiguous property which will be countable EVEN IF the life interest holder does NOT agree to sell the life interest.

Contiguous property assessed value
X Remainder interest factor based on life interest owner's age (from table in M1140.120)
Remainder interest value

Step 4 – Calculate the contiguous property lien amount – the portion of the lien that is against the contiguous property:

Contiguous property assessed value
÷ Whole property assessed value
Portion of whole property value represented by the contiguous property
x Balance due on the lien(s) to which the applicant is subject
Contiguous property lien amount

Step 5: Calculate the equity value of applicant's share of the remainder interest in contiguous property:

Remainder interest value
÷ Number of remaindermen (joint owners of property)
Applicant's share of remainder interest
- Contiguous property lien amount
Equity value of applicant's remainder interest = Countable value of contiguous property

Step 6 - If the countable value of the contiguous property causes excess resources, determine if the contiguous property can be excluded for another reason, such as income-producing. Re-evaluate the home property applying the definition of the home used in the State Plan for Medical Assistance in Virginia in effect on January 1, 1972. At that time, a "home" meant the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value.

Example #5 Joint Owners (Remaindermen), One Life Estate Owner, Lien

An applicant owns ½ remainder interest (2 owners) in non-home, non-business real property; there is one life interest owner, age 80. There is a lien on this property and the applicant is the only remainderman owner subject to the lien. The lien balance due is \$10,000. The assessed value of the property is \$181,500. The life interest owner agrees to sell, but the other remainderman owner does not agree to sell. No estimated costs of partitioning or selling the property are deducted.

Example #5, Step 1:

Whole property assessed value = \$181,500
Assessed value of homesite (the excluded house, homesite, buildings, etc.) = \$64,000
Balance due on property's lien (applicant is the only owner subject to the lien) = \$10,000

\$ 64,000 Assessed value of home & homesite
+ 47,000 Value of additional property excluded as homesite
\$111,000 Excluded home property value

\$181,500 Assessed value of whole property
-111,000 Excluded home property value
\$ 70,500 Contiguous property assessed value

The life interest owner is 80 years old.

\$ 70,500.00 Contiguous property assessed value
X .56341 Remainder interest factor based on life interest owner's age (from table in M1140.120)
\$39,720.41 Remainder interest value

\$ 70,500 Contiguous property assessed value
÷ 181,500 Whole property assessed value
.3884 Portion of whole property value represented by the contiguous property
X 10,000 Balance due on the lien(s)
\$ 3,884 Contiguous property lien amount

\$39,720.41 Remainder interest value
- 3,884.00 Contiguous property lien amount
\$35,836.41 Re-evaluated countable value of remainder interest in contiguous property

Because the \$35,836.41 re-evaluated countable value is less than \$39,720.41, the re-evaluated value of the applicant's remainder interest in the contiguous property, \$35,836.41, is used for the contiguous property countable value of the property and is added to all other resources to determine eligibility.

\$35,836.41 contiguous property countable value

ABD Home Property Evaluation Worksheet

<p>I. \$5,000 Exclusion</p> <p>1. Assessed Value (AV) (1a) <i>House & homesite</i> _____ (1b) Contiguous + _____ (1c) Total AV = _____</p> <p>2. Enter Lien <i>Balance Due</i> _____</p> <p>3. AV <i>house & homesite</i> (1a) _____ 4. Exclusion + \$5,000 _____ 5. Excluded Property = _____</p> <p>6. Total AV (1c) _____ 7. *Partition Costs - _____ 8. Countable AV = _____</p> <p>9. Excluded Property (5) - _____</p> <p>10. Contiguous Property AV= _____</p> <p>11. Total AV (1c) ÷ _____ 12. % Contiguous Property = _____</p> <p>13. Lien <i>Balance</i> (2) X _____</p> <p>14. Lien on <i>Contiguous</i> Property = _____</p> <p>15. Contiguous Property AV (10) _____</p> <p>16. Lien on Contiguous Property (14) - _____</p> <p>17. Equity in Contiguous Property = _____</p> <p>18. Applicant's Share ÷ _____</p> <p>19. Countable Equity Contiguous = _____ Property</p> <p>20. *Applicant's Attorney Fees - _____</p> <p>21. Countable Equity <i>in</i> Contiguous = _____ Property</p> <p>If countable equity + all other countable resources exceed resource limit, go to Section II.</p> <p>*Use if jointly owned, undivided or unprobated estate and partition is required</p>	<p>II. January 1972 Use of Land Home Exclusion</p> <p>22. #Acres Used/Essential to Home _____ 23. Assessed Value Per Acre X _____ 24. <i>Additional</i> Exclusion = _____</p> <p>25. AV <i>House & homesite</i> (1a) _____</p> <p>26. <i>Additional</i> Exclusion (24) + _____</p> <p>27. Excluded Property = _____</p> <p>29. Total AV (1c) _____</p> <p>30. *Partition Costs - _____</p> <p>31. Countable AV = _____</p> <p>32. Excluded Property (27) - _____</p> <p>33. Contiguous Property AV= _____</p> <p>34. Total AV (1c) ÷ _____</p> <p>35. % Contiguous Property = _____</p> <p>36. Lien <i>Balance</i> (2) X _____</p> <p>37. Lien on <i>Contiguous</i> Property = _____</p> <p>38. Contiguous Property AV (33) _____</p> <p>39. Lien <i>on</i> Contiguous Property (37) - _____</p> <p>40. Equity in Contiguous Property = _____</p> <p>41. Applicant's Share ÷ _____</p> <p>42. Countable Equity Contiguous = _____ Property</p> <p>43. *Applicant's Attorney Fees - _____</p> <p>43. Countable Equity/Contiguous = _____ Property</p> <p>Compare line 21 to line 43. Countable resource is the lesser of the two.</p>
--	---

DETERMINING THE COUNTABLE VALUE OF NON-HOME REAL PROPERTY

Definitions

1. "Assessed value" means the tax assessed value that the tax assessor's office places on the real property for tax purposes; the tax assessed value is the current fair market value (FMV) of the real property. In Virginia, all real property is assessed at 100% of its current FMV, so the assessed value of the real property is the current FMV of the property.
2. "Equity value" means the property's assessed value minus the balance due on the lien (a mortgage or a court-ordered judgment) against the property, **when the lien is in the Medicaid applicant's name, when the Medicaid applicant is one of the individuals listed on the lien, or when the Medicaid applicant is one of the owners subject to the lien, meaning responsible for paying the lien. If the Medicaid applicant is not subject to the lien, the balance due on the lien is not subtracted from the value of the property. If the Medicaid applicant is one of two or more individuals subject to the lien, then ONLY the Medicaid applicant's fractional share of the lien balance is deducted from the applicant's share of the property's value.**
3. "Life estate interest" is a limited type of ownership in real property. A life estate conveys to the individual to whom it is given certain property rights for the duration of his or her life, or someone else's life. In some cases, it may be conditional: e.g., for life or until remarriage. The owner of a life estate can sell the life estate interest but does not have title to the property and normally cannot sell the property or pass it on as an inheritance.
4. "Remainderman" is the term used when an individual has an ownership interest in the real property, but does not have the right to possess and use the property until termination of the life estate interest.

A. Procedure A: Non-business Real Property Owned by One Owner, Not Producing Income

Step 1 - Determine the total property assessed value and the balance due on all liens against the property that are in the applicant's name.

Step 2 - Property assessed value

- Lien amount balance (when Medicaid applicant is subject to the lien)
Equity value

Example A1 (one-owner non-business, non-income-producing property):

Example #A1, Step 1:

Total property assessed value = \$81,500

Balance due on property's mortgage (applicant is subject to the lien) = \$72,000

Example #A1, Step 2:

\$81,500 Total property assessed value
- 72,000 Lien balance
\$ 9,500 Equity value

\$9,500 is countable value

B. Procedure B: Non-business Real Property Owned by One Owner, producing income

Step 1 - Determine the total property assessed value and the balance due on all liens against the property to which the Medicaid applicant is subject.

Step 2 - Property assessed value
- Lien amount balance (the applicant is subject to the lien)
Equity value of property

Step 3 - The real property is not business property, so determine if the \$6,000 disregard applies to the property because the property is essential to self-support (S1130.502 and S1130.503):

Ask: Does property produce goods/services essential to the individual's daily activities?

If yes, subtract the \$6,000 disregard from the equity value, regardless of how much income the property produces – no rate of return is calculated.

If no, does the property produce net annual income (after all expenses are subtracted from the gross annual income produced by the property) that equals or exceeds 6% of the property's **excluded equity** value?

If yes, subtract the \$6,000 disregard from the equity value.

If no, do not subtract the \$6,000 disregard.

Example B1 (one-owner non-business, income-producing property, essential to daily living - M1130.502):

Example #B1, Step 1:

Total property assessed value = \$81,500
Balance due on property's mortgage (applicant is subject to the lien) = \$72,000

Example #B1, Step 2:

\$81,500 Total property assessed value
- 72,000 Lien balance
\$ 9,500 Equity value

Example #B1, Step 3:

Does property produce goods/services essential to the individual's daily activities?

Yes – property is used as a garden for the individual's household's consumption – only any excess not used by the household is sold, and the individual receives only \$100 a year from selling the excess. Rate of return is not calculated because the property is used to produce goods essential to the individual's daily activities.

\$ 9,500 Equity value
- 6,000 Disregard
\$ 3,500 Countable value of property

Example #B2 (one-owner non-business, income-producing property, NOT essential to daily living – M1130.503):

Example #B2, Step 1:

Total property assessed value = \$90,500
Balance due on property's mortgage (applicant is subject to the lien) = \$70,000

Example #B2, Step 2:

\$90,500 Total property assessed value
- 70,000 Lien balance
\$20,500 Equity value

Example #B2, Step 3:

Does property produce goods/services essential to the individual's daily activities? No.

Does the property produce net annual income (after all expenses are subtracted from the gross annual income produced by the property) that equals or exceeds 6% of the excluded equity value? Because the equity value is over \$6,000, the excluded equity value cannot exceed \$6,000; the rate of return is calculated on the maximum \$6,000 excluded equity value.

Calculate rate of return:

\$10,000 Gross annual income from property
- 2,000 Annual expenses to produce income
\$ 8,000 Net annual income from property

\$6,000 Excluded equity value of property
X .06 6%
\$ 360 6% of equity

Because \$8,000 net annual income from the property exceeds \$360 (6% of the excluded equity value), the property produces the required rate of return and the \$6,000 disregard is subtracted from the equity value to determine the countable value of the property:

\$ 20,500 Equity value
- 6,000 Disregard
\$ 14,500 Countable value of property

Example #B3 (one-owner non-business, income-producing, NOT essential, equity < \$6,000 – M1130.503):

Example #B3, Step 1:

Total property assessed value = \$12,500
Balance due on property's mortgage (applicant is subject to the lien) = \$7,000

Example #B3, Step 2:

\$12,500 Total property assessed value
- 7,000 Lien balance
\$ 5,500 Equity value

Example #B3, Step 3:

Does property produce goods/services essential to the individual's daily activities? No.

Does the property produce net annual income (after all expenses are subtracted from the gross annual income produced by the property) that equals or exceeds 6% of the excluded equity value? Yes.

Calculate rate of return:

\$2,000 Gross annual income from property
- 100 Annual expenses to produce income
\$1,900 Net annual income from property

\$5,500 Equity value of property
X .06 6%
\$ 330 6% equity

Because the \$1,900 net annual income from the property exceeds \$330 (6% of the excluded equity value of \$5,500), the property produces the required rate of return and the \$6,000 disregard is applicable. Because the equity value of the property is less than \$6,000, the entire equity value is subtracted from the equity value to determine the countable value of the property:

\$ 5,500 Equity value
-5,500 Disregard
\$ 0 Countable value of property

C. Procedure C: Real Property Owned by One Owner (Remainderman) and One Life Interest Owner

Step 1 - Determine the age of the life interest owner, the property's assessed value and the balance due on the lien against the property when the applicant is subject to the lien. If there is more than one owner subject to the lien, determine the number of owners subject to the lien.

Step 2 - The applicant is the remainderman on this property – determine the value of the remainder interest in the property which will be countable EVEN IF the life interest holder does NOT agree to sell the life interest. No estimated costs of selling the remainder interest are deducted:

Assessed value of property
X Remainder interest factor based on life interest owner's age (from table in M1140.120)
Remainder interest value
- Lien balance (or portion) if applicant is subject to the lien
Countable value of remainder interest in property

Example #C1 - Real Property Owned by One Owner (Remainderman) and One Life Interest Owner:

Example #C1, Step 1:

Total property assessed value = \$81,500
Balance due on property's mortgage; applicant is NOT subject to the lien = \$72,000

Example #C1, Step 2:

The life interest owner's age is 60 years old.

\$81,500.00 Assessed value
X .25509 Factor from table for life interest owner 60 years old
\$20,789.84 Remainder interest value
- 0 Lien balance (applicant is not subject to the lien)
\$20,789.84 Equity value of remainder interest

\$20,789.84 countable value of real property

D. Procedure D: Joint Ownership - Undivided Estate or Unprobated Estate

This is non-home real property that is owned jointly (undivided estate).

Step 1 - Determine the total property assessed value and the balance due on all liens against the property to which the applicant is subject. If there is more than one owner subject to the lien, determine the number of owners subject to the lien.

Step 2 - When a partition suit is necessary to liquidate the property: Determine the shared partition costs for liquidating the property. Use the average cost of partitioning in the locality where the property is located, based on the **assessed** (not equity) value of the TOTAL property.

If a partition suit is NOT necessary to liquidate the property (all the owners agree to sell it), do not subtract any partition costs or attorneys' fees; insert zeros in the formula in place of partition costs and attorneys fees.

Step 3 - Assessed value of property
- Shared partition costs
Assessed value less shared partition costs

Step 4 - Assessed value less shared partition costs
÷ Applicant's ownership share of property
Applicant's share
- Balance due on the lien(s) (or portion) when applicant is subject to the lien
- Applicant's attorney fees
Applicant's equity value

Step 5 – When the property produces income to the applicant, determine if the \$6,000 disregard can be subtracted from the Applicant's Equity Value (S1130.502 and S1130.503):

Ask: Does property produce goods/services essential to the individual's daily activities?

If yes, subtract the \$6,000 from the Applicant's Equity Value, regardless of how much income the property produces to the applicant – no rate of return is calculated.

If no, does the property produce net annual income (after all expenses are subtracted from the gross annual income produced by the property) that equals or exceeds 6% of the property's **excluded equity** value (the excluded equity value cannot exceed \$6,000)? If yes, subtract the \$6,000 disregard from the Applicant's Equity Value. If no, do not subtract the \$6,000 disregard.

Example #D1 (undivided joint ownership, producing income):

Example #D1 - An applicant owns a 1/3 interest in non-home, non-business real property. There is a lien on this property; the applicant and another owner are subject to the lien that has a balance due of \$10,000. The assessed value of the property is \$100,000. A co-owner does not agree to sell, so a partition suit is required to sell the property. The estimated shared cost of partitioning is \$2,000 and the applicant's attorney's fees will be \$1,000. The property produces \$200 per year gross income to the applicant; there are no expenses to produce the income.

Example #D1, Step 1:

Assessed value of total property = \$100,000
Balance due on entire property's mortgage = \$10,000
Applicant's one-half share of lien balance = \$5,000

Example #D1, Step 2:

Shared partition costs = \$2,000
Applicant's attorney's fees = \$1,000

Example #D1, Step 3:

\$100,000 Total property assessed value
- 2,000 Shared partition costs
98,000 Assessed value less shared partition costs

Example #D1, Step 4:

\$98,000 Assessed value less shared partition costs
÷ 3 Applicant's ownership share of property owners
\$32,666.67 Applicant's share
- 5,000.00 Applicant's share of balance due on the lien
- 1,000.00 Applicant's attorney fees
\$26,666.67 Applicant's equity value

Example #D1, Step 5:

Does property produce goods/services essential to the individual's daily activities? No

Does the property produce net annual income (after all expenses are subtracted from the gross annual income produced by the property) to the applicant that equals or exceeds 6% of the excluded equity value (\$6,000)? If yes, subtract the \$6,000 disregard from the Applicant's Equity Value. If no, do not subtract the \$6,000 disregard.

Calculate rate of return:

\$6,000 Excluded equity value of property
X .06 6%
\$ 360 6% Rate of Return

Since the annual net income received from the property is \$200, which is **less than** the required rate of return of \$360, the \$6,000 disregard is **not** subtracted when determining the countable value of the property:

\$26,666.67 Applicant's equity value
- 0 Disregard
\$26,666.67 Countable value of real property

E. Procedure E: Joint Owners (Remaindermen), One Life Interest Owner, produces income

This is non-home real property that is owned jointly (undivided estate), has one life interest owner, and the property produces income to the applicant who is one of the owners (remaindermen). No \$6,000 disregard is applicable to remainder interests in real property. No estimated partition costs & attorney's fees are deducted because the property is subject to a life estate interest.

Step 1 - Determine the total property assessed value and the balance due on all liens against the property to which the applicant is subject. When there is more than one owner subject to the lien, determine the number of owners subject to the lien to determine the Medicaid applicant's share of the lien balance. No estimated partition costs & attorney's fees are deducted.

Step 2 - Determine value of the remainder interest in the property (M1140.120) regardless of whether the life interest owner agrees to sell the life interest, using the age of the life interest owner:

Assessed value of property
X Remainder interest factor based on life interest owner's age (from table in M1140.120)
Remainder interest value

Step 3: Remainder interest value
÷ Applicant's ownership share of remaindermen (joint owners of property)
Applicant's share of remainder interest
- Lien balance (or portion) when applicant is subject to lien
Countable value of property

Example #E1 - Joint Owners (Remaindermen), 1 Life Interest Owner, produces income:

An applicant owns 1/2 remainder interest in non-home, non-business real property; there is one life interest owner, aged 80 years. There is a lien on this property; the applicant is the only owner who is subject to the lien. The balance due on the lien is \$10,000. The assessed value of the property is \$81,500. The life interest owner agrees to sell, but the other remainder owner does not agree to sell. No estimated costs of partitioning or selling the property are deducted. No \$6,000 disregard for income-producing property is allowed on a remainder interest.

Example #E1, Step 1:

Total property assessed value = \$81,500
Balance due on property's mortgage (applicant is only owner subject to lien) = \$10,000

Example #E1, Step 2:

The life interest owner's age is 80 years old.

\$81,500.00 Total property assessed value
X .56341 Factor from table for life interest owner's Age (80 years old)
\$45,917.92 Value of remainder interest

Example #E1, Step 3:

\$45,917.92 Value of remainder interest
÷ 1/2 Applicant's ownership share of remainder interest (joint owners of property)
\$22,958.96 Applicant's share of remainder interest
- 10,000.00 Lien balance (applicant is the only owner subject to lien)
\$12,958.96 Countable value of property

\$12,958.96 countable value of property

Virginia DSS, Volume XIII

S1140 Changes

Updated With	Effective Date	Pages Changed
TN #96	10/1/11	Table of Contents pages 12-12a, 24
TN #93	1/1/10	pages 13-15 pages 24, 25
TN #91	5/15/09	pages 11-12a

d. Life Estate Created on or after February 24, 2009

The value of a life estate created on or after February 24, 2009 is not counted as a resource. Exception: The value of a life estate owned by a QDWI enrollee is countable, regardless of the date on which it was created.

7. Remainder Interests

When the owner of property gives it to one party in the form of a life estate, and designates a second party to inherit it upon the death of the life estate holder, the second party has a remainder interest in the property.

B. Development and Documentation

1. General

Treat the items in A. above as real property and develop ownership and value per S1140.100. See 4. below for additional instructions regarding life estates and remainder interests.

2. Mineral Rights

a. Ownership of Land and Mineral Rights

If the individual owns the land to which the mineral rights pertain, the CMV of the land can be assumed to include the value of the mineral rights. Additional development is unnecessary.

b. Ownership of Mineral Rights Only

If the individual does not own the land to which the mineral rights pertain, obtain a CMV estimate from a knowledgeable source. Such sources include, in addition to those listed in S1140.100 D.2.c.:

- the Bureau of Land Management;
- the U.S. Geological Survey;
- any mining company that holds leases.

3. Lease for Life

Refer any "lease for life" agreement and related information to the regional coordinator for a determination of whether it creates a life estate under State law.

4. Value of Life Estate

a. General

The value of a life estate created on or after August 28, 2008 but before February 24, 2009 is a countable resource to the owner of the life estate unless the life estate is excluded under one of the real property exclusions contained in Chapter S11.

b. Calculate Value of Life Estate

To determine the countable value of a life estate, use the table in S1140.120, *Life Estate and Remainder Interest Tables*. Multiply the CMV of the property by the "life estate" decimal that corresponds to the *applicant's* or *enrollee's* age. Record the result *in the case record*.

If there is more than one life estate owner, divide the *CMV* of the real property by the number of people *owning* a life estate interest. Multiply the prorated *CMV* of the property by the life estate decimal that corresponds to the *applicant's or enrollee's* age. Record the result *in the case record*.

c. Life Estate Interest Owned by Another Person Affects Property Value

Any countable equity value of real property *is* affected if it is:

- subject to someone else having life estate interest, or
- the applicant/recipient transfers real property *and retains* a life estate interest, thus affecting the *real property* value used to calculate the *uncompensated value* of the asset transfer.

See S1140.120, Life Estate and Remainder Interest Tables to determine *the value of the life estate interest*.

**5. Value of
Remainder
Interest**

a. General

A “*remainder*” interest in real property is the term used when an individual has an ownership interest in the real property, but usually does not have the right to possess and use the property until termination of the life estate interest. The individual who owns a remainder interest in real property is called the “*remainderman*.” An individual’s ownership of a remainder interest in real property must be evaluated to determine the real property’s countable value.

b. Calculate Value of Remainder Interest – One Remainderman

To determine the countable value of a remainder interest when only one individual owns the remainder interest, use the table in S1140.120, Life Estate and Remainder Interest Tables. Multiply the *CMV* of the real property by the “*Remainder*” decimal that corresponds to the **life estate owner’s age**. The result is the value of the remainder interest. Record the result in the case record.

c. Calculate Value of Remainder Interest – Two or More Remaindermen

To determine the countable value of a remainder interest when more than one individual owns a remainder interest in the property, divide the *CMV* of the real property by the number of remainder interests owned. Multiply the prorated *CMV* of the property by the “**Remainder**” decimal that corresponds to the **life estate owner’s age**. If a remainderman is subject to a lien against the property, subtract the remaining balance or portion of the balance from the *CMV* value. The result is the countable value of the remainder interest. Record the countable value calculation and result in the case record.

**6. Examples in
S1130 Appendix 1
and Appendix 4**

See Appendix 1 and Appendix 4 to subchapter S1130 for instructions for, and examples of, determining the countable value of life estate and remainder interests in real property.

S1140.240 U.S. SAVINGS BONDS

A. Introduction

U.S. Savings Bonds are obligations of the Federal Government. Unlike other government bonds, they are not transferable; they can only be sold back to the Federal Government. U.S. Savings Bonds have a mandatory retention period:

- 6 months for Series E, EE and I bonds issued prior to 2/1/03,
- 12 months for Series EE and Series I bonds issued on or after 2/1/03, and
- 6 months for Series H and HH bonds.

U.S. Savings Bonds are resources the first month following the mandatory retention period.

NOTE: The mandatory retention period is the same for both paper and electronic Series EE and I bonds. Series E bonds have not been issued since June 1980.

B. Operating Policy

1. Sole Ownership

The individual in whose name a U.S. Savings Bond is registered owns it (the Social Security Number shown on the bond is not proof of ownership).

2. Co-Ownership

The co-owners own equal shares of the value of the bond.

3. Status as Resources

a. General

U.S. Savings Bonds are not resources during a mandatory retention period. They are resources (not income) as of the first day of the month following the mandatory retention period.

b. Co-ownership Without Access

A U.S. Savings Bond is not a resource to a co-owner if another co-owner has and will not relinquish physical possession of it.

C. Development and Documentation

1. Ownership

a. Paper Bonds

Have the individual submit any bonds that he or she has an ownership interest in. Use the name(s) shown on the bond to determine ownership per B.1. or B.2. above.

b. Electronic Bonds

When an individual alleges ownership of electronic savings bonds, document bond ownership by asking the individual to download a record of his bond holdings from the Treasury Department. (see C.3.b below).

M1350 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	pages 7, 8

\$11,100	countable income for June through August
+ 9,000	countable income for September through November
20,100	countable income for spenddown budget period of June through September
- 3,150	MNIL for 5 persons Group III
\$16,950	spenddown liability for spenddown budget period June through November

The family's recalculated spenddown liability for the June 1 - November 30 spenddown budget period is \$16,950.

M1350.400 INCOME LIMIT CHANGES

A. Policy

Recalculate the spenddown liability for the spenddown budget period when:

- the applicant moves to a different locality group at some point within the spenddown budget period; or
- the Medicaid income limit(s) changes at some point within the spenddown budget period. *Note that the effective date for changes in MN income limits is July 1.*

B. Procedure

1. Use the “old” income limit for the month in which the applicant moved. Multiply the “old” monthly income limit by the number of months in the spenddown budget period during which it was effective.
2. Multiply the “new” monthly income limit by the number of months in the spenddown budget period during which it was effective. Add both results together. The total is the recalculated income limit.
3. Subtract the applicant's countable income for the spenddown budget period from the recalculated income limit. The result is the recalculated spenddown liability for the spenddown budget period.

C. Example--Income Limit Changes When Individual Moves

EXAMPLE #4 (Using July 2011 figures): Mr. E lives in Group III and applies for Medicaid on July 6 for himself. He is aged and lives alone. His income totals \$1,575 per month SSA benefit. The first prospective budget period is July 1 through December 31. The income limit for 1 person in Group III is \$2,567.56. His spenddown liability is \$6,762.44.

\$ 1,575.00	SSA per month
- 20.00	general income exclusion
1,555	countable monthly income
x 6	months
\$9,330.00	countable income for the spenddown budget period
- 2,567.56	1 person semi-annual MNIL Group III for spenddown budget period
\$6,762.44	spenddown liability for spenddown budget period July through December

On *September 23* he moves to a Group II locality and requests re-evaluation of his spenddown.

His spenddown liability is recalculated for the *July -December* spenddown budget period:

<i>\$1,283.76</i>	1 person MNIL Group III for 3 months <i>July - September</i>
<u><i>+ 987.51</i></u>	1 person MNIL Group II for 3 months <i>October - December</i>
<i>2,271.27</i>	MNIL for spenddown budget period
<i>\$ 9,330.00</i>	countable income for the spenddown budget period
<u><i>- 2,271.27</i></u>	MNIL for spenddown budget period
<i>\$7,058.73</i>	spenddown liability for the spenddown budget period
	<i>July 1 – December 31, 2011</i>

M1350.500 RESOURCE CHANGES

A. Policy

When determining if the spenddown is met, evaluate any change in resources owned or in the value of resources owned to determine if the assistance unit's resources are still within the Medicaid limit. When resources exceed the Medicaid limit in some months, the spenddown budget period and the spenddown liability must be recalculated. Prorate the spenddown budget period to include the month(s) before the first full month in which the excess resources create ineligibility.

If resources exceed the limit, send a written notice to the applicant informing him of his ineligibility for Medicaid spenddown for the month(s) in which the resources exceeded the limit during the entire month.

B. Notice Requirements

Send a written notice to the applicant that states:

- the reason for ineligibility for Medicaid (excess resources) for the months in which excess resources exist (specify the months), and
- the spenddown liability amount for the months during which resources were within the limit (specify the months). Include the explanation that if medical or dental bills equal or exceed the spenddown liability, he may be eligible for limited Medicaid eligibility for the month(s) during which his resources were within the Medicaid limit (specify the dates).

C. Example-- Resource Changes

EXAMPLE #5 (Using June 2000 figures): Mr. G lives in Group I and applies for Medicaid on June 6 for himself. He is disabled and lives alone. His income totals \$1,475 per month SSA benefit. The first prospective budget period is June 1 through November 30; the income limit for 1 person in Group I is \$1,300. His spenddown liability is \$7,430.

Virginia DSS, Volume XIII

M14 Table of Contents Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	pages i, ii

TABLE OF CONTENTS

M14 LONG-TERM CARE	SUBCHAPTER	Page
GENERAL RULES.....	M1410	
General--Long-term Care	M1410.010	1
Nonfinancial Eligibility Requirements.....	M1410.020	3
Facility Care	M1410.030	3
Community-based Care Waiver Services.....	M1410.040	5
Financial Eligibility Requirements.....	M1410.050	8
Post-eligibility Treatment of Income.....	M1410.060	9
Long-term Care Applications	M1410.100	8
Initiating Long-term Care for Current Medicaid Recipients.....	M1410.200	10
Notice Requirements.....	M1410.300	11
 PRE-ADMISSION SCREENING	 M1420	
What Is Pre-admission Screening.....	M1420.100	1
Pre-admission Screening	M1420.200	2
Communication Procedures.....	M1420.300	3
Screening Certification.....	M1420.400	4
 FACILITY CARE.....	 M1430	
Facility Care	M1430.000	1
Types of Facilities & Care.....	M1430.010	1
Basic Eligibility Requirements	M1430.100	3
 COMMUNITY-BASED CARE	 M1440	
Governing Laws	M1440.001	1
Basic Eligibility Requirements	M1440.010	2
Institutional Status.....	M1440.020	3
CBC Waiver Descriptions	M1440.100	11
Covered Services	M1440.200	18a
 TRANSFER OF ASSETS.....	 M1450	
Overview	M1450.001	1
<i>Reserved</i>	M1450.100	7
Transfers On/After February 8, 2006	M1450.200	7
<i>Policy Principles</i>	M1450.300	8
Transfers That Do Not Affect Eligibility.....	M1450.400	10

Transfers That Affect Eligibility M1450.50015a
 Penalty Period Determination M1450.60025
 Claims of Undue Hardship..... M1450.70039
 Agency Action..... M1450.80042

LTC FINANCIAL ELIGIBILITY M1460

Overview M1460.0011
 Definitions M1460.1001
 Determination of Covered Group..... M1460.2004a
 Assistance Unit M1460.30012
 Steps For Determining Financial Eligibility M1460.40012
 Resource Determination..... M1460.50017
 Income Determination M1460.60026
 Medically Needy Income & Spenddown M1460.70040

PATIENT PAY--POST-ELIGIBILITY TREATMENT OF INCOME M1470

Overview M1470.0011
 Available Income For Patient Pay..... M1470.1001a
 Facility Patients - Allowable Deductions From
 Income..... M1470.2003
 Facility Patients..... M1470.30015
 Medicaid CBC Patients - Allowable Deductions From
 Income..... M1470.40018
 Medicaid CBC Patients M1470.50029
 MN Patients - Spenddown Liability M1470.60032
*Communication Between Local DSS
 and LTC Providers* M1470.80043
 Adjustments and Changes..... M1470.90044
 Lump Sum Payments..... M1470.100050
 Reduction of Excess Resources M1470.110053
 Incorrect Payments to Provider M1470.120055

MARRIED INSTITUTIONALIZED INDIVIDUALS' ELIGIBILITY AND PATIENT PAY M1480

General..... M1480.0001
 Resource Assessment Rules..... M1480.2008a
 Income Eligibility of Institutionalized Spouse M1480.30048
 Patient Pay M1480.40066
 Notices & Appeals..... M1480.50092

M1410 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	page 11, 12
TN #95	3/1/11	pages 13, 14 Page 15 was removed.
TN #94	9/1/10	pages 6, 7, 13
TN #93	1/1/10	pages 1, 7, 9, 12
TN #91	5/15/09	pages 11-14

screening is not required (See M1420.400). If an individual is receiving private-pay home health services, a pre-admission screening **is required** (see M1410.200 B. above).

If an annual renewal **has been** done within the past six months, a partial review to address factors pertinent to receipt of LTC, such as asset transfer, spousal resource assessment, etc., must be done. If an annual renewal **has not** been done within the past six months, a complete renewal must be done. A new application is not required; *complete the renewal telephonically* or use the Medicaid Redetermination for Long-Term Care form (032-03-369), available on SPARK at:

http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi.

- *For an SSI recipient who has no community spouse and owns no countable real property, verify continued receipt of SSI through SOLQ-I or SVES, obtain information regarding asset transfer from the enrollee or authorized representative, and document the case record. See section M1430.104 for additional information regarding an SSI recipient who enters a nursing facility.*
- Rules for married institutionalized recipients who have a community spouse are found in subchapter M1480.

D. Notification

When the re-evaluation is done, the EW must complete and send all required notices. See section 1410.300 below. If it is known at the time of application processing that the individual did not or will not receive LTC services, do not determine eligibility as an institutionalized individual.

M1410.300 NOTICE REQUIREMENTS

A. Introduction

A notice to an applicant or recipient provides formal notification of the intended action or action taken on his/her case, the reason for this action and the authority for proposing or taking the action. The individual needs to clearly understand when the action will take place, the action that will be taken, the rules which require the action, and his right for redress.

Proper notice provides protection of the client's appeal rights as required in 1902(a)(3) of the Social Security Act.

The Notice of Action on Medicaid provides an opportunity for a fair hearing if action is taken to deny, suspend, terminate, or reduce services.

The Medicaid Long-term Care Communication Form (DMAS-225) notifies the LTC provider of changes to an enrollee's eligibility for Medicaid and for Medicaid payment of LTC services.

The notice requirements found in this section are used for all LTC cases.

Individuals in the AAL Waiver have Medicaid eligibility determined in the AG covered group (see M0320.202) and do not have Medicaid eligibility determined as institutionalized individuals. There are no post-eligibility requirements. The enrollment and notification procedures used with non-institutionalized Medicaid recipients are followed (see M0130.300).

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 patient's deductions (*e.g. a medical expense allowance*);
 - 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.

M1450 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	Table of Contents pages 4-8 pages 15, 16, 25, 26 pages 31-38 page 31a removed.
TN #95	3/1/11	pages 4, 24,32, 36, 37, 37a, pages 39, 42, 43
TN #94	9/1/10	Table of Contents pages 36-37a, 39-44
TN #93	1/1/10	Table of Contents pages 3, 17-18, 29 Appendix 2, page 1
TN #91	5/15/09	pages 41, 42

TABLE OF CONTENTS

M14 LONG-TERM CARE

M1450.000 TRANSFER OF ASSETS

	Section	Page
Overview.....	M1450.001.....	1
Legal Base.....	M1450.002.....	1
Definition of Terms.....	M1450.003.....	2
<i>Transfer of Assets Flow Chart</i>	M1450.004.....	6
<i>Reserved</i>	M1450.100.....	7
<i>Policy Principles</i>	M1450.200.....	7
Assets That Are Not Resources for Transfer Rule	M1450.300.....	8
Transfers That Do Not Affect Eligibility	M1450.400.....	10
Transfers That Affect Eligibility	M1450.500.....	15
Purchase of Term Life Insurance.....	M1450.510.....	16
Purchase of Annuity Before February 8, 2006.....	M1450.520.....	17
Purchase of Annuity On or After February 8, 2006.....	M1450.530.....	18
Purchase of a Promissory Note, Loan, of Mortgage On or After February 8, 2006.....	M1450.540.....	19
Transfers Involving Life Estates	M1450.545.....	20
Transfers Involving Trusts	M1450.550.....	20
Income Transfers.....	M1450.560.....	23
Services Contracts	M1450.570.....	24
<i>Applying a Penalty Period</i>	M1450.600.....	25
Uncompensated Value.....	M1450.610.....	25
<i>Reserved</i>	M1450.620.....	31
Penalty Period <i>Calculation</i>	M1450.630.....	36
Subsequent Receipt of Compensation.....	M1450.640.....	38
Claim of Undue Hardship.....	M1450.700.....	39
Agency Action	M1450.800.....	42
Applicant/Enrollee Notice.....	M1450.810.....	42
Provider Notice	M1450.820.....	43
DMAS Notice	M1450.830.....	44

Appendices

Average Monthly Private Nursing Facility Cost Prior to October 1, 1996.....	Appendix 1.....	1
Life Expectancy Table.....	Appendix 2.....	1
Settlement Statement, HUD-1.....	Appendix 3.....	1

are housed in an area certified as a nursing facility or intermediate care facility for the mentally retarded; or

- a Medicaid applicant/enrollee who has been screened and approved for or is receiving Medicaid community-based care (CBC) waiver services, services through the Program of All Inclusive Care for the Elderly (PACE) or hospice services.

H. Legally Binding Contract

Virginia law requires written contracts for the sale of goods (not services) valued over \$500, and for transactions involving real estate. Contracts for services may be oral.

To prove a contract is **legally binding**, the individual must show:

1. Parties Legally Competent

The parties to the contract were legally competent to enter into the contract. (Generally, this excludes (1) individuals declared to have mental incapacity or a diminished mental capacity and (2) children less than 18 years of age, who may not enter into a contract under Virginia law. The purpose here is to ensure that both parties knew what they were doing when they entered into the contract).

2. Valuable Consideration

“Valuable consideration” is received by each party when the “adequate compensation” requirement for the asset transfer rule is met.

3. Definite Contract Terms

Contract terms are sufficiently definite so that the contract is not void because of vagueness. Payments under contracts with immediate family members must be at reasonable rates. Those rates must be discernable from the terms of the contract. For example, it is not sufficient for a mother to agree to give her son all the stocks she owns upon her death in exchange for his agreeing to take care of her for an undefined period of time (such a contract might have to be written, depending on the value). The contract must set forth the per diem rate, specify a time period, or in some other manner establish definable and certain terms.

4. Mutual Assent

Contract terms were agreed to by mutual assent. Confirm that both parties understood and agreed upon the same specific terms of the contract when they entered into the contract.

I. Look-Back Date

The **look-back date** is the date that is 60 months before the first date the individual is both (a) an institutionalized individual and (b) has applied for Medicaid. The **look-back date** is the earliest date on which a penalty for transferring assets for less than fair market value can be imposed. Penalties can be imposed for transfers that take place on or after the look-back date. Penalties cannot be imposed for transfers that take place before the look-back date.

- J. Look-back Period** The **look-back period** is the period of time that begins with the look-back date and ends with the baseline date. The look-back period is 60 months.
- K. Other Person** **Other person** means:
- the individual's spouse or co-owner of an asset;
 - a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; and
 - a person, including a court or administrative body, acting at the direction, or upon the request, of the individual or the individual's spouse.
- L. Payment Foreclosed** Payment to any individual from an irrevocable trust that is not for the benefit of the individual for whom the trust was created is an uncompensated transfer of assets. See M1140.404 B. 4. c. for information regarding when a trust is foreclosed.
- M. Penalty Period** The **penalty period** is the period of time during which Medicaid payment for LTC services is denied because of a transfer of assets for less than market value. The length of the penalty period is based on the value of the uncompensated transfer of assets and the average cost of nursing facility care in Virginia.
- N. Property/ Resources** “Property” and “resources” both refer to real and personal property legally available to the individual or the individual's spouse.

O. Uncompensated Value

The uncompensated value is the amount of an asset's fair market value that was not or will not be received as a result of the asset transfer.

The uncompensated value for **real property** at the time of transfer is:

- the difference between the asset's FMV and the Gross Amount Due to Seller, when the lien/other encumbrance against the asset is satisfied from the seller's proceeds, or
- the difference between the asset's equity value (FMV minus the lien) and the Gross Amount Due to Seller, when the lien is assumed by the buyer. Refer to examples in M1450.610 H.

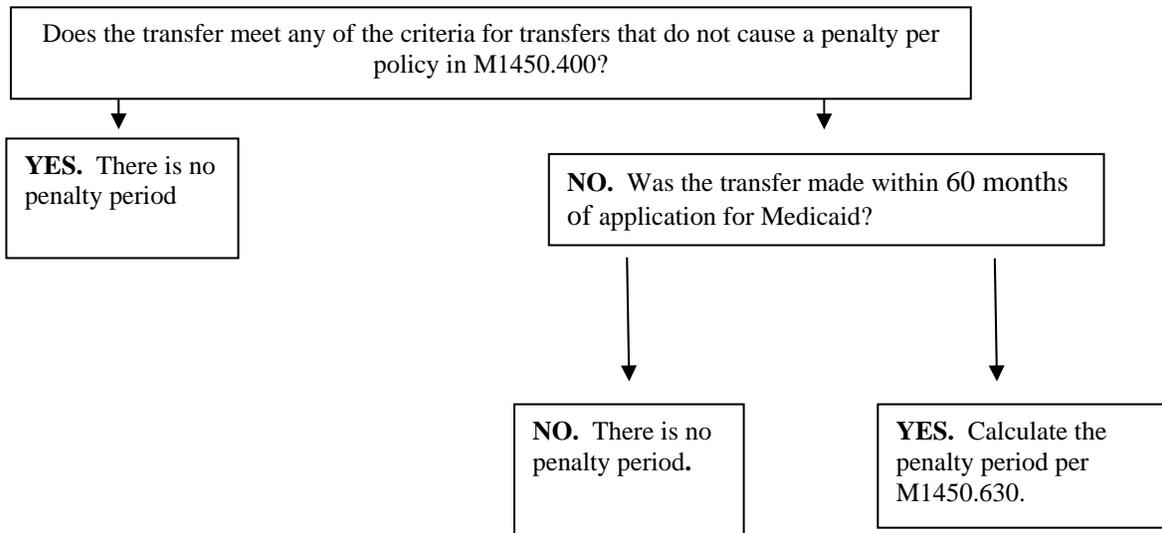
P. Undue Hardship

An undue hardship exists when the imposition of a penalty period would deprive the individual of medical care such that his health or his life would be endangered or be deprived of food, clothing, shelter, or other necessities of life.

M1450.004 TRANSFER OF ASSETS FLOW CHART

The flow chart below illustrates when an asset transfer penalty period is required.

Transfer of Assets Flow Chart



M1450.100 RESERVED**M1450.200 POLICY PRINCIPLES**

- A. Policy** An institutionalized individual who transfers (or has transferred), or whose spouse transfers or has transferred, an asset in ways not allowed by policy is not eligible for Medicaid payment of long-term care services. The DRA established new policy for evaluating transfers made on or after February 8, 2006. The look-back period for all transfers is 60 months; there is no distinction between transfers involving trusts and other transfers.
- B. Procedures** When a Medicaid enrollee is institutionalized, review the individual's eligibility to determine if an asset transfer occurred within the 60 months prior to institutionalization. When a Medicaid applicant reports an asset transfer, or the worker discovers a transfer, determine if the transfer occurred within 60 months prior to the month in which the individual is both institutionalized and a Medicaid applicant/enrollee.
- 1. All Transfers** Determine if any assets of the individual or the individual's spouse were transferred during the 60 months (the "look-back period") prior to the first date on which the individual was both an institutionalized individual and a Medicaid applicant/enrollee.
- 2. Determine Effect** If an asset was transferred during the look-back periods specified above, determine if the transfer affects eligibility for LTC services' payment, using sections M1450.520 through M1450.550 below.
- If the transfer affects eligibility and was for less than market value, determine the uncompensated value (M1450.610) and establish a penalty period (period of ineligibility for Medicaid payment of LTC services, M1450.630).

**M1450.300 ASSETS THAT ARE NOT RESOURCES FOR TRANSFER
RULE**

- A. Policy** The assets listed in this section are NOT resources for asset transfer purposes. Therefore, the transfer of any of the assets listed in this section does NOT affect eligibility for Medicaid payment of LTC services.
- B. Personal Effects and Household Items** A transfer of personal effects or household items does not affect eligibility.
- C. Certain Vehicles** The transfer of a vehicle that meets the following requirements does not affect Medicaid payment for LTC services:
- a vehicle used by the applicant/enrollee to obtain medical treatment.
 - a vehicle used by the applicant/enrollee for employment.
 - a vehicle especially equipped for a disabled applicant or enrollee.
 - a vehicle necessary because of climate, terrain, distance, or similar factors to provide necessary transportation to perform essential daily activities.

If the vehicle was not used as provided above at the time of transfer, \$4,500 of the trade-in value of the vehicle used for basic transportation is excluded. Any value in excess of \$4,500 must be evaluated as an asset transfer.

a transfer for less than fair market value and no penalty period will be calculated.

Assets transferred on or after February 8, 2006, that have a total cumulative value of more than \$1,000 but less than or equal to \$4,000 per calendar year may not be considered a transfer for less than fair market value if documentation is provided that such transfers follow a pattern that existed for at least three years prior to applying for Medicaid payment of LTC services. Christmas gifts, birthday gifts, graduation gifts, wedding gifts, etc. meet the criteria for following a pattern that existed prior to applying for Medicaid payment of LTC services.

- I. LTC Partnership Policy** The value of assets transferred that were disregarded as a result of an LTC Partnership Policy does not affect an individual's eligibility for Medicaid payment of LTC services. See M1460.160 for more information about LTC Partnership Policies.
- J. Return of Asset** The transfer of an asset for less than fair market value does not affect eligibility for Medicaid LTC services' payment if the asset has been returned to the individual.
- K. Home Foreclosure** The repossession and/or sale of a home by the mortgage lender for less than fair market value due to foreclosure is not evaluated as an uncompensated transfer. Documentation of the foreclosure must be retained in the case record.
- L. Transfer of Income Tax Refund or Advance Payment Received After December 31, 2009 but Before January 1, 2013** *Under Section 728 of the Tax Relief, Unemployment Insurance Reauthorization and Job Creation Act of 2010 (P.L. 111-312, the transfer of an income tax refund or advance payment received after December 31, 2009 but Before January 1, 2013, to another individual or to a trust does NOT affect eligibility for Medicaid payment of LTC services. If the funds are given away or placed in a trust, other than a trust established for a disabled individual (see M1120.202), after the end of the exempt period, the transfer is subject to a transfer penalty or being counted under the Medicaid trust provisions, as applicable.*

M1450.500 TRANSFERS THAT AFFECT ELIGIBILITY

- A. Policy** If an asset transfer does not meet the criteria in sections M1450.300 or M1450.400, the transfer will be considered to have been completed for reasons of becoming or remaining eligible for Medicaid payment of LTC services, unless evidence has been provided to the contrary.

Asset transfers that affect eligibility for Medicaid LTC services payment include, but are not limited to, transfers of the following assets:

- cash, bank accounts, savings certificates,
- stocks or bonds,
- resources **over \$1,500** that are excluded under the burial fund exclusion policy,
- cash value of life insurance when the total face values of all policies owned on an individual exceed \$1,500
- interests in real property, including mineral rights,
- rights to inherited real or personal property or income.

- B. Procedures** Use the following sections to evaluate an asset transfer:

- M1450.510 for a purchase of term life insurance.

- M1450.520 for a purchase of an annuity before February 8, 2006.
- M1450.530 for a purchase of an annuity on or after February 8, 2006.
- M1450.540 for promissory notes, loans, or mortgages.
- M1450.550 for a transfer of assets into or from a trust.
- M1450.560 for a transfer of income.

M1450.510 PURCHASE OF TERM LIFE INSURANCE

A. Policy

The purchase of any term life insurance after April 7, 1993, except term life insurance that funds a pre-need funeral under section 54.1-2820 of the Code of Virginia, is an uncompensated transfer for less than fair market value if the term insurance's benefit payable at death does not **equal or exceed twice the sum of all premiums paid for the policy.**

B. Procedures

1. Policy Funds Pre-need Funeral

Determine the purpose of the term insurance policy by reviewing the policy. If the policy language specifies that the death benefits shall be used to purchase burial space items or funeral services, then the purchase of the policy is a compensated transfer of funds and does not affect eligibility.

However, any benefits **paid** under such policy in excess of the actual funeral expenses are subject to recovery by the Department of Medical Assistance Services for Medicaid payments made on behalf of the deceased insured Medicaid enrollee.

2. Policy Funds Irrevocable Trust

Since **an irrevocable trust for burial is not a pre-need funeral**, the purchase of a term life insurance policy(ies) used to fund an irrevocable trust is an uncompensated transfer of assets for less than fair market value.

3. Determine If Transfer Is Uncompensated

When the term life insurance policy does not fund a pre-need funeral, determine if the purchase of the term insurance policy is an uncompensated transfer:

- a. Determine the benefit payable at death. The face value of the policy is the "benefit payable at death."
- b. From the insurance company, obtain the sum of all premium(s) paid on the policy; multiply this sum by 2. The result is "twice the premium."
- c. Compare the result to the term insurance policy's face value.
 - 1) If the term insurance's face value equals or exceeds the result (twice the premium), the purchase of the policy is a transfer for fair market value and does not affect eligibility.
 - 2) If the term insurance's face value is less than the result (twice the premium), the purchase of the policy is an uncompensated transfer for less than fair market value. Determine a penalty period per M1450.620 or M1450.630 below.

EXAMPLE #1: Mr. C. uses \$5,000 from his checking account to purchase a \$5,000 face value term life insurance policy on August 13, 1995. Since the policy was purchased after April 7, 1993, and \$5,000 (benefit payable on death) is not twice the \$5,000 premium, the purchase is an uncompensated transfer. The uncompensated value and the penalty period for Medicaid payment of long-term care services must be determined.

M1450.600 APPLYING A PENALTY PERIOD

A. Introduction

When a transfer of assets was for less than fair market value, the individual is not eligible for Medicaid payment of LTC services for a specific period of time (penalty period) based on the uncompensated value of the transferred asset and the date the transfer occurred. However, if the individual meets all other Medicaid eligibility requirements, the individual is enrolled in Medicaid and is eligible for Medicaid payment of all other Medicaid-covered services.

The asset transfer precludes Medicaid payment for LTC services during the penalty period unless and until the individual receives adequate compensation in return for the transferred asset.

Penalty periods that are imposed cannot overlap or run concurrently. The total cumulative uncompensated value of the assets transferred is used to determine the length of the penalty period.

Once a penalty period begins it does not change or stop. The penalty period continues regardless of whether Medicaid eligibility continues, the institutionalized individual is discharged from LTC, or the individual changes from nursing facility care to community-based care. If the individual is re-admitted to LTC and the penalty period has not expired or ended, Medicaid payment for LTC services will continue to be denied for the remainder of the penalty period. **EXCEPTION:** The penalty period may be shortened if subsequent compensation is received (see M1450.640) or eliminated if an undue hardship is granted (see M1450.700).

B. Determination Procedures

Determine the uncompensated value using policy and procedures in M1450.610 below. Go to M1450.630 to determine the penalty period.

If the individual subsequently receives compensation in return for the transferred asset, re-evaluate the penalty period using policy and procedures in M1450.640 below.

M1450.610 UNCOMPENSATED VALUE

A. Policy

The uncompensated value is the amount of an asset's fair market value (FMV) that was not or will not be received as a result of the asset transfer. FMV is based on criteria used in determining the value of assets in determining Medicaid eligibility.

The uncompensated value for **real property** at the time of transfer:

- is the difference between the asset's FMV and the Gross Amount Due to Seller, when the lien/other encumbrance against the asset is satisfied from the seller's proceeds, or
- the difference between the asset's equity value (FMV minus the lien) and the Gross Amount Due to Seller, when the lien is assumed by the buyer.

See M1450.610 H for the procedures for determining the uncompensated value of transferred real property.

Determine the uncompensated value of the transferred asset in this section and go to M1450.630 to determine the penalty period.

B. Term Life Insurance Purchase On or Before April 7, 1993

For term life insurance policies purchased on or before April 7, 1993, the purchase is a compensated transfer of assets and the purchase does not affect eligibility.

C. Term Life Insurance Purchase After April 7, 1993

For term life insurance policies purchased after April 7, 1993, the purchase is a transfer of assets for less than fair market value if the term insurance's face value is less than twice the sum of all premium(s) paid on the policy. The uncompensated value is the total premium(s) paid on the policy.

If more than one premium was paid on the policy, and the premiums were paid in different months, each premium paid on the policy is a separate transfer of assets for less than fair market value. A transfer occurred in the month each premium was paid.

EXAMPLE #7: Mr. C applied for Medicaid on November 2, 1996. On August 13, 1995, Mr. C. used \$3,000 from his checking account to pay a \$3,000 premium on a \$5,000 face value term life insurance policy. On October 5, 1995, he used \$2,000 from his checking account to pay up premiums on the same \$5,000 face value term life insurance policy. Since the policy was purchased after April 7, 1993, and \$5,000 (benefit payable on death) is not twice the \$5,000 total premiums, the premium payments are transfers of assets for less than fair market value.

The uncompensated value of the first transfer on 8-13-95 is \$3,000. The uncompensated value of the second transfer on 10-5-95 is \$2,000. The penalty period for the first transfer is based on the \$3,000 uncompensated value and the transfer date of August 1995. The penalty period for the second transfer is based on the \$2,000 uncompensated value and the transfer date of October 1995.

D. Annuity Purchase

When the average number of years of expected life remaining for the individual (the "life expectancy" number in the table) *is less than* the life of the annuity, the annuity is NOT actuarially sound. The annuity purchase is a transfer for less than fair market value.

The transfer occurred at the time the annuity was purchased.

To determine the transferred asset's uncompensated value:

1. divide the face value of the annuity by the number of years in the life of the annuity.
2. the result is the yearly payout amount.

Example #13b: On October 20, Mr. B. was admitted to a nursing facility. He transferred his home in July of the same year, which was within the look-back period. His home was assessed at \$100,000 in July. The mortgage against his home had a balance due of \$16,000 in July.

In reviewing the settlement statement for the sale of the property, it is noted that the sale price of the home was \$70,000 (gross amount due to seller), which was less than the tax assessed value of the home. The lien of \$16,000 was satisfied at closing from the \$70,000 sale price. The other fees deducted were usual and customary and were determined to have been paid by the buyer. Mr. B. received a \$54,000 net settlement for the sale of his home.

The uncompensated value of the transferred real property is calculated as follows:

\$100,000	tax assessed value
<u>- 70,000</u>	Gross Amount Due to Seller (includes the lien amount)
\$ 30,000	uncompensated value

The penalty period is based on the uncompensated transfer value of \$30,000. When the penalty period begins depends on whether the transfer took place prior to or after February 8, 2006.

Example #13c: The scenario is the same as in example 13b. However, the lien will be assumed by the purchaser rather than satisfied from the seller's gross settlement amount (Gross Amount Due to Seller). The equity value of the home is used to determine the uncompensated value in this case, because the seller was not responsible for satisfaction of the lien.

\$100,000	tax assessed value
<u>-16,000</u>	lien amount
\$ 84,000	equity value (EV)

\$ 84,000	EV
<u>- 70,000</u>	Gross Amount Due to Seller
\$ 14,000	uncompensated value

Page is intentionally blank.

Page is intentionally blank.

Page is intentionally blank.

Page is intentionally blank.

M1450.630 PENALTY PERIOD CALCULATION

A. Policy

When a transfer of assets on or after February 8, 2006, affects eligibility, the penalty period begins when the individual would otherwise be eligible for Medicaid payment for LTC services if not for the penalty period. The penalty period includes the fractional portion of the month, rounded down to a day. Penalty periods for multiple transfers cannot overlap.

Individuals in a penalty period who meet all other Medicaid eligibility requirements may be eligible for Medicaid payment for all other Medicaid covered services.

B. Penalty Begin Date

For individuals not receiving LTC services at the time of transfer, the penalty period begins the first day of the month in which the individual would otherwise be eligible for Medicaid payment for LTC services, except for the imposition of a penalty period. This includes the application retroactive period for nursing facility patients who have been in the facility during the retroactive period.

For individuals who are receiving Medicaid payment for LTC services at the time of transfer, the penalty period begins the month following the month of transfer.

1. Medicaid LTC Not Received at Time of Transfer

If the individual is not receiving Medicaid-covered LTC services at the time of the asset transfer, the penalty period begins the first day of the month in which the individual would otherwise be eligible for Medicaid payment for LTC services but for the application of the penalty period, as long as the date does not fall into another period of ineligibility imposed for any reason.

2. Receiving Medicaid LTC Services at Time of Transfer

If the individual is receiving Medicaid LTC services at the time of the asset transfer, the penalty period begins the first day of the month following the month in which the asset transfer occurred. A referral to the DMAS Enrollee Audit Unit (RAU) must be made for the months in the penalty period during which the individual received Medicaid LTC services. See Chapter M17 for instructions on RAU referrals.

3. Penalty Periods Cannot Overlap

When multiple asset transfers result in multiple penalty periods, the penalty periods cannot overlap. One penalty period must be completed prior to the beginning of the next penalty period.

4. Nursing Facility

If the individual in a nursing facility meets all Medicaid eligibility requirements, he is eligible for Medicaid payment of all other covered services.

5. CBC, PACE, Hospice

If the individual has been screened and approved for or is receiving Medicaid CBC, PACE, or hospice services, he cannot be eligible for Medicaid in the 300% of SSI covered group or for the Medicaid payment of LTC services in any other covered group. The individual's Medicaid eligibility in other covered groups must be determined. His penalty period cannot be imposed unless and until he is (1) eligible for Medicaid in a covered group other than the 300% of SSI covered group, (2) he meets a spenddown and would otherwise be eligible for the Medicaid payment of LTC services, or (3) he is admitted to a nursing facility.

C. Penalty Period Calculation

The penalty period is the number of months, including any fractional portion of a month that an individual will be ineligible for the Medicaid payment of LTC services.

The period is calculated by taking the uncompensated value of the assets transferred on or after the look-back date, divided by the average monthly cost of nursing facility services to a private-pay patient in his locality at the time of the application for Medicaid. The remainder is divided by the daily rate (the monthly rate divided by 31).

When the uncompensated value of an asset transfer is less than the monthly nursing facility rate, go to step #4 in E below to calculate the partial month penalty period.

D. Average Monthly Nursing Facility Cost

<u>Application Date</u>	<u>Average Monthly Private Nursing Facility Cost*</u>	
	<u>Northern Virginia</u>	<u>All Other Localities</u>
10-1-96 to 9-30-97	\$2,564	\$2,564
10-1-97 to 12-31-99	\$3,315	\$2,585
01-01-00 to 12-31-00	\$3,275	\$2,596
01-01-01 to 12-31-01	\$4,502	\$3,376
01-01-02 to 12-31-03	\$4,684	\$3,517
01-01-04 to 9-30-07	\$5,403	\$4,060
10-1-07 to 12-31-10	\$6,654	\$4,954
01-01-11 and after	\$7,734	\$5,933

*Figures provided by Virginia Health Information.

See M1450, Appendix 1 for amounts prior to October 1, 1996.

E. Partial Month Transfer

The following example shows how to compute a penalty period for an uncompensated transfer that occurred on or after February 8, 2006 and involving a partial month.

Example #19: An individual makes an uncompensated asset transfer of \$30,534 in April 2006, the same month he applies for Medicaid. The uncompensated value of \$30,534 is divided by the average monthly rate of \$4,060 and equals 7.52 months. The full 7-month penalty period runs from April 2006, the month of the transfer, through October 2006, with a partial penalty calculated for November 2006. The partial month penalty is calculated by dividing the partial month penalty amount (\$2,114) by the daily rate. The calculations are as follows:

$$\begin{array}{r}
 \text{Step \#1 } \$30,534.00 \text{ uncompensated value of transferred asset} \\
 \div 4,060.00 \text{ avg. monthly nursing facility rate at time of application} \\
 = 7.52 \text{ penalty period (7 full months, plus a partial month)}
 \end{array}$$

$$\begin{array}{r}
 \text{Step \#2 } \$ 4,060.00 \text{ avg. monthly nursing facility rate at time of application} \\
 \times 7 \text{ seven-month penalty period} \\
 \$28,420.00 \text{ penalty amount for seven full months}
 \end{array}$$

Step #3 \$30,534.00 uncompensated value
- 28,420.00 penalty amount for seven full months
\$ 2,114.00 partial month penalty amount

Step #4 \$2,114.00 partial penalty amount
÷ 130.97 daily rate (\$4,060 ÷ 31)
= 16.14 number of days for partial month penalty

For November 2006, the partial month penalty of 16 days would be added to the seven (7) month penalty period. This means that Medicaid would authorize payment for LTC services beginning November 17, 2006.

F. Penalty Period for a Couple When Both Are Eligible and Institutionalized

When an institutionalized individual is ineligible for Medicaid payment of long-term care services because of a transfer made by the spouse, and the spouse is or becomes institutionalized and eligible for Medicaid, the penalty period must be apportioned between the spouses. M1450.620 J. contains instructions for apportioning the penalty period.

M1450.640 SUBSEQUENT RECEIPT OF COMPENSATION

A. Policy

When all assets transferred are returned to the individual, no penalty for transferring assets can be assessed. When a penalty has been assessed and payment for services has been denied, a return of the assets requires a retroactive evaluation, including erasure of the penalty, back to the beginning of the penalty period.

However, such an evaluation does not necessarily mean that Medicaid payment for LTC services must be paid on behalf of the individual. Return of the assets in question to the individual leaves the individual with assets which must be evaluated in determining eligibility during the retroactive period. Counting those assets as available may result in the individual being ineligible (because of excess income or resources) at the time of evaluation as well as for a period of time after the assets are returned.

NOTE: To void imposition of a penalty, all of the assets in question or their fair market equivalent must be returned. For example, if the asset was sold by the individual who received it, the full market value of the asset must be returned to the transferor.

When only part of an asset or its equivalent value is returned, a penalty period can be modified but not eliminated. For example, if only half of the value of the asset is returned, the penalty period can be reduced to one-half.

B. Example #20 Full Compensation Received

Example #20 Mr. G., who is in a nursing facility, applied for Medicaid on November 24, 2004. On October 10, 2004, he transferred his non-home real property worth \$30,000 to his son. The transfer did not meet any of the criteria in M1450.501, so a penalty period was imposed from October 1, 2004, through April 30, 2005.

On December 12, 2004, Mr. G.'s son paid medical bills for his father totaling \$30,000. The agency re-evaluated the transfer and determined a penalty period was no longer appropriate since full compensation was received. Mr. G.'s eligibility for Medicaid payment of long-term care services was re-evaluated, beginning with October 1, 2004.

M1460 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	pages 3, 20, 21
TN #95	3/1/11	pages 3, 4, 35
TN #94	9/1/10	page 4a
TN #93	1/1/10	pages 28, 35
TN #91	5/15/09	pages 23, 24

- 10. Old Bills** Old bills are unpaid medical, dental, or remedial care expenses which:
- were incurred prior to the Medicaid application month and the application's retroactive period,
 - were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and
 - remain a liability to the individual.

EXCEPTION: Bills paid by a state or local program and which meet the definition of "old bills" are treated as old bills even though they are not the individual's liability.

- 11. Projected Expenses** Expenses for services that have not yet been incurred but are reasonably expected to be incurred are projected expenses.

- 12. Spenddown Liability** The spenddown liability is the amount by which the individual's countable income exceeds the MNIL for the budget period.

M1460.150 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LTC

- A. Applicability** The policy in this section applies to nursing facility and CBC/PACE patients, who meet the requirements for LTC on or after January 1, 2006. This includes individuals who filed reapplications after a break in Medicaid eligibility. It does **not apply** to Medicaid recipients who were approved for LTC prior to January 1, 2006, and who maintain continuous Medicaid eligibility.

For Medicaid applicants or enrollees approved for LTC on or after July 1, 2006, the amount of equity in the home at the time of the initial LTC determination and at each renewal must be evaluated.

- B. Policy** Individuals with equity value (tax assessed value minus encumbrances) in home property that exceeds the limit are NOT eligible for Medicaid payment of long-term care services unless the home is occupied by
- a spouse,
 - a dependent child under age 21 years, or
 - a blind or disabled child of any age.

Individuals with substantial home equity may be eligible for Medicaid payment of other covered services if they meet all the other Medicaid eligibility requirements.

- 1. Home Equity Limit** The home equity limit applied is based on the date of the application or request for LTC coverage. Effective January 1, 2011, the home equity limit is subject to change annually. The home equity limit is:
- Effective January 1, 2006 through December 31, 2010: \$500,000
 - Effective January 1, 2011: \$506,000.

- 3. Home Property** The home property is defined based on the individual's covered group, except when the individual is married with as community spouse. When the individual is married with a community spouse, **go to subchapter M1480.**
- a. ABD Groups**
- The home property definition in section M1130.100 applies to ABD covered groups. An individual's home is property that serves as his or her principal place of residence. A home shall mean the house and lot used as the principal residence and all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed \$5,000. If the individual has property contiguous to his home, the value of the non-home contiguous property over \$5,000 is a countable resource, unless it can be excluded for another reason listed in subchapter S1130.
- b. F&C Groups**
- The home property definition in section M0630.115 applies to F&C covered groups. Home property is the home used as the principal residence and all contiguous property. Contiguous property is the land, and improvements on that land, which adjoins the home and which is not separated by land owned by others.
- 4. Former Home** The patient's former home (including a mobile home) is his primary residence:
- which he owns, and
 - which he occupied as his residence prior to admission to an LTC facility, or prior to moving out to receive Medicaid CBC waiver services in another person's home.
- C. Exclude Former Home Indefinitely** The former home property can be excluded indefinitely when one of the following conditions is met:
- 1. Occupied By Spouse or Minor Child** The former home is occupied by the individual's spouse, minor dependent child under age 18, or dependent child under age 19 if attending school or vocational training.
- 2. Occupied By Disabled Adult Child or Disabled Parent** The former home is occupied by the individual's parent or adult child who:
- is age 65 years or older (is presumed to be disabled because of age),
 - or, if under age 65 years, *has been determined to be* disabled according to the Medicaid disability definition;
 - lived in the home with the recipient for at least one year prior to the recipient's institutionalization; and
 - is dependent upon the recipient for his shelter needs.

- 3. ABD Groups-- Home Exclusion Does Not Apply To Contiguous Property** For unmarried individuals and married individuals with no community spouses, the home exclusion for ABD covered groups applies to the home (dwelling) and the plot of land on which the home is located, and to the property contiguous to the home that comes under the home exclusion by using one of the two different calculations in section M1130.100. The home exclusion DOES NOT apply to the property contiguous to the home that does **not** come under the home definition in section M1130.100 A.2.

If the ABD individual owns property contiguous to his home, the value of the non-home contiguous property is a countable resource, regardless of whether the home is occupied by a dependent relative, unless the contiguous property can be excluded for another reason listed in subchapter S1130.

- D. 6-Months Home Exclusion** The home is excluded as a primary residence during temporary absences for visits or to obtain medical treatment. The former home property is excluded as a resource for 6 months, beginning with the month **following** the month institutionalization begins.

- 1. ABD Groups-- Exclusion Does Not Apply To Contiguous Property** The 6-month home exclusion for ABD covered groups applies to the home (dwelling) and the plot of land on which the home is located, and to the property contiguous to the home that comes under the home exclusion by using one of the two different calculations in section M1130.100. The 6-month home exclusion DOES NOT apply to the property contiguous to the home that does **not** come under the home definition in section M1130.100 A.2.

Therefore, if the ABD individual owns property contiguous to his home, the value of the non-home contiguous property is a countable resource, regardless of the individual's temporary absence, unless the contiguous property can be excluded for another reason in subchapter S1130.

- 2. Facility Admission** The former home property is excluded for 6 full months beginning with the month **following** the month of institutionalization in a medical facility. The property is no longer "home property" after 6 months of absence due to institutionalization. An individual who has been receiving Medicaid CBC waiver services in his own home and who then enters a nursing facility receives the six months former home exclusion starting with the month following the month of admission to the facility.

Individuals re-admitted to a medical facility 30 days or more after discharge will have the six-months former home exclusion start over again.

M1470 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	pages 3, 4, 7-9, 19, 22-24, 43
TN #95	3/1/11	pages 9, 19, 20, 23
TN #94	9/1/10	Table of Contents pages 1, 1a, 3, 3a, 11, 12, pages 19, 20, 24, 28, 31
TN #93	1/1/10	pages 9, 13, 19-20, 23, 43, 44
TN #91	5/15/09	Table of Contents pages 1-56 Appendix 1

- If average interest income per month exceeds \$10.00 and is received less often than monthly, it must be treated as a lump sum payment for patient pay purposes. Refer to Section M1470.1000 of this subchapter for procedures and instructions.

3. Repayments Amounts withheld from monthly benefit payments to repay prior overpayments *are* income for patient pay *unless the exception in S0830.110 is met*. The patient or his representative should be advised to appeal the withholding *with the benefit source*.

4. CBC Additional Care Additional care purchased outside of a CBC recipient's plan of care is not counted as income available for patient pay if it is purchased by someone other than the recipient. This additional care may be purchased from any source including the agency providing the CBC.

5. Refundable Payments to LTC Facilities The family of a prospective Medicaid patient or other interested party may make an advance payment on the cost of facility care prior to or during the Medicaid application process to assure the patient's admission and continued care. The individual may have been promised that the advance payment will be refunded if Medicaid eligibility is established.

Advance payments made by a person other than the patient and which are expected to be reimbursed once Medicaid is approved, as well as payments made by outside sources to hold the facility bed while the patient is hospitalized, are **not counted as income** in determining eligibility or patient pay.

The facility must reimburse any payment contributed toward the cost of patient care pending a Medicaid eligibility determination once Medicaid eligibility is established.

6. Survivor's Benefit Plan Deductions from Military Pensions Any portion of a military retiree's pension that is withheld as a contribution to participate in the Survivor's Benefit Plan (SBP) is not income for patient pay. To participate in SBP in conjunction with their retirement, military members must elect to receive reduced retirement pay for their lifetime so that a percentage of their retirement pay can continue to be paid to their survivors following their death. Once SBP is elected, retirees cannot discontinue the deductions from their pensions.

M1470.200 FACILITY PATIENTS - ALLOWABLE DEDUCTIONS FROM INCOME

A. Introduction Sections M1470.210 through 240 are the only allowable deductions from a facility patient's gross monthly income when calculating patient pay in the month of entry and subsequent months when the patient does not have a community spouse.

If the individual is married and his spouse is in a nursing facility, then there is no community spouse and each spouse is treated as an unmarried individual for patient pay purposes. When the patient is an institutionalized spouse with a community spouse, as defined in subchapter M1480, go to subchapter M1480 to determine the institutionalized spouse's patient pay.

- | | |
|---------------------------------------|---|
| 2. Dependent Child Allowance | See section M1470.220 "Dependent Child Allowance." |
| 3. Noncovered Medical Expenses | See section M1470.230 "Facility - Noncovered Medical Expenses." |
| 4. Home Maintenance Deduction | See section M1470.240 "Facility - Home Maintenance Deduction." |

C. Appeal Rights

The patient or his representative has the right to appeal the patient pay determination, the amounts used in the calculation and denial of any request for adjustment. If a recipient or his representative appeals the patient pay, the EW or Medicaid Technician who made the decision prepares the appeal summary and attends the hearing.

M1470.210 FACILITY PERSONAL NEEDS ALLOWANCE**A. Policy**

The personal needs allowance is calculated according to the instructions in this section for the month of entry and subsequent months. The amount of the personal needs allowance depends on whether or not:

- the patient has a guardian or conservator who charges a fee; or
- the patient has earnings from employment that is part of the treatment plan.

The personal needs allowance is the sum of the basic personal allowance plus the guardianship fee and/or special earnings allowance, if applicable.

- | | |
|------------------------------------|--|
| 1. Basic Personal Allowance | Deduct \$40 per individual, effective July 1, 2007. The basic personal allowance for prior months is \$30. |
| 2. Guardianship Fee | Deduct an amount up to 5% of the patient's gross monthly income (including amounts not counted as income and excluded income) for guardianship fees, if the patient has a legally appointed guardian or conservator AND the guardian or conservator charges a fee. The guardianship filing fees CANNOT be deducted from the individual's income. Document how it was determined that the guardian/conservator charges a fee and the amount of the fee. |

No deduction is allowed if the patient's guardian is affiliated with a public agency or organization that receives funding for guardianship services.

No deduction is allowed for representative payee or "power of attorney" fees or expenses.

- | | |
|--------------------------------------|--|
| 3. Special Earnings Allowance | Working patients are allowed a higher personal needs allowance if they meet the following criteria. These patients will be identified by the facility. The patient must regularly participate in vocational activity which is a planned habilitation program and is carried out as a therapeutic work program, such as: <ul style="list-style-type: none"> • sheltered workshops • vocational training • pre-vocational training. |
|--------------------------------------|--|

The amount deducted is the amount of the **monthly** premium. If the patient pays the premium less often than monthly, such as quarterly, prorate the amount paid by the number of months covered by the payment to obtain the monthly amount to deduct in the patient pay calculation.

“Health benefit plan” means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA (Multiple Employer Welfare Arrangement) or plan provided by another benefit arrangement.

Health benefit plan does not mean accident only, credit, or disability insurance; long-term care insurance; vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers’ compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance (14VAC5-234-30).

Income protection insurance (indemnity) policy premiums are not medical expenses and are not deducted from the patient pay.

Membership fees for an organization that sponsors or provides the health insurance are not part of the premium and are not deductible.

2. Medicare Part A and/or B Premiums

Medicare Part B premiums and/or Medicare Part A premiums are paid by Medicaid for eligible individuals. The premiums are paid by Medicaid via the “buy-in” and are not usually deducted from patient pay. However, Medicaid does not start paying the premiums immediately for all eligible patients, so the Medicare premium(s) must be deducted from patient pay in those months for which Medicaid does not pay the premium.

For CNNMP and MN recipients, the Medicare buy-in is effective **2 months after the begin date** of Medicaid coverage. If the begin date of coverage is other than the first day of a month, the buy-in is effective the first of the month in which the 60th day occurs. Part B premiums (and Part A premiums if the recipient must pay the Part A premium) must be deducted from patient pay in the month(s) in which the buy-in is not effective.

Deduct the Medicare premium(s) for the first two months of coverage for the following recipients:

- CNNMP individuals who are not dually eligible QMB,
- MN recipients who are not dually eligible QMB.

The Medicaid Medicare buy-in does NOT pay for Medicare premiums in closed periods of coverage for LTC patients who are on spenddown and whose eligibility is for a closed period. Deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from patient pay in the month(s) in which the buy-in is NOT effective.

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.

3. Example--Dual Eligible QMB

Mrs. Q has Medicare coverage and SSA income of \$580 per month. Her Medicare premiums are deducted from her SSA check. She was admitted to the nursing facility on September 9. Her daughter filed a Medicaid application for her on September 10.

Mrs. Q is eligible in the CNNMP 300% SSI group in September and is eligible as QMB. Her Medicare premiums are not deducted for September because they will be paid by Medicaid.

4. Example--Not Dual Eligible QMB

Mr. A was admitted to a nursing facility on March 5. He applied for Medicaid on June 2. His monthly income is \$1,295, and his Medicare Part B premium is deducted from his SSA check. He is determined to be eligible in the CNNMP 300% SSI covered group effective March 1.

His patient pay for March (the month of entry) includes a deduction for the Medicare premium. Because he is not QMB eligible, the buy-in is effective in May, the second month following the month in which his ongoing Medicaid coverage began. The cost of his Medicare Part B premium is deducted from his patient pay for the months of March and April, as his buy-in will be in effect beginning with the month of May.

If the buy-in is delayed for any reason, the individual will be reimbursed by SSA for premiums deducted after the second month.

5. Medicare Advantage (Part C) Premiums

Medicare Advantage plans, also referred to as Medicare Part C, are voluntary managed-care Medicare plans. In addition to Medicare Part B premiums, some individuals may pay an extra Medicare Advantage premium. The Medicaid Medicare buy-in is initiated for individuals with Medicare Advantage ; however, the buy-in covers only the allowable Medicare Part A and/or B premiums. The individual is responsible for any additional Medicare Advantage monthly premium. The Medicare Advantage monthly premium remains the individual's responsibility and is an allowable deduction from patient pay.

6. 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 2011 is \$33.25.

7. LTC Insurance

a. Deduct LTC premium in admission month only

When an individual has an LTC insurance policy, the individual stops paying premiums beginning the month after he is admitted to LTC. The premium paid for the policy in the admission month can be deducted from the admission month’s patient pay only. The LTC insurance premium is not deducted from patient pay for the months following the admission month.

b. LTC insurance benefits

LTC insurance benefits are treated as 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.

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, Intellectual Disabilities/Mental Retardation (ID/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,
- ID/MR Waiver,
- Technology-Assisted Individuals Waiver
- DD Waiver, and
- DS Waiver

The PMA is:

- January 1, 2011 through December 31, 2011: \$1,112 (no change for 2011)
- January 1, 2010 through December 31, 2010: \$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 if the patient's guardian is affiliated with a public agency or organization that receives funding for guardianship services.

No deduction is allowed for representative payee or "power of attorney" fees or expenses.

- the premium is paid from the patient's own funds; OR
- the premium is paid by a relative (other than a spouse or parent for minor child) when that relative receives a benefit payment (income) which includes a benefit amount for the patient.

The amount deducted is the amount of the monthly premium. If the patient pays the premium less often than monthly, such as quarterly, prorate the amount paid by the number of months covered by the payment to obtain the monthly amount to deduct in the patient pay calculation.

“Health benefit plan” means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA (Multiple Employer Welfare Arrangement) or plan provided by another benefit arrangement.

Health benefit plan does not mean accident only, credit, or disability insurance; long-term care insurance; vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance (14VAC5-234-30).

Income protection insurance (indemnity) policy premiums are not medical expenses and are not deducted from the patient pay.

Membership fees for an organization that sponsors or provides the health insurance are not part of the premium and are not deductible.

1. Medicare Part A and/or Part B Premiums

For CNNMP and MN recipients, the Medicare buy-in is effective **2 months after the begin date** of Medicaid coverage. If the begin date of coverage is other than the first day of a month, the buy-in is effective the first of the month in which the 60th day occurs. Part B premiums (and Part A premiums if the recipient must pay the Part A premium) must be deducted from patient pay in the month(s) in which the buy-in is not effective.

Deduct the Medicare premium(s) for the first two months of coverage eligibility for the following recipients:

- CNNMP individuals who are not dually eligible QMB,
- MN recipients who are not dually eligible QMB.

The Medicaid Medicare buy-in does NOT pay for Medicare premiums in closed periods of coverage for LTC patients who are on spenddown and whose eligibility is for a closed period. Deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from patient pay in the month(s) in which the buy-in is NOT effective.

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
Advantage
(Part C)
Premiums**

Medicare Advantage plans, also referred to as Medicare Part C, are voluntary managed-care Medicare plans. In addition to Medicare Part B premiums, some individuals may pay an extra Medicare Advantage premium. The Medicaid Medicare buy-in is initiated for individuals with Medicare Advantage; however, the buy-in covers only the allowable Medicare Part A and/or B premiums. The individual is responsible for any additional Medicare Advantage monthly premium. The Medicare Advantage monthly premium remains the individual's responsibility and is an allowable deduction from patient pay.

**4. Medicare Part
D Premiums**

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 2011 is \$33.25.

5. LTC Insurance

a. Deduct LTC premium in admission month only

When an individual has an LTC insurance policy that covers long-term care services received in the home, the individual stops paying premiums beginning the month after he is admitted to the home-based LTC. The premium paid for the policy in the LTC admission month can be deducted from the admission month's patient pay only. The LTC insurance premium is not deducted from patient pay for the months following the admission month.

b. LTC insurance benefits

LTC insurance benefits are treated as TPL. If the individual receives the payment from the insurance company, the payment is not income for patient pay or eligibility determinations. The individual should assign it to the waiver services provider. If the individual cannot do this, or the policy prohibits assignment, the LTC insurance payment should be given directly to the provider. The provider should report the payment as a third party payment on its claim form.

If the provider is unable to accept payment directly from the individual, the individual must send the insurance payment to:

DMAS Fiscal Division, Accounts Receivable
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

**C. Noncovered
Medical/Dental
Services**

Deductions for the cost of a patient's medically necessary medical or dental services not covered by Medicaid, other insurance (such as Medicare), or another person are subtracted from income to determine patient pay.

See M1470.430 B.3 for the procedures used to deduct Medicare Part D prescription drug co-pays for patients who have Medicare.

DMAS approval **is not** required for deductions of noncovered services from patient pay when the individual receives CBC services, regardless of the amount of the deduction.

**1. Zero Patient
Pay
Procedures**

If deductions from patient pay cannot be allowed because the recipient has no income remaining after deducting the personal maintenance allowance, dependent child allowance(s) and health insurance premiums, or the recipient has no income available for patient pay, deny the request.

Notify the patient or the patient's representative using the Notice of Action.

If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service has been approved, notify the patient or his authorized representative that the deduction for the new non-covered service will be made after the first noncovered service deductions are completed.

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;
- notify a new provider that the patient pay is available through the verification systems;
- reflect changes in the patient's deductions, *such as a medical expense allowance*;
- document admission, death or discharge of a patient to an institution or community-based care services;

M1480 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	pages 7, 14, 66, 71
UP #5	7/1/11	page 66
TN #95	3/1/11	pages 7-9, 13, 18a, 18c, 66, pages 69, 70
TN #94	9/1/10	pages 64, 66, 69, 70
TN #93	1/1/10	Table of Contents, page ii pages 3, 8b, 18, 18c, 20a pages 21, 50, 51, 66, pages 69, 70, 93 Appendix 4 removed.
Update (UP) #1	7/1/09	page 66
TN # 91	5/15/09	pages 67, 68 pages 76-93

- 27. Spousal Share** means ½ of the couple's combined countable resources at the beginning of the **first** continuous period of institutionalization, as determined by a resource assessment.
- 28. Spouse** means a person who is legally married to another person under Virginia law.
- 29. Waiver Services** means Medicaid-reimbursed home or community-based services covered under a 1915(c) waiver approved by the Secretary of the United States Department of Health and Human Services.

M1480.015 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LONG-TERM CARE

- A. Applicability** The policy in this section applies to nursing facility and CBC/PACE patients, who meet the requirements for LTC on or after January 1, 2006. This includes individuals who filed reapplications after a break in Medicaid eligibility. It does **not apply** to Medicaid recipients who were approved for LTC prior to January 1, 2006, and who maintain continuous Medicaid eligibility.

For Medicaid applicants or enrollees approved for LTC on or after July 1, 2006, the amount of equity in the home at the time of the initial LTC determination and at each renewal must be evaluated.

- B. Policy** Individuals with equity value (tax assessed value minus encumbrances) in home property that exceeds the limit are NOT eligible for Medicaid payment of long-term care services unless the home is occupied by

- a spouse,
- a dependent child under age 21 years, or
- a blind or disabled child of any age.

Individuals with substantial home equity may be eligible for Medicaid payment of other covered services if they meet all the other Medicaid eligibility requirements.

- 1. Home Equity Limit** The home equity limit applied is based on the date of the application or request for LTC coverage. Effective January 1, 2011, the home equity limit is subject to change annually. The home equity limit is:
- Effective January 1, 2006 through December 31, 2010: \$500,000
 - Effective January 1, 2011: \$506,000.
- 2. Reverse Mortgages** Reverse mortgages **do not** reduce equity value until the individual begins receiving the reverse mortgage payments from the lender.

Resources owned in the name of one or both spouses are considered available regardless of whether either spouse agrees to sell or liquidate the resource, and regardless of whether either spouse refuses to make the resource available. The resource assessment is not affected by the amount disregarded in the eligibility determination as a result of a Partnership Policy.

C. Appeal Rights

When the resource assessment is completed as part of a Medicaid application and eligibility determination, the spousal share calculation can be appealed pursuant to the existing Client Appeals regulations (VR 460-04-8.7).

D. Eligibility Worker Responsibility

Each application for Medicaid for a person receiving LTC services who has a community spouse requires the completion of a resource assessment to determine the spousal share used in determining eligibility.

The EW must provide the applicant with a written request for verification of:

- all reported countable resources owned by the couple **on the first moment of the first day of the first month (FOM)** of the first continuous period of institutionalization. *Request this information using the Medicaid Resource Assessment form (#032-03-816) when the FOM is prior to the application's retroactive period.*
- all reported countable resources owned by the couple on the first moment of the first day of the month of application, and
- all reported countable resources owned by the couple as of the first moment of the first day of each retroactive month for which eligibility is being determined.

To expedite the application processing, the EW may include a copy of the "Intent to Transfer Assets to A Community Spouse" form, available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi with the request for verifications.

The same verification requirements as for all Medicaid applications apply to the resource assessment.

If the applicant reports to the EW that he cannot obtain certain verifications, the EW must determine why he cannot obtain them and what the EW can do to assist the applicant.

E. Procedures

The resource assessment is only a part of the eligibility determination process. The spousal share is calculated as a result of the resource assessment. The spousal share is used in the calculation of the spousal protected resource amount (PRA) and the institutionalized spouse's countable resources.

1. Forms

The applicant or his representative does not complete a Medicaid Resource Assessment Request form. The Medicaid application is the resource assessment request.

Either the Medicaid Resource Assessment form (#032-03-816) or the electronic Resource Assessment and Eligibility Workbook may be used to complete the assessment of resources and spousal share calculation at the time of the first continuous period of institutionalization. The workbook is located on the VISSTA web site at: http://www.vcu.edu/vissta/bps/bps_resources/ltc_medicaid.htm.

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**

\$1,838.75	7-1-11
\$1,821.25	7-1-10
- C. Maximum Monthly Maintenance Needs Allowance**

\$2,739.00	1-1-11 (no change for 2011)
\$2,739.00	1-1-10
- D. Excess Shelter Standard**

\$551.63	7-1-11
\$546.38	7-1-10
- E. Utility Standard Deduction (SNAP)**

\$274	1 - 3 household members	10-1-11
\$345	4 or more household members	10-1-11
\$303	1 - 3 household members	10-1-10
\$382	4 or more household members	10-1-10

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).

D. Community Spouse Monthly Income Allowance

The community spouse monthly income allowance is the difference between the community spouse's gross monthly income and the minimum monthly maintenance needs allowance determined below.

1. Determine Minimum Monthly Maintenance Needs Allowance (MMMNA)

Calculate the minimum monthly maintenance needs allowance using the following procedures (**do NOT round any cents to a dollar**):

- a. the monthly maintenance needs standard, plus
- b. an excess shelter allowance for the community spouse's principal place of residence, if applicable. The excess shelter allowance is the amount by which the total of verified allowable expenses in 1) through 5) below **exceeds** the excess shelter standard.

Allowable expenses are:

- 1) rent,
- 2) mortgage (including interest and principal),
- 3) taxes and insurance,
- 4) any maintenance charge for a condominium or cooperative, and
- 5) the utility standard deduction, unless utilities are included in the community spouse's rent or maintenance charges.

The utility standard deduction for a household of 1-3 members is different than the deduction for households of 4 or more members.

2. Maximum Allowance

The minimum monthly maintenance needs allowance calculated above cannot exceed the maximum.

3. DMAS Hearing Officer or Court Ordered Amount

The Eligibility Worker has no flexibility to calculate a minimum monthly maintenance needs allowance greater than the one calculated using the steps listed above. If the individual states there is a need for a greater amount, he has the right to file an appeal using the procedures in chapter M16. A Hearing Officer may increase the community spouse income allowance if it is determined that exceptional circumstances resulting in extreme financial duress exist. If the individual disagrees with the outcome of the appeal, he may then appeal the decision through his local circuit court.

The EW cannot accept a court order for a greater community spouse allowance unless the individual has exhausted the Medicaid administrative appeals process.

M1510 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/01/11	pages 8a, 10
TN #95	3/1/11	Table of Contents Pages 8, 11-15
TN #94	9/1/10	pages 2a, 8-8a
TN #93	1/1/10	page 6
Update (UP) #2	8/24/09	page 11
TN #91	5/15/09	page 14

cannot begin prior to the disability onset date when the disability onset date falls after the application date.

4. Redetermination Required When More Than 12 Months Have Passed

If, based upon the re-evaluation, the individual is determined to be eligible and more than 12 months have passed since the application was filed, complete a redetermination to determine whether or not the individual remains eligible.

5. Spenddown

If, based upon the re-evaluation, the individual is determined not eligible but met the requirements in Chapter M13 for placement on a spenddown, *a first prospective and additional 6 month spenddown budget period are established to cover the period of time between the date of application and the date action is taken on his case.*

A new application is not required for each 6 month spenddown budget period leading up to the date of processing; however, verification of all income and resources for those time periods must be obtained.

M1510.104 FOSTER CARE CHILDREN

A. Policy

Entitlement begins the first day of the month of commitment or entrustment IF a Medicaid application is filed within 4 months of the commitment or entrustment date.

If the Medicaid application is filed more than 4 months after entrustment or commitment, entitlement begins the first day of the application month if retroactive coverage is NOT requested.

B. Retroactive Entitlement

If the Medicaid application is filed within 4 months of entrustment or commitment, retroactive eligibility exists only if the child met another covered group and all other Medicaid eligibility requirements in the

B. Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs

The "Notification of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs" (Form 032-03-008) must be used to notify the applicant:

- that his application has been approved and the effective date(s) of his Medicaid coverage.
- that retroactive Medicaid coverage was approved and the effective dates.
- that his application has been denied including the specific reason(s) for denial.
- that retroactive Medicaid coverage was denied, including the specific reason(s) for denial.
- of the reason for delay in processing his application.
- of the status of his request for reevaluation of his application in spenddown status.

When the application was filed by the applicant's authorized representative, a copy of the notification must be mailed to the applicant's authorized representative.

1. MI Children or Pregnant Women

When the application of a medically indigent child or pregnant woman is denied because of excess income, the denial notice ("Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs ") must state the reason for denial. The notice must also include the *resource questions pages from the "Application For Benefits" form or the form "Eligibility Review Part B,"* and must advise the applicant of the following:

- a. that he/she may complete and *return the enclosed form for a Medicaid spenddown to be evaluated*, and
- b. *if the information is returned* within 10 days of this notice, the medically indigent application date will be used as the Medicaid spenddown application date.

2. Qualified Medicare Beneficiaries

a. Excess resources

When a Qualified Medicare Beneficiary's (QMB's) application for medically indigent Medicaid coverage is denied because of excess resources, the denial notice must state that the applicant is not eligible for Medicaid because of excess resources.

b. Excess income

- 1) If the QMB's resources are within the medically indigent limit but are over the medically needy limit, and the income exceeds the medically indigent limit, the notice must state that the applicant is not eligible for QMB Medicaid because of excess income, and is not eligible for

Virginia DSS, Volume XIII

M1520 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	Table of Contents pages 1-7g pages 11-13 pages 21-24
TN #95	3/1/11	pages 6a, 7, 21, 22
TN #94	9/1/10	Table of Contents pages 3, 4b, 5, 6-6a, 10 Appendix 1 removed.
UP #4	7/1/10	page 4
TN #93	1/1/10	pages 3, 4b, 5-6, 10, 15 pages 21, 22
Update (UP) #2	8/24/09	pages 1, 2, 13, 14, 17, 18
Update (UP) #1	7/01/09	page 3

TABLE OF CONTENTS

M15 ENTITLEMENT POLICY & PROCEDURES

M1520.000 MEDICAID ELIGIBILITY REVIEW

	Section	Page
General Principle.....	M1520.001	1
Partial Review.....	M1520.100	2
Renewal Requirements	M1520.200	7
Medicaid Cancellation or Services Reduction	M1520.400	8
Notice Requirements	M1520.401	8
Cancellation Action/Services Reduction	M1520.402	10
Recipient Requests Cancellation.....	M1520.403	10a
Extended Medicaid Coverage	M1520.500	11
Four Month Extension	M1520.501	11
Twelve Months Extension.....	M1520.502	12
Case Transfers	M1520.600	21

M1520.000 MEDICAID ELIGIBILITY REVIEW

M1520.001 GENERAL PRINCIPLE

A. Policy

A Medicaid recipient's eligibility must be partially reviewed whenever the agency becomes aware of any change in the enrollee's circumstances that might affect the enrollee's continued Medicaid eligibility.

An annual review of all of the enrollee's Medicaid eligibility requirements is called a "renewal." A renewal of the enrollee's eligibility must be completed at least once every 12 months. *The renewal should be initiated in the 11th month to ensure timely completion of the renewal.*

When a Medicaid enrollee no longer meets the requirements for his current covered group, prior to cancelling his coverage, *he must be evaluated in all covered groups for which he may meet the definition. If the individual is not eligible for full benefit Medicaid coverage and is not eligible as a Medicare beneficiary, he must be evaluated for Plan First, unless he has declined that coverage.*

1. Negative Action Requires Advance Notice

When a change is reported that impacts eligibility or a renewal is completed and the enrollee is no longer eligible, the Advanced Notice of Proposed Action must be sent to the enrollee before the enrollee's benefits can be reduced or his eligibility can be terminated (see M1520.401).

2. Renewal Approval Requires Notice

When a change is reported and eligibility continues, no notice is necessary. When a renewal is completed and eligibility continues, the Notice of Action is used to inform the enrollee of continued eligibility and the next scheduled renewal.

3. Voter Registration

If the individual reports a change of address in person, voter registration application services must be provided (see M0110.300 A.3).

B. Procedures For Partial Review and Renewals

The policy and procedures in this subchapter are contained in the following sections:

- the requirements for **partial reviews** are in section M1520.100;
- the requirements for **renewals** are in section M1520.200;
- the policy and procedures for **cancelling** a enrollee's Medicaid coverage or reducing the enrollee's Medicaid services (benefit package) are in section M1520.400;
- the policy and procedures for **extended Medicaid coverage** are in section M1520.500;
- the policy and procedures for **transferring cases** within Virginia are in section M1520.600.

M1520.100 PARTIAL REVIEW

A. Enrollee's Responsibility Enrollees must report changes in circumstances which may affect eligibility and/or patient pay within 10 days from the day the change is known. For enrollees participating in the Health Insurance Premium Payment (HIPP) Program, changes that may affect participation in HIPP must also be reported to the DMAS HIPP Unit within the 10 day timeframe.

B. Eligibility Worker's Responsibility The eligibility worker has a responsibility for keeping a record of changes that may be anticipated or scheduled, and for taking appropriate action on those changes. The worker can set a follow-up review in the MMIS for anticipated changes. Examples of anticipated changes include, but are not limited to, the receipt of an SSN, receipt of SSA benefits and the delivery date for a pregnant woman.

Appropriate agency action on a reported change must be taken within 30 days of the report. If the enrollee reports any changes requiring verifications, such as changes in income or resources, or an asset transfer for enrollees receiving LTC services, send the enrollee a checklist requesting the necessary verifications, and allow at least 10 calendar days for the information to be returned. Document the information and evaluation in the case record.

1. Changes That Require Partial Review of Eligibility When changes in an enrollee's situation are reported by the enrollee or when the agency receives information indicating a change in an enrollee's circumstances (i.e. SSI purge list, reported transfer of assets), the worker must take action to partially review the enrollee's continued eligibility.

A reported increase in income and/or resources can be acted on without requiring verification, unless a reported change causes the individual to move from a limited-benefit covered group to a full-benefit covered group. The reported change must be verified when it causes the individual to move from a limited-benefit covered group to a full-benefit covered group.

2. Changes That Do Not Require Partial Review When changes in an enrollee's situation are reported or discovered, such as the enrollee's SSN and card have been received, the worker must document the change in the case record and take action appropriate to the reported change in the appropriate computer system(s).

Example: The Medicaid enrollee who did not have an SSN, but applied for one when he applied for Medicaid, reports by calling the worker that he received his SSN. The worker records the telephone call and the enrollee's newly assigned SSN in the case record, verifies the SSN via SPIDeR and enters the enrollee's verified SSN in MMIS and ADAPT.

3. HIPP The eligibility worker must provide the enrollee with a copy of the HIPP FACT Sheet when it is reported that he or a family member is employed more than 30 hours per week and is eligible for coverage under an employer's group health plan. The HIPP Fact Sheet is available on-line at: <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>. The eligibility worker must report to the HIPP Unit at DMAS any changes in an enrollee's situation that may affect the premium payment. *The worker may report changes by e-mail to hipp@dmass.virginia.gov. This e-mail address is for use by the local agency staff only. See M0130.200 G for additional information about HIPP requirements.*

- 4. Program Integrity** The Medicaid eligibility of enrollees is subject to periodic review through the program integrity process (such as Medicaid Quality Control and the DMAS Recipient Audit Unit). It may be necessary for program integrity staff to request information, such as income verification, from the enrollee. The enrollee will be notified in writing and given a reasonable amount of time, as determined by the program integrity staff, to provide the information.

Should the enrollee not provide the requested information to the program integrity staff within the specified time, program integrity staff will notify the eligibility worker, and the worker must take action to follow up by requesting the appropriate verifications and/or sending advance notice, if necessary, to cancel coverage due to the inability to determine continued eligibility. An individual's failure to provide information to program integrity staff does not affect any future Medicaid applications.

C. Covered Group 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. F&C Enrollee Becomes Entitled to SSI** *When an individual who is enrolled in a Families and Children (F&C) covered group becomes entitled to SSI, the enrollee must be given the opportunity to provide information regarding ownership interest in countable real property for eligibility in the SSI Medicaid covered group. Contact the individual by telephone, inquire about any ownership interest in real property, and document the case record regarding the individual's statement. If the enrollee cannot be reached by telephone, send the Application/Redetermination for Medicaid for SSI Recipients to request the information.*

If the individual reports no ownership interest in countable real property, take action to change the individual's AC to the appropriate SSI Medicaid AC. Because full coverage continues, no notice is required.

If the SSI individual reports ownership of countable real property, request verification of all countable resources. If verification is provided, determine eligibility in the SSI Medicaid covered group. If eligible, change the AC to the appropriate SSI Medicaid AC. Otherwise, the individual remains enrolled as an F&C enrollee as long as F&C eligibility continues.

See M0320.201 for information regarding eligibility requirements for the SSI Medicaid covered group.

4. 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) or the State Online Query-Internet system (SOLQ-I) *must be completed.*

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.

D. Child Discharged From A Psychiatric Residential Treatment Facility

Children who receive Medicaid-covered treatment in a psychiatric residential treatment facility may receive a special benefit package through the Children's Mental Health Program following discharge from the facility. Effective July 1, 2010, children receiving Children's Mental Health Program services after discharge from a psychiatric residential treatment facility continue to be eligible for Medicaid without the need for an eligibility review. When determining the Medicaid eligibility of these children, each child is considered an assistance unit of one (1) as long as the child continues to receive Children's Mental Health Program services.

1. Notification to LDSS

The discharge planner with the psychiatric residential treatment facility will send a Children's Mental Health Program Pre-Release Referral (form DMAS-800) to the agency. The referral will identify the child, the proposed date of discharge, and the proposed placement in the community. Transitional services care coordinators may download the official form from the DMAS web site, <http://www.dmas.virginia.gov>.

2. Agency Responsibility

Upon receipt of the Children's Mental Health Program Pre-Release Referral, the agency will document in the case record that the child has been approved for Children's Mental Health Program services. The child continues to be an assistance unit of one (1) for Medicaid eligibility purposes as long as the child continues to receive Children's Mental Health Program services.

Unless a change is subsequently reported that may impact eligibility, the child's Medicaid eligibility is not reviewed until the next annual renewal is due. A copy of the completed referral form must be kept in the case record.

E. Child Moves From Parental Home

When an enrolled child moves out of the parental home but is still living in Virginia, do not cancel Medicaid coverage solely on the basis of the move, and do not require a new application. Complete a partial review to determine the child's continuing eligibility if any changes in income, such as the child becoming employed, are reported.

1. Case Management

The necessary case management actions depend on the child's age and whether or not the child has moved to an arrangement in which an authorized representative is necessary.

a. Child Age 18 years or Under 18 and Living with a Relative

If the child is age 18, he may be placed in his own Medicaid case if he was previously on a case with other enrollees. If the child is under age 18 and moved in with an adult relative, the child may be placed on a case with the relative and the relative authorized to conduct Medicaid business on behalf of the child.

b. Child Under Age 18 years Living with Non-relative

When a child under age 18 moves to the home of a non-relative adult without legal custody, the non-relative adult does not have to be an authorized representative to report changes in the child's situation. However, the worker cannot discuss the case or send the non-relative adult a copy of the child's Medicaid card unless the person is authorized to handle the Medicaid business for the child. Follow the procedures in M1520.100 E.2 through E.4 below.

2. MMIS Enrollment

a. MMIS Case Number

The child's MMIS member ID number does not change, but the child's Member ID number must be moved to an MMIS base case number in the child's name as case head, if the person with whom the child is living does NOT have authority to act on the child's behalf.

b. MMIS Demographics Comment Screen

On the child's MMIS Demographics screen, enter a Comment that will inform staff that the person with whom the child lives cannot be given information from the child's MMIS records. Type a message in the Comment screen that says "information from the case cannot be shared with (the name of the person with whom the child lives) because he/she is NOT authorized to receive the information."

c. Renewal Date

If establishing a new MMIS case for the child, enter the child's existing renewal date from his former MMIS case. If moving the child to the adult relative's already established MMIS case, the child's renewal date will be the adult relative's case renewal date only if this action does not extend the child's renewal date past one year.

d. Medicaid Card

A new Medicaid insurance ID card is only generated when the enrollee's name, SSN or gender changes, or when a worker requests a replacement ID card.

Changing the child's address or MMIS case number does not generate a new card. The worker must request a replacement card in MMIS if one is needed. The existing card will be voided when the replacement is issued.

3. Obtain Authorization from Parent Prior to Renewal

Prior to the next scheduled renewal, the agency should try to obtain an authorization from the parent to allow the agency to communicate with the adult. However, as long as the parent has not formally lost custody of the child, the parent is still the responsible party and can transact the Medicaid business if he is capable and willing, or until there is a guardian/custodian established. If the parent cannot or will not designate an authorized representative, refer the case to the agency's Family Services Unit so that guardianship can be established per M0120.200 C.

4. Renewal

Follow the rules in M0120.200, which apply to both applications and renewals. If the adult is a relative, the adult can complete the renewal for the child. If the adult is a non-relative and not an authorized representative, then the adult cannot complete the child's renewal. If the child's parent cannot or will not complete the renewal, a referral to the agency's Family Services Unit is needed to pursue guardianship.

F. Recipient Enters LTC

An evaluation of continued eligibility must be done when a Medicaid enrollee begins receiving Medicaid-covered long-term care (LTC) services. When the re-evaluation is done, complete and send all required notices to the enrollee/authorized representative, and send a DMAS-225 to the provider (see M1410.300).

Note: To determine the enrollee's Medicaid eligibility as an institutionalized individual, a pre-admission screening may be required (see M1420.100).

1. Partial Review Required

If an annual renewal has been done within the past 6 months, a partial review to address factors pertinent to receipt of LTC, such as asset transfer, spousal resource assessment, etc., must be completed. If the enrollee reports any changes requiring verifications, such as changes in income or resources, or an asset transfer, send the enrollee a written request for the necessary verifications, and allow at least 10 calendar days for the information to be returned. Document the renewal information and evaluation in the case record. Send all required notices (see M1410.300).

If the individual is already enrolled in a full benefit Medicaid covered group other than the ABD with Income \leq 80% FPL covered group, do not change the AC. If the individual is enrolled as \leq 80% FPL, the individual must be evaluated for eligibility in one of the covered groups for institutionalized individuals (i.e. income \leq 300% of SSI). Follow the procedures in M1460 to determine the appropriate covered group/AC for the individual.

2. Renewal Required

If an annual renewal has not been done within the past 6 months, a complete renewal must be completed (see M1520.200). A new application is not required; complete a telephone interview renewal or a paper-based renewal. For individuals age 19 years and older, use the Medicaid Redetermination for Long-Term Care form (#032-03-369), available on SPARK at: http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi. For children under age 19, use the Families & Children Medicaid and FAMIS Plus Renewal Form (#03-032-018), available on SPARK at <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>

- 3. SSI Recipients** *For an SSI recipient who has no community spouse and owns no countable real property, verify continued receipt of SSI through SOLQ-I or SVES, obtain information regarding asset transfer from the enrollee or authorized representative, and document the case record. As long as the individual continues to receive SSI, do not change the AC. If the individual loses SSI, evaluate his Medicaid eligibility in other covered groups. See M1430.104 for additional information regarding an SSI recipient who enters a nursing facility.*

- 4. Individual on a Spenddown** *When an individual on a spenddown enters LTC, his Medicaid eligibility must be determined using the procedures in subchapter M1460.*

An individual on a spenddown in an assistance unit with a spouse and/or children becomes a separate assistance unit when he enters LTC. The spouse's and/or children's spenddown liability is recalculated to reflect a decrease in assistance unit size. See M1350.220 for additional information.

- 5. Married Institutionalized Individuals with a Community Spouse** *Rules for determining Medicaid eligibility for married institutionalized recipients who have a community spouse are found in subchapter M1480.*

M1520.200 RENEWAL REQUIREMENTS

- A. Policy** *The agency must evaluate the eligibility of all Medicaid enrollees, with respect to circumstances that may change, at least every 12 months. Each renewal must be authorized by an eligibility worker or supervisor, although administrative staff may assist in the gathering of information.*
- 1. Required Verifications** *An individual's continued eligibility for Medicaid requires verification of income for all covered groups and resources for covered groups with resource requirements. Blindness and disability are considered continuing unless it is reported that the individual is no longer blind or disabled.*

 - 2. SSN Follow Up** *If the enrollee's Social Security Number (SSN) has not been assigned by the renewal date, 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.*

 - 3. Evaluation and Documentation** *An evaluation of the information used to determine continued eligibility must be completed and included in the case record. For ex parte renewals, the Record of Ex Parte Medicaid Renewal (#032-03-0740) is recommended. For contact-based renewals, either a paper renewal form or the Record of Telephone Interview for Medicaid Renewal (#032-03-0741), available on SPARK at <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi> must be used to document 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 Advance Notice of Proposed Action must be used when there is a reduction of benefits or termination of eligibility.

 - 4. Voter Registration Requirement** *The National Voter Registration Act of 1993 (NVRA) requires local social services agencies to offer Medicaid enrollees an opportunity to apply to register to vote at each renewal (redetermination) of eligibility (see M0110.300.A.3).*

- 5. 12-Month Renewal Period** Renewals must be completed prior to cut-off in the 12th month of eligibility. The first 12-month period begins with the month of application for Medicaid.

Subsequent renewals must be completed by the MMIS cut-off date no later than 12 months following the month *in which* the last renewal was filed/initiated. Monthly annual renewal lists are generated by the VDSS Data Warehouse using MMIS data. These reports notify eligibility workers of enrollees due and overdue for renewal.

- 6. Scope of Renewals** The scope of renewals is limited to information that is necessary to determine ongoing eligibility and that relates to circumstances that are subject to change, such as income and resources. Verification of information that is not subject to change, such as date of birth and Social Security Number (SSN), is not required at renewal, *unless it has not been verified previously.*

- 7. Types of Renewals** *There are two types of Medicaid eligibility renewals: non-contact based (ex parte) and contact-based (telephone interview or paper-based). The type of renewal required depends on the enrollee's covered group requirements and availability of information necessary to determine continued eligibility. Whenever the necessary renewal information is available to the worker through data verification sources and policy permits, the client is not to be contacted and an ex parte renewal is to be completed. When an ex parte renewal is not possible, contact the individual by telephone or in writing.*

For all types of Medicaid eligibility renewals, the agency must make all reasonable efforts to obtain relevant information from Medicaid files and other sources (subject to confidentiality requirements).

a. Ex Parte Renewal

An ex parte renewal is an internal review of eligibility based on *information available to the agency*. By relying on information available, the agency avoids unnecessary and repetitive requests for information from individuals and families that can add to administrative burdens, make it difficult for individuals and families to retain coverage, and cause eligible individuals and families to lose coverage. *The procedures for completing an ex parte renewal are in M1520.200 B, below.*

Individuals in the SSI Medicaid covered group must have an ex parte renewal unless they have reported ownership of non-excluded real property prior to the renewal.

When the ex parte process is used, a contact-based renewal, either through a telephone interview or paper form, must be completed at least once every five years.

b. Telephone Interview Renewal Process

If an ex parte renewal cannot be done, the eligibility worker may conduct a telephone interview renewal, either in conjunction with the renewal for other benefits or for Medicaid only. The procedures for completing a telephone renewal interview are in M1520.200 C below.

c. Renewal Using a Paper Form

If ongoing eligibility cannot be established through an ex parte renewal *and a telephone renewal interview is not feasible*, the agency must provide the individual the opportunity to present additional or new information on a paper renewal form and *to present* verifications necessary to determine ongoing eligibility. *The procedures for completing a renewal when a paper form is used are in section M1520.200 D, below.*

The following Medicaid renewal forms are available on SPARK at <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>:

- The Families & Children Medicaid and FAMIS Plus Renewal Form (#03-032-0187);
- The ABD Medicaid Renewal Form (#03-032-0186) ;
- *The BCCPTA Redetermination Form (#032-03-0653), for woman enrolled in the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) covered group.*
- The Medicaid Application/Redetermination for Long-Term Care (#032-03-0369), available at: http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi, for individuals *receiving LTC services*;
- The Eligibility Review Part A (#032-03-729A) and Eligibility Review Part B (#032-03-729B) for individuals required to complete them for another benefit program.

B. Ex Parte Renewal Process

Local departments of social services are **required** to conduct renewals of ongoing *Medicaid* eligibility through *the* ex parte renewal process when:

- *the local agency has access to on-line systems information for verifications necessary to determine ongoing eligibility and/or income verifications obtained for other benefit programs, and*
- *the enrollee's covered group is not subject to a resource test.*

1. F&C Ex Parte Renewal Procedures

a. Use Available Information

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

The eligibility worker is to take every opportunity to renew Medicaid eligibility when information is reported/verified that will allow a renewal of eligibility to be completed. For example, when an ongoing Medicaid enrollee applies for SNAP or TANF or reports a change in income, use the income information obtained to complete an early ex parte Medicaid renewal and extend the Medicaid renewal for another 12 months.

b. Income Verification

The *eligibility* worker must document the date and method used to obtain the *verification* information (viewed *pay stub dated xx/xx/xxxx*, telephone *call on xx/xx/xxxx date*, etc.), the type of verification, the source and a description of the information. Income verification *that is* 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 income verifications in the case record. If the renewal is not processed *and documented* in ADAPT, the documentation must be in the case record.

An enrollee who has previously reported \$0 income must provide written confirmation of income at each renewal. If the agency has not obtained written confirmation for another program (e.g. SNAP), do not complete an ex parte renewal when an enrollee has reported \$0 income. \$0 income statements must be no more than 30 days old to be used. If written confirmation was provided for another program, it cannot be used if it is more than 30 days old.

**2. Renewal
Procedures For
SSI Recipients
and 1619(b)
Individuals**

a. Review Case Record

An ex parte renewal for an SSI recipient (*including an LTC recipient with no community spouse*) who has reported no *ownership interest* in countable real property can be completed by verifying *the individual's* continued receipt of SSI through SVES or SOLQ-I and documenting the case record. The ex parte process cannot be used for an SSI recipient who owns *non-excluded* real property. He is subject to a resource evaluation and the agency has no internal means to verify all his resources.

For a 1619(b) individual, check the Medicaid Test Indicator field in SVES or SOLQ-I to verify there is a code of A, B or F.

The case record must also contain documentation that the individual reported no ownership interest in countable real property, either on the application form or on a subsequent renewal form. If the case record does not contain documentation that the individual reported no ownership interest in real property, a contact-based (telephonic or paper form) renewal is to be completed at the next annual renewal.

b. Individual Loses SSI or 1619(b) Status

If the individual is no longer an SSI recipient or no longer has 1619(b) status and the information needed to determine continued eligibility is not known to the agency, a *contact-based (telephone interview or paper form)* renewal must be completed and necessary verifications obtained to evaluate the individual's eligibility in all other covered groups prior to canceling his Medicaid coverage.

**C. Telephone Interview
Renewal Procedures**

*When an ex parte renewal cannot be completed for an enrollee in any covered group, the eligibility worker may contact the enrollee by telephone. When a renewal is completed by telephone, no renewal form is sent to the enrollee, and the enrollee's signature is **not** required. Send the enrollee a written request for the necessary verifications, and allow at least 10 calendar days for the information to be returned. **If an enrollee reports \$0 income from any source, obtain a written statement indicating that he has no income.***

The renewal information and evaluation must be documented in the case record. The enrollee must be informed of the findings of the renewal.

D. Paper Renewal Procedures

When a Medicaid renewal form is *used*, the form must be sent to the enrollee no later than the 11th month of eligibility. The worker can complete the renewal form and send it to the enrollee to sign and return ,or the worker can mail the form to the enrollee for completion. Allow at least 10 calendar days for receipt of the necessary verifications; additional time may be allowed *at the enrollee's request*. The specific information requested and the deadline for receipt of the verification must be documented *in the case record*.

E. Disposition of Renewal

1. Renewal Completed

Notify the enrollee in writing of the findings of the renewal and the action taken. When eligibility continues, use the Notice of Action, and include the month and year of the next scheduled renewal. When the individual is no longer eligible, use the Advance Notice of Proposed Action and include spenddown information, if applicable. When there is a reduction of benefits, use the Advance Notice of Proposed Action and include the month and year of the next scheduled renewal.

2. Renewal Not Completed

If information necessary to redetermine eligibility is not available through online information systems that are available to the agency and the enrollee has been asked but has failed to provide the information, the renewal must be denied and the coverage cancelled due to the inability to determine continued eligibility. *Action cannot be taken to cancel coverage until after the deadline for the receipt of verifications has passed, except for situations when the deadline falls on a weekend or holiday.*

3. Action Taken After Cutoff but Prior to Cancellation Date

When the enrollee fails to return the renewal form and verifications by the requested date and cutoff falls on a weekend or holiday, cancel the individual's coverage on the last business day before Medicaid cutoff, and send advance notice of the cancellation to the enrollee. However, if the early cancel action is taken, LDSS must *re-evaluate* the renewal if the individual provides the necessary information by the last day of the month in which the renewal is due.

If the individual's is determined eligible, the LDSS must reinstate the individual's coverage and send a notice to the individual notifying him of the reinstatement, *his continued coverage and the next renewal month and year. If the re-evaluation determines that the enrollee is not eligible, send a Notice of Action indicating the correct reason for the cancellation (e.g. countable income exceeds the limit).*

F. 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 the pregnancy occurs.

When eligibility in a pregnant woman covered group ends, *prior to the cancellation of her coverage*, determine if the woman meets the definition for another Medicaid covered group (see M0310.002). If the woman meets the definition of a full-benefit covered group, or *for limited coverage under Plan First*, 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, *determine her eligibility in the limited benefit Plan First covered group using the eligibility requirements in M0320.302.*

If the woman is eligible for Plan First, reinstate her coverage in Plan First and send the Advance Notice of Proposed Action indicating that she has been enrolled in Plan First. On the notice, state that if she does not wish to remain covered by Plan First, to contact the eligibility worker and request that the coverage be cancelled. Include a Plan First Fact Sheet, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>, with the Advance Notice of Proposed Action.

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

2. 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)
- SSN or proof of application
- verification of income
- verification of resources for the MN child.

3. MI Child Under Age 19—Income Exceeds FAMIS Plus Limit

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, *ADAPT will evaluate the child for the Family Access to Medical Insurance Security Plan (FAMIS).*

If the worker must determine eligibility outside ADAPT, use 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. *It is not necessary to obtain a new application. The necessary information regarding resources can be obtained using either Review Form Part B or the resource section of the Application for Benefits.*

4. 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, *outside ADAPT*.

If information in the case record indicates that the child is disabled or may be disabled, verify the child's SSI benefits through SVES or SOLQ-I. If the child does not receive SSI, complete a referral to Disability Determination Services (DDS) following the procedures in M0310.112. The referral to DDS must be made at least 90 calendar days prior to the child's 19th birthday *to allow the disability determination to be made prior to the child's 19th birthday.*

If the child does not meet the definition for another covered group, determine the child's eligibility in Plan First *using the eligibility requirements in M0320.302. If the child is eligible for Plan First, reinstate coverage in Plan First and send the Advance Notice of Proposed Action indicating that he has been enrolled in Plan First. On the notice, state that if he does not wish to remain covered by Plan First, to contact the eligibility worker and request that the coverage be cancelled. Include a Plan First Fact Sheet, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>, with the Advance Notice of Proposed Action.*

5. Child Under 21 Turns Age 21

When an individual who is enrolled in the Child Under Age 21 covered group turns 21, redetermine his continuing Medicaid eligibility in other covered groups, including Plan First.

6. IV-E FC & AA Children and Special Medical Needs Children From Another State

The renewal of Medicaid coverage for Title IV-E foster care or adoption assistance children and non-IV-E special medical needs adoption assistance children requires only the following information:

- verification of continued IV-E eligibility status or non-IV-E special medical needs status,
- the current address, and
- any changes regarding third-party liability (TPL).

This information can be obtained from agency records, the parent or the Interstate Compact office from another state, when the child's foster care or adoption assistance agreement is held by another state. A renewal form is not required. The information must be documented in the case record.

7. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)

The BCCPTA Redetermination Form (#032-03-653), is used to redetermine eligibility for the BCCPTA covered group. The form is available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.html>. The enrollee must provide a statement from her medical provider verifying continued treatment for breast or cervical cancer. There are no Medicaid financial requirements for the BCCPTA covered group.

8. **Hospice Covered Group** At the annual renewal for an individual enrolled in the Hospice covered group (AC 054), the worker must verify the enrollee's continued election and receipt of hospice services, *in addition to determining continued Medicaid eligibility.*
9. **Qualified Individuals** Coverage for individuals enrolled in the Qualified Individuals (QI) covered group (AC 056) is automatically cancelled effective December 31 of the current year. However, coverage for QIs can be renewed annually provided that there is no break in Medicaid eligibility.

Renewals for all QIs are due by December 31 of each year. 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. Follow the ABD Medicaid renewal procedure to request verifications and complete the evaluation.

a. Renewal form returned BEFORE December 31st

If the individual remains eligible for QI coverage, do not act *do not* change the renewal date in MMIS prior to December 31. On or after January 1 of the following year, reinstate the QI coverage in MMIS, effective January 1. Change the renewal date in MMIS to December 31 *of the current year*. 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. LTC

The ex parte renewal process is used for institutionalized individuals who receive SSI and have no countable real property. It can also be used for other enrollees when the local agency has access to on-line information for verifications necessary to determine ongoing eligibility and/or income verifications obtained for other benefit programs and the covered group has no resource test.

For all others, the eligibility worker may complete a telephone interview renewal or a paper-based renewal. For individuals age 19 years and older, use the Medicaid Redetermination for Long-Term Care form. For children under age 19, use the Families & Children Medicaid and FAMIS Plus Renewal Form.

Send the enrollee a written request for the necessary verifications, and allow at least 10 calendar days for the information to be returned. Document the renewal information and evaluation in the case record. Send all required notices (see section 1410.300).

The patient pay must be updated in MMIS at least every 12 months, even if there is no change in patient pay. Send the provider a DMAS-225 when there has been a change in circumstances resulting in a change in eligibility. If there has been no change in circumstances, do not send a DMAS-225 to the provider.

M1520.500 EXTENSIONS OF MEDICAID COVERAGE

A. Policy

Medicaid recipients may be eligible for an extended period of Medicaid coverage when the family meets all the requirements for the Low Income Families with Children (LIFC) covered group except income.

LIFC families who received Medicaid in 3 of the last 6 months and who became ineligible for Medicaid due to increased income from child and/or spousal support may be eligible for a 4-month extension.

LIFC families who received Medicaid in 3 of the last 6 months and who became ineligible for Medicaid due to an increase in earnings may be eligible for a 12 months extension. Earnings could increase because of a new job, a raise in the rate of pay or more hours are being worked.

NOTE: Children must first be evaluated for Medicaid eligibility in the MI Child Under Age 19 (FAMIS Plus) covered group and if eligible, enrolled using the appropriate MI Child Under Age 19 AC. If ineligible as MI, the child must be evaluated for the Medicaid extensions. If ineligible for the Medicaid extensions, the child must be evaluated for FAMIS. If ineligible for FAMIS, the family must be given an opportunity for a medically needy determination prior to the worker taking action to cancel the Medicaid coverage.

B. Procedure

The policy and procedures for the four-month extension are in section M1520.501 below.

The policy and procedures for the twelve-month extension are in section M1520.502 below.

M1520.501 FOUR-MONTH EXTENSION

A. Policy

An LIFC Medicaid family is entitled to four additional months of Medicaid coverage after they lose Medicaid LIFC eligibility when the following conditions are met:

- The family received Medicaid as LIFC in at least three of the six months immediately preceding the month in which they became ineligible for LIFC;
- The family lost eligibility solely or partly due to receipt of or increased child or spousal support income; and
- All other Medicaid eligibility factors except income are met.

B. Procedures

1. Received in Error

For purposes of this subsection, "received Medicaid as LIFC" does not include received Medicaid erroneously. Therefore, a family unit who received Medicaid erroneously during 3 or more of the 6 months *before* the month of ineligibility does **not** qualify for the Medicaid extension.

- 2. New Family Member** A new member of the family unit is eligible for Medicaid under this provision if he/she was a member of the unit in the month the unit became ineligible for LIFC Medicaid. However, even if a baby was not born as of that month, a baby born to an eligible member of the unit during the 4-month extension is eligible under this provision because the baby meets the categorically needy non-money payment newborn child under age 1 covered group.
- 3. Moves Out of State** Eligibility does not continue for any member of the family unit who moves to another state.
- 4. Coverage Period** Medicaid coverage will continue for a period of four months beginning with the month in which the family became ineligible for LIFC Medicaid because of support income.
- 5. Aid Category** Cases eligible for this four-month extension are categorically needy non-money payment. A Medicaid-Only application and case are recorded statistically. The aid category (AC) for the recipients in the unit remains "081" for an LIFC family unit with one parent or caretaker-relative or "083" for a two-parent family unit.
- 6. Case Handling** Those cases closed in a timely manner must be held in a suspense file until the fourth month after the LIFC Medicaid cancellation month. At that time, action must be taken to evaluate continuing Medicaid eligibility.

If all eligibility factors are met, the children in the case may continue eligible as MI or medically needy. Make the appropriate AC changes to the enrollee's MMIS record.

The caretaker's Medicaid coverage must be canceled if he/she does not meet a Medicaid covered group. An appropriate "Advance Notice of Proposed Action", form 032-03-018 must be sent to the recipient if the caretaker or the case is no longer eligible for Medicaid.

M1520.502 TWELVE-MONTHS EXTENSION

- A. Policy** An LIFC Medicaid family is entitled to six additional months, with possible extension to twelve months, of Medicaid coverage after they lose Medicaid LIFC eligibility when the following conditions are met:
- The family received Medicaid as LIFC in at least three of the six months immediately preceding the month in which they became ineligible for LIFC;
 - The family lost eligibility solely or partly due to receipt of or increased income from earnings or expiration of \$30 + one-third or \$30 earned income exclusion; and
 - All other Medicaid eligibility factors except income are met.

The family consists of those individuals living in the household whose needs and income were included in determining the LIFC Medicaid

eligibility of the assistance unit at the time that the LIFC Medicaid eligibility terminated. It also includes family members born, adopted into, or returning to the family after extended benefits begin who would have been considered a member of the unit at the time the LIFC Medicaid eligibility terminated.

The earned income of family members added after the family loses LIFC Medicaid eligibility must be counted to determine gross family income.

B. Eligibility Conditions

The following conditions must be met:

1. Received LIFC Medicaid in 3 of 6 Months

The family received LIFC Medicaid in at least 3 of the 6 months immediately before the month in which the family became ineligible for LIFC. *Months during which the family received Extended Medicaid are not considered months in which the family received LIFC Medicaid.*

2. Cancel Reason

LIFC Medicaid was canceled solely because of:

- the caretaker/relative's new employment,
- the caretaker/relative's increased hours of employment,
- the caretaker/relative's increased wages of employment, or
- expiration of any assistance unit member's \$30 plus 1/3, or \$30, earned income disregard.

3. Has A Child Living in Home

The family continues to have at least one child under age 18, or under age 19 if in school, living in the home.

4. No Fraud

The family has not been determined to be ineligible for LIFC Medicaid because of fraud any time during the last six months in which the family received LIFC Medicaid.

C. Entitlement & Enrollment

Entitlement does not continue for any member of the unit who moves to another state.

Enrollees receiving this extension are categorically needy non-money payment aid category (AC) "081" for an LIFC family unit with one parent or caretaker-relative or "083" for a two-parent family unit.

1. Determining Extension Period

Medicaid coverage will continue for six months beginning with the first month the family is not eligible for LIFC Medicaid because of excess income due to any unit member's expiration of the \$30 plus 1/3 or \$30 earned income disregard, or due to the increased earnings of the caretaker/relative. Extension for an additional 6-month period is possible if the reporting and financial requirements are met (below).

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.
- C. 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.
- D. Cases From DMAS FAMIS Plus Unit FIPS 976 - Receiving LDSS Responsibilities** 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. Do Not Review Eligibility** Do not review eligibility for cases transferred from the DMAS FAMIS Plus Unit for eligibility until
- a change is reported that potentially impacts the individual's non-financial or financial Medicaid eligibility, or
 - the annual renewal is due.
- 3. Entering Case in ADAPT** When *entering* the case into ADAPT, use the gross monthly income for each individual in the FAMIS Plus assistance unit who has income, to ensure that the income determination made by the FAMIS Plus Unit is captured. On the ADAPT income screen, use the "Monthly" code for frequency even if the income is received more or less frequently. Complete instructions for entering a case transferred from the FAMIS Plus Unit into ADAPT are available at: <http://spark.dss.virginia.gov/divisions/bp/me/training/index.cgi>.

- 4. LDSS Not Responsible for Any Errors** LDSS will not be held responsible for errors found if the case is pulled for a program integrity review or audit as long as (1) no partial review or annual renewal was completed since the case transfer and (2) the annual renewal is not overdue.
- 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:

- 1) Case Data screen - change the case address to the case's new address. Do not change the Case FIPS or Caseworker number because the sending LDSS worker retains responsibility for the case until the renewal is completed.
- 2) Enrollee Demographics screen, Enrollee FIPS – change each enrollee's Enrollee FIPS to the new address's FIPS code.

When the renewal is completed and the enrollee remains eligible, transfer the ADAPT case (if in ADAPT) or update the enrollee's MMIS Case FIPS to the enrollee's locality of residence and update the Caseworker number to M0000. Send the paper case record to the enrollee's locality of residence with a completed Case Record Transfer Form.

c. Do Not Transfer Ineligible Cases

If the annual renewal or the partial review finds that eligibility no longer exists for one or all enrollees in the case, the agency must take the necessary action, including advance notice to the individuals, to cancel the ineligible individuals' coverage. Only eligible enrollees' cases are transferred.

d. Transfer Eligible Enrollees/Cases

If the renewal or the partial review indicates that the enrollee(s) will continue to be eligible for Medicaid in the new locality, the sending locality must update the ADAPT case, if the case is in ADAPT, or MMIS if the case is not in ADAPT. The sending locality must prepare the "Case Record Transfer Form" and forward it with the case record to the LDSS in the new locality of residence.

e. Transfer Pending Medicaid Applications

Pending applications must be transferred to the new locality for an eligibility determination.

f. Foster Care & Adoption Assistance

Foster care and adoption assistance Medicaid cases are not transferred unless custody or responsibility for services and/or payment is transferred.

g. Sending Transferred Cases

The eligibility record must be sent by certified mail, delivered personally and a receipt obtained or, at the agency's discretion, the case may be sent via the courier pouch.

**2. Receiving
Locality
Responsibilities**

a. Confirm Receipt

The receiving agency must confirm receipt of the case by completing the Case Record Transfer Form and returning the copy to the sending agency.

b. Process Pending Applications

When a pending application is transferred, the receiving agency makes the eligibility determination and takes all necessary action, including sending the notice and enrolling eligible individuals in MMIS.

c. Review Eligibility

LDSS workers must review (partial review) the Medicaid eligibility determination for cases transferred from other LDSS and must take any necessary corrective action.

d. Corrective Action

If an eligibility error(s) is found or the case is overdue for renewal, do not send the case back. Correct the error(s), and/or complete the renewal, send the notice to the case head if required, and refer the case to the LDSS supervisor for possible contact with the sending agency's supervisor.

F. Spenddown Cases

Cases in spenddown status (denied or canceled and placed on a spenddown) must be transferred when the applicant notifies the agency that he/she has moved to a new Virginia locality.

1. Sending Locality Responsibilities

Within 10 working days of notification that the applicant has moved, the case must be transferred to the new locality, using the "Case Record Transfer Form." The sending agency must:

- inform the applicant of the receiving agency's name, address, and telephone number;
- deduct all known spenddown items from the spenddown balance on the worksheet before sending the case record;
- note the spenddown period and balance on the case transfer form.

2. Receiving Locality Responsibilities

The receiving locality logs the case record on file, but does not open it statistically. The receiving locality must review the spenddown to determine if a recalculation based on a different income limit is required.

If the spenddown is met, the application is recorded statistically as taken, approved, and added to the caseload at that time.

G. Receiving LDSS Case Management Procedure

To identify and manage transferred Medicaid cases, use the report titled "Caseworker Alpha Case/Enrollee Listing." This report is posted in the Data Warehouse, MMIS Reporting, Medicaid Management Reports. It is updated on or about the 22nd of each month.

Most LDSS agencies and the DMAS FAMIS Plus Unit transfer cases in MMIS to Worker Number "M000" or "M0000." To identify transferred Medicaid cases, check the locality's report for Worker Number "M000" and "M0000." If the receiving LDSS uses another worker or caseload number for transferred-in cases, and the sending locality or DMAS FAMIS Plus Unit knows about the worker/caseload number for transfer cases, also check for cases in that worker number.

M1550 Transmittal Changes

Changed With	Effective Date	Pages Changed
TN #96	10/01/11	Appendix 1, page 1
TN #93	01/01/10	Title page Table of Contents pages 1-9 Appendix 1, page 1
TN #91	05/15/09	Appendix 1

**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 FAX-434-947-2114	CVTC-caseload-A-L
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 FAX-434-947-2114	CVTC-caseload-M-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 FAX-540-375-4383	Catawba-caseload-all NVTC-caseload-all HDMC-caseload-all
Frances Jones (T004)	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0841 FAX-276-782-9732	SWVTC-caseload-all ESH-caseload-A-O SSVTC-caseload-A-G
Vickie C. Simmons (T005)	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0842 FAX-276-782-9732	SEVTC-caseload-all ESH-caseload-P-Z SSVTC-caseload-H-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	HDMC-Hiram Davis Medical Center

M18 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/01/11	pages 3, 4, 16
TN #95	3/1/11	page 9
TN #94	9/1/10	page 12
TN #93	1/1/10	pages 4, 5
TN #91	5/15/09	page 2 pages 5, 6 page 8

**1. Provider
Enrollment**

In instances where an out-of-state provider is not currently enrolled as a DMAS provider, DMAS will accept the provider's initial billing and will contact the provider to determine the provider's wish to become enrolled so that subsequent services can be paid through the computerized Medicaid claims processing system.

M1830.100 MANAGED CARE

**A. General
Information**

Most Virginia Medicaid enrollees are required to receive medical care through a managed care program. There are two managed care programs that operate simultaneously within the Commonwealth: The MEDALLION Program, a Primary Care Case Management program, and Medallion II, a program that requires mandatory enrollment into a contracted Managed Care Organization (MCO) for certain groups of Medicaid enrollees. Both programs require enrollees to choose a primary care provider (PCP) who provides primary health care services and makes referrals as needed. Enrollment in managed care is based on information provided by the eligibility worker to the Medicaid Management Information System (MMIS) during Medicaid enrollment.

**B. Enrollees Exempt
from Managed
Care**

General

The following enrollees are not required to enroll in a managed care program and may seek medical care from any provider enrolled by DMAS as eligible to receive payment:

- children in Foster Care (including Treatment Foster Care), Adoption Assistance, and Residential Treatment Facility programs;
- inpatients in State mental hospitals, including but not limited to:
 - Central State Hospital,
 - Eastern State Hospital,
 - Western State Hospital,
 - Hiram W. Davis Medical Center,
 - Northern Virginia Mental Health Institute,
 - Southern Virginia Mental Health Institute,
 - Southwestern Virginia Mental Health Institute, and
 - The Commonwealth Center for Children and Adolescents (formerly known as the DeJarnette Center);
- inpatients in long-stay hospitals, nursing facilities, and intermediate care facilities for the mentally retarded (ICF-MR);
- enrollees *approved for or receiving* Medicaid community-based care services *under the Technology Assisted Waiver*;

- *enrollees receiving Medicaid community-based care waiver services, except for the Technology Assisted Waiver, who were not in an MCO prior to being enrolled in waiver services. Enrollees who were enrolled in an MCO when they began receiving waiver services, other than Technology Assisted Waiver services, continue to receive primary and acute care services through their MCO. Waiver services are provided through fee-for-service Medicaid.*
- Qualified Medicare Beneficiaries (QMB), dually-eligible enrollees, Special Low-income Medicare Beneficiaries (SLMB), Qualified Individuals, and Qualified Disabled and Working Individuals (QDWI);
- enrollees 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;
- enrollees who receive hospice services in accordance with DMAS criteria;
- refugees; and
- enrollees on a spenddown.

MEDALLION

The following enrollees are excluded from participating in MEDALLION:

- enrollees who are not accepted to the caseload of any participating PCP, and
- enrollees 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 enrollees are excluded from participating in Medallion II:

- enrollees, 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;

20. Rehabilitation Services

Preauthorization requirement

All rehabilitative services must be pre-authorized by DMAS.

Intensive Inpatient Rehabilitation

Medicaid covers intensive inpatient rehabilitation services provided in facilities certified as rehabilitation hospitals or in rehabilitation units in acute care hospitals, which are certified by the Department of Health as excluded from the Medicare prospective payment system.

Intensive Outpatient Rehabilitation

Intensive outpatient rehabilitation services provided by facilities certified as comprehensive rehabilitation facilities (CORFs), or by an outpatient program administered by a rehabilitation hospital or exempted rehabilitation unit of an acute care hospital, which are certified and participating in Medicaid are covered.

21. Substance Abuse Services

Substance abuse (SA) services are covered as follows:

- assessment and evaluation,
- outpatient therapy (individual, family, and group),
- crisis intervention,
- intensive outpatient services,
- day treatment,
- case management, and
- opioid treatment.

Treatment for nicotine and caffeine dependence/abuse is not covered.

22. Transplant Services

Transplant services are covered as follows:

- kidney, cornea, heart, lung, liver without age limits;
- liver, heart, lung, small bowel, bone marrow, and any other medically necessary transplant procedures that are not experimental or investigational for enrollees under age 21; and
- bone marrow transplants for individuals over age 21 for a diagnosis of lymphoma, breast cancer, leukemia, or myeloma.

DMAS must preauthorize all transplants except corneal transplants.

23. Transportation to Receive Medical Services

Transportation *services must be pre-authorized and* are only covered when the enrollee is being transported for the purpose of receiving or returning home from a Medicaid-covered service. For individuals *not enrolled in an MCO or enrolled in an MCO that does not provide its own transportation services*, non-emergency transportation to a medical provider must be preauthorized by the DMAS transportation broker. The toll-free telephone number for the DMAS transportation broker is 866-386-8331.

If the enrollee's MCO provides transportation services, the enrollee must call his MCO for preauthorization.

Virginia DSS, Volume XIII

M20 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	Table of Contents pages 1, 2 Pages 3-18 and Appendices 1-9 were removed.
Update (UP) #3	3/01/10	Table of Contents, page ii Appendix 3, page 1
TN #93	1/1/10	Table of Contents, page ii pages 3, 5, 6, 7, 10, 11, 15 Appendix 1, page 1 Appendix 2, page 1 Appendix 3, page 1 Appendix 4, page 1

TABLE OF CONTENTS

M20 – EXTRA HELP - MEDICARE PART D LOW-INCOME SUBSIDY

	Section	Page
Extra Help General Information	M2010.100.....	1

M2000.000 EXTRA HELP - MEDICARE PART D LOW-INCOME SUBSIDY

M2010.100 EXTRA HELP GENERAL INFORMATION

A. Introduction

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173) amended Title XVIII of the Social Security Act by establishing Medicare Part D, the Voluntary Prescription Drug Benefit Program for individuals who are entitled to Medicare Part A and/or enrolled in Medicare Part B.

B. Medicaid and Medicare Part D Prescription Drug Coverage

For the purposes of Medicare Part D, *individuals who are eligible for both Medicare and Medicaid benefits are considered dually eligible*. Effective January 1, 2006, Medicaid *does not* provide prescription drug coverage for *dually eligible individuals*. *These individuals receive their prescription drug coverage through Medicare Part D. Medicaid will only cover prescription medication that cannot be covered by Medicare under the MMA, including some controlled medications.*

Medicare beneficiaries who are not eligible for Medicaid and who choose to participate in Medicare Part D are subject to cost-sharing obligations, including monthly premiums, deductibles, and copayments.

C Extra Help Low Income Subsidy

Extra Help is the subsidy provided under Medicare Part D that reduces out-of-pocket expenses for Medicare Part D enrollees who, based on their income and resources, are determined to be low-income. *Extra Help is the public name for the subsidy program; the Social Security Administration (SSA) generally refers to the subsidy as Low-Income Subsidy (LIS) in its contacts with state Medicaid programs. There are two levels of the LIS - the partial subsidy and the full subsidy. The individual's income and resources determine the level of subsidy an eligible individual receives.*

1. Dually Eligible Individuals Have Full LIS – No Premiums, Deductibles or Copays

Dually eligible individuals are automatically eligible for the full LIS and are enrolled using data matches from the Department of Medical Assistance Services (DMAS) and the Centers for Medicare and Medicaid Services (CMS). Under the full LIS, dually eligible individuals have no Medicare Part D premiums, deductibles, or threshold costs. All dually eligible individuals except those in nursing facilities have copayments ranging from \$1 to \$5 per prescription.

2. Non Dually Eligible Individuals

Medicare beneficiaries who are not eligible for Medicaid must apply for the subsidy and be determined eligible in order to receive assistance with their Medicare Part D cost-sharing obligations. More information about the benefits available under the LIS for non-dually eligible individuals is available on-line at <http://www.centerforbenefits.org>.

D. LIS Medicaid Applications

Effective January 1, 2011, all applications for the Extra Help LIS made to SSA are also considered applications for Medicaid. The SSA transmits data on all LIS applicants residing in Virginia to the Virginia Department of Social Services. A pre-populated Application for Adult Medical Assistance is generated by the Medicaid LIS system for individuals who are not currently enrolled in Medicaid and transmitted to the appropriate local agency. See M0120.240 B.8 for additional information about LIS Medicaid applications.

**E. Extra Help LIS
Eligibility for Non
Dual Eligibles**

Individuals who are not dually eligible and *not* automatically eligible for the LIS may be eligible for the LIS if all of the following are met:

- he is a resident of the United States,
- he is entitled to Medicare Part A and/or enrolled in Medicare Part B,
- he and his spouse, if married and living together, have countable income less than 150% of the federal poverty level (FPL) for his assistance unit size,
- he, and his spouse if married, has countable resources within the limits *for the LIS*, and
- he resides in the service area of a Part D prescription drug plan (service area does not include facilities in which individuals are incarcerated but otherwise covers the 50 States, District of Columbia, and U.S. Territories).

**F. LDSS
Responsibilities**

The MMA mandates that eligibility for the Extra Help LIS can be determined by both the Social Security Administration (SSA) and the states. The local department of social services (LDSS) may also assist an individual with applying for Extra Help from the SSA in several ways, such as helping complete and/or submit the subsidy application directly to SSA, referrals to the SSA toll-free helpline, and helping to complete the on-line SSA application form. When the LDSS assists the individual with the application but does not determine eligibility, the LDSS does not have responsibility for the case.

**1. Individual
Requests LDSS
Determine LIS
Eligibility**

*If an individual requests that the LDSS determine his eligibility for Extra Help, inform the individual that, when the Social Security Administration determines eligibility for Extra Help, the SSA is able to verify most income and resources **without** requesting documentation from the individual. Indicate that assistance with completing the application for the Extra Help LIS can also be provided by the SSA.*

**2. LDSS
Responsibility for
LIS Applications**

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

- determine eligibility,
- enroll the recipient if eligible,
- provide notice,
- participate in appeals,
- comply with reporting requirements, and
- provide ongoing case maintenance, including notices, appeals, and redeterminations, unless the applicant is later found to be deemed eligible for Extra Help or has been found eligible by SSA.

If the LDSS is required to determine an individual's eligibility for the LIS, contact a regional Medical Assistance Program Consultant for additional instructions.

Virginia DSS, Volume XIII

M21 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	pages 3, 8
TN #95	3/1/11	Table of Contents pages 5, 6, 14, 15, page 16 added Appendix 1
TN #94	9/1/10	page3 Appendix 3, pages 1 and 2
UP #3	3/1/10	pages 2-5
TN #93	1/1/10	page 2-4, 8
Update (UP) #2	8/24/09	page 4

opportunity period must be given to the applicant. The C&I verification requirements in M0220.100 apply to FAMIS, including use of the Social Security Administration (SSA) data match when a Social Security number (SSN) has been provided. If an SSN has not been provided for the child, a reasonable opportunity to provide acceptable documentation of C&I must be given. The reasonable opportunity period will last until the time of the first annual renewal.

If the child is not a U.S. citizen, the child must meet the FAMIS alienage requirements.

1. 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),
 - victims of a severe form of trafficking (see M0220.313 B.5), and
 - Iraqi and Afghan Special Immigrants (see M0220.313 A.6).

- 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. Lawfully Residing Non-citizen Children < 19 Not Applicable

The *lawfully residing non-citizen* 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.

- 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;
- any siblings, half-siblings, and stepsiblings under age 19 who live in the home with the child; and
- *any half-sibling's parent who is not married to the child's parent and who lives in the home.*

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.

M22 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	pages 3, 3a
TN #95	3/1/11	pages 4-6 Appendix 1
UP #4	7/1/10	page 10
TN #94	9/1/10	page 3
UP #3	3/01/10	page 2
TN #93	1/1/10	pages 2-10
UP #2	8/24/09	page 3
Update (UP) #1	7/1/09	pages 1, 2, 7 Appendix 1, page 1

- 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),
 - victims of a severe form of trafficking (see M0220.313 A. 5), and
 - Iraqi and Afghan Special Immigrants (see M0220.313 A.6)..
- 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. 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. FAMIS MOMS for Certain Qualified Aliens Ineligible for Full Medicaid Benefits

If a pregnant woman is ineligible for full-benefit Medicaid because she does not meet the alien status requirements for full-benefit Medicaid, the woman is to be enrolled in FAMIS MOMS as long as she (1) meets the FAMIS MOMS alien status requirements and all other FAMIS MOMS non-financial eligibility requirements and (2) has income less than or equal to 200% FPL. See subchapter M0220 for additional information. This policy does NOT apply to Unqualified aliens, including illegal and non-immigrant aliens, because they do not meet the alien status requirements for FAMIS MOMS. FAMIS MOMS does not provide any emergency services eligibility for unqualified aliens (see M2220.100 C.5, below).

The table below lists the differences between the qualified alien status policies for full Medicaid coverage and FAMIS MOMS coverage for individuals who entered the U.S. on or after August 22, 1996:

Qualified Alien Group (see M0220.400)	Meets Medicaid alien status requirement for full coverage	Meets FAMIS MOMS alien status requirement
<i>veterans or active military</i>	<i>yes, with no time limit</i>	<i>yes, with no time limit</i>
<i>refugees; asylees; deportation withheld; Cuban/Haitian entrants; victims of a severe form of trafficking; and Iraqi and Afghan Special Immigrants</i>	<i>yes, only for first 7 years in U.S.</i>	<i>yes, with no time limit</i>
<i>lawful permanent residents (LPRs),</i>	<i>yes, only after 5 years in U.S. and with 40 qualifying work quarters</i>	<i>yes, only after 5 years in U.S., no work requirement</i>
<i>conditional entrants; aliens paroled in the U.S.; and battered aliens, alien parents of battered children, alien children of battered parents</i>	<i>No</i>	<i>yes, only after 5 years in U.S.</i>

*If a pregnant woman is ineligible for full-benefit Medicaid because of her alien status **and** her countable income is less than or equal to the Medicaid 133% FPL income limit, the pregnant woman's FAMIS MOMS eligibility determination and enrollment (if she is eligible for FAMIS MOMS) must be performed manually **outside of ADAPT**. If the pregnant woman is eligible for FAMIS MOMS, she is to be enrolled in FAMIS MOMS aid category 005.*

Because this process is a manual determination, the paper case record must be transferred to the FAMIS CPU for ongoing case maintenance. The case transfer must include copies of the application, evaluation of eligibility, proof of income and notice of action. Case transfer procedures are located in M2140.100 E.2.

**4. Lawfully
Residing Non-
citizen Children
< 19 Not
Applicable**

The *lawfully residing non-citizen* children policy in M0220.314 does NOT apply to the FAMIS *and* FAMIS MOMS programs.

**5. 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.

**6. SSN not
Required**

The applicant is not required to provide an SSN or proof of an application for an SSN.