MISSISSIPPI
DIVISION OF MEDICAID
Quality Health Care Services Improving Lives

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Transmittal 135 Effective April 1, 2008 pdf

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MISSISSIPPI
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GENERAL PROVISIONS
HISTORY & LEGAL BASE

A. PROGRAM DESCRIPTION

Title XIX of the Social Security Act, enacted in 1965, provides authority for states to establish Medicaid programs to provide medical assistance to needy individuals. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the providers that furnish the services.

B. BACKGROUND

Enabling legislation for the Medicaid program in Mississippi was enacted during a special session of the legislature in 1969. Funds were appropriated and the Mississippi Medicaid Commission was designated as the single state agency to administer the program. State statutes governing Medicaid may be found in Sections 43-13-101 et. seq. of the Mississippi Code of 1972.

From 1969 to 1973, the determination of Medicaid eligibility was the responsibility of the State Department of Public Welfare (DPW). During this time period, DPW authorized money payments for the aged, blind and disabled and dependent children.

C. SSI PROGRAM

The passage of Public Law 92-603 amended Title XVI of the Social Security Act and established the Supplemental Security Income (SSI) Program for the aged, blind and disabled. State statutes were amended to specify that DPW would no longer determine eligibility for a monthly payment for the aged, blind and disabled.

P.L. 92-603 allowed States an option to either grant Medicaid to all persons receiving SSI (known as Section 1634) or to grant Medicaid to persons who met more restrictive criteria set by States (known as 209-b). The Mississippi Legislature voted to limit Medicaid eligibility to persons who met more restrictive criteria and to designate the DPW as the certifying agency for Medicaid.

D. 1634 AGREEMENT

During the 1980 Session of the Mississippi Legislature, Senate Bill 2118 changed the Medicaid eligibility criteria to 1634 status whereby Medicaid would be granted to all individuals receiving SSI. In addition, SSI criteria would be used to determine eligibility for all aged, blind and disabled individuals. During the 1981 Legislative Session, Senate Bill 2478 authorized the Mississippi Medicaid Commission to make its own Medicaid determination for aged, blind and disabled individuals.

E. CURRENT STRUCTURE

Senate Bill 3050 entitled the "Mississippi Administrative Reorganization Act of 1984" transferred the powers and responsibilities of the Mississippi Medicaid Commission to the Division of Medicaid in the Office of the Governor. Thus, the Division of Medicaid is currently the single State agency designated to administer the Medicaid Program.

A. DIVISION OF MEDICAID

The duties of the Medicaid agency were set out by enabling legislation and include:

-- To set regulations and standards for the administration of the Medicaid program

-- to receive and expend funds for the program

-- to submit a State Plan for Medicaid in accordance with Federal regulations

-- to make the necessary reports to the State and Federal governments

-- to define and determine the scope, duration, and amount of Medicaid coverage

-- to cooperate and contract with other state agencies for the purpose of conducting the Medicaid program

-- to bring suit in its own name

-- to recover payments incorrectly made to or by recipients or providers

-- to investigate alleged or suspected violations or abuses of the Medicaid program

-- to establish and provide methods of administration for the operation of the Medicaid program

-- to contract with the Federal government to provide Medicaid to certain refugees

-- to determine eligibility for Medicaid for categorically needy aged, blind, and disabled coverage groups

-- to provide Medicaid Quality Control for AFDC-related Medicaid only recipients and SSI-related aged, blind and disabled recipients

B. DEPARTMENT OF HUMAN SERVICES (DHS)

The duties of the staff of DHS(formerly Department of Public Welfare/DPW) with regard to Medicaid include:

-- to provide the opportunity for persons to apply for Medicaid benefits through all AFDC-related Medicaid programs for families and children, including refugee programs.

-- to determine eligibility of AFDC-related Medicaid applicants and certify them as eligible, to notify them of ineligibility, to determine retroactive eligibility when appropriate.

-- to redetermine AFDC-related Medicaid assistance eligibility at the required intervals.

-- to provide the opportunity for filing appeals and to conduct the hearings.

-- to furnish information to the Division of Medicaid on persons included in AFDC budgets who are eligible for medical services and for use in the payment of the Buy-in for Part B of the Medicare program.

-- to identify cases of improper payment made to AFDC recipients and report these to the Division of Medicaid.

-- to provide information and referral services on Early and Periodic Screening, Diagnosis and Treatment.

-- to provide Medicaid Quality Control for AFDC-cash assistance recipients.

-- to provide information on family planning services.

-- to identify and report third party resources for AFDC recipients.

-- to provide referral for Social Services.

GENERAL PROVISIONS
COVERAGE GROUPS

A. INTRODUCTION

Title XIX of the Social Security Act provides authority for states to establish Medicaid programs to provide medical assistance to needy individuals. Section 1902(a)(10) of the Act describes the group of individuals to whom medical assistance may be provided under two broad classifications: The categorically needy and the medically needy.

1. Categorically Needy

This group consists of:

a. mandatory categorically needy - Includes needy individuals who are receiving, or are deemed to be receiving, cash payments under cash assistance programs (AFDC, SSI, title IV-E). Generally, states must cover all mandatory groups.

b. optional categorical needy - Includes needy individuals who share financial and categorical (age, blindness, disability, for example) requirements with cash assistance recipients but states may cover these groups at their option.

2. Medically Needy

Includes individuals who meet the nonfinancial eligibility requirements of the cash assistance programs but who have income/resources that exceed allowable levels. Individuals with excess income may become Medicaid eligible if they incur medical expenses equal to the amount by which their income exceeds a medically needy level. This process is called "spending down."

Coverage of this group is also at states' option. Mississippi does not cover this optional classification of eligibles.

B. MANDATORY COVERAGE OF FAMILIES AND CHILDREN

The following groups of eligibles are handled by the State Department of Human Services (DHS). Applications are filed at the county offices of DHS.

These are coverage groups that Mississippi is required to cover under federal law and are referred to as Mandatory Categorically Needy coverage groups:

1. Pre-reform AFDC Eligibles (42 CFR 435.110, Sec. 1931 and 1902(a)(10)(A)(i)(I) of the Act

The Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193) eliminated the AFDC Program and replaced it with a block grant program for Temporary Assistance for Needy Families (TANF). Mississippi implemented the TANF Program effective October 1, 1996.

The PRWOA of 1996 (welfare reform law) established a new Medicaid eligibility group for low income families with children which is referred to as the Pre-reform AFDC category of eligibles or Section 1931 eligibles as this is the newly created section of the Social Security Act describing pre-reform AFDC eligibility.

Since the TANF Program requirements mirrors the pre-reform AFDC requirements in Mississippi, TANF recipients receive Medicaid with no separate application required. Individuals who do not receive TANF cash assistance but who are eligible using pre-reform AFDC criteria are eligible for Medicaid-only.

All references to AFDC or title IV-A are references to AFDC under the AFDC State Plan in effect on July 16, 1996.

Individuals deemed to be receiving AFDC:

a. an assistance unit is deemed to be Medicaid eligible for four (4) calendar months because of increased child support that terminates the pre-reform AFDC eligibility (42 CFR 435.115).

b. families terminated from pre-reform AFDC due to increased earnings receive up to 12 months of extended Medicaid effective 04-01-90 (P.L. 100-485, Family Support Act of 1988, Section 1925 of the Act).

c. individuals who are ineligible for pre-reform AFDC because of requirements that do not apply under title XIX of the Act (42 CFR 435.113).

2. **COL Eligibles (42 CFR 435.114)**

Individuals who would be eligible for AFDC except for the increase in Social Security benefits effective July 1, 2972.

3. **Qualified Pregnant Women and Children (42 CFR 435.116)**

a. a pregnant woman who would be eligible for AFDC if the child were born and living with her; or

b. a pregnant woman in an intact family (or pregnant female eligible as a minor child in an intact family) who meets the income and resource requirements of the AFDC program; or

c. a child under age 8 who meets the income and resource requirements of the AFDC program

4. **Newborn Children (42 CFR 435.117)**

Effective 07-01-85, newborn children born on or after 10-01-84 are covered by Medicaid if the mother is eligible for and receiving Medicaid when the child is eligible for and receiving Medicaid when the child is born. Effective 01-01-91, the child is eligible from birth and remains eligible for one (1) year as long as the mother remains eligible or would remain eligible if pregnant and the child remains in the same household as the mother. (P.L. 101-508, OBRA 1990).

5. **Postpartum Eligibility Mothers (42 CFR 435.170)**

A woman who, while pregnant, is eligible for and applies and qualifies for Medicaid continues to be eligible for all pregnancy related and postpartum medical assistance for sixty (60) days after the pregnancy ends.

6.	**IV-E Adoption Assistance (42 CFR 435.145)**	Children under age 18 for whom an adoption assistance agreement under Title IV-E is in effect and children who receive Title IV-E foster care maintenance payments. Effective 07/01/01, continuous Medicaid coverage is granted to foster care adolescents from age 18 to 21 who leave DHS foster care.
7.	**Expanded Medicaid-133% FPL (P.L. 100-360, OBRA 1989)**	Effective 07/01/90, pregnant women and children under age 6 whose income does not meet or exceed 133% of the federal poverty level.
8.	**Poverty Level Medicaid (P.L. 101-508, OBRA 1990)**	Effective 07/01/91, pregnant women and children born after 09/30/83 whose age does not exceed 19 years are covered if family income does not exceed 100% of the federal poverty level.

C. **OPTIONAL COVERAGE OF FAMILIES AND CHILDREN**

These are coverage groups that Mississippi has chosen, at option, to cover for families and children. They are referred to as Optional Categorically Needy:

1. **Ribicoff Children (42 CFR 435.222)**

Children under 18 and born before 09/30/83 who meet the income and resource requirements of AFDC, but do not qualify as dependent children. (Children born after 9/30/83 are mandatory eligibles.)

2. **CWS Foster Care Children (42 CFR 435.227)**

Foster children under age 21 in custody of DHS and children receiving State subsidized adoption payments.

Effective 07/01/01, continuous Medicaid coverage is granted to foster care children.

3. **185% FPL (P.L. 100-203, OBRA 1987)**

Effective 10/01/88, pregnant women and children up to age 1 are covered provided income does not exceed 185% of the federal poverty level.

4. **Children's Health Insurance Program (CHIP) (P.L. 105-33, BBA of 1997)**

The Balanced Budget Act of 1997 amended the Social Security Act to add a new Title XXI, State Children's Health Insurance Program, for the purpose of expanding child health assistance to uninsured, low income children. In Mississippi, the first or transitional phase of CHIP will extend Medicaid coverage to all children under age 19 whose family income does not exceed 100% of the federal poverty limit effective 07/01/98. This will accelerate the phase in of children ages 15-19. (Children born after 09/30/83 whose family income does not exceed the poverty level are mandatory eligibles.)

Effective 01/01/00, uninsured children whose family income does not exceed 200% of the federal poverty limit can qualify for separate health insurance coverage through the Childrens Health Insurance Program (CHIP). Coverage is effective either the month following application or the following month, depending on the date of disposition of the application.

D. MANDATORY COVERAGE OF THE AGED, BLIND AND DISABLED

The following groups of the aged, blind and disabled are handled by the Social Security Administration through the Supplemental Security Income (SSI) Program.

1. Individuals Receiving SSI (42 CFR 435.120)

A person is considered to be receiving an SSI payment even if:

a. SSI payments are withheld solely to recover an overpayment or assess a penalty.

b. SSI payments are received under the terms of an agreement to dispose of excess resources.

c. an individual is receiving an emergency advance payment based on presumptive eligibility.

d. an individual is receiving SSI based on presumptive disability.

e. an individual receives payment as a disabled individual under Section 1619(a).

f. disabled or blind individuals who are not eligible for SSI cash payments are considered SSI recipients under Section 1619(b) to receive Medicaid.

g. an individual continues to receive SSI payments while an adverse decision is under appeal.

2. Individuals Receiving Mandatory State Supplement Payments (42 CFR 435.130)

In order to protect aged, blind and disabled cash assistance recipients who were converted to SSI beneficiaries as of 01/74 from suffering a loss of income under income under the SSI Program, Congress passed P.L. 93-66 in 07/73 requiring all States to furnish supplementary payments to certain recipients The purpose of the mandatory payment is to ensure that no individual or couple who received, or was eligible to receive, assistance in one of the adult categories in 12/73 will have lower income under SSI in 01/74 and in subsequent months.

This payment is certified by the State DHS and is paid by the SSA. The payment amount is reflected on the SDX provided by SSA and is shown as the "State Amount."

E. MANDATORY COVERAGE OF THE AGED, BLIND AND DISABLED AS MAO

The following groups of eligibles are handled by the Division of Medicaid, Office of the Governor, as Medical Assistance Only (MAO) cases. Applications are filed at the Medicaid Regional Office which serves the county where the individual and/or medical facility is located.

These are coverage groups that Mississippi is required to cover under federal law and are referred to as Mandatory Categorically Needy coverage groups:

1. **Grand-fathered Eligibles (42 CFR 435.132)**

Institutionalized individuals who were eligible in December 1973 provided they remain institutionalized and remain eligible under December 1973 financial criteria.

2. **HR-1 Eligibles (42 CFR 435.134)**

Individuals who would be eligible for SSI except for the increase in Social Security in July 1972.

3. **COL Eligibles (42 CFR 435.135)**

Current recipients of Title II (Social Security) benefits who after April 1977 were entitled to and received both Title II and received benefits and who lost SSI eligibility, but who would still be eligible for SSI if the Title II cost-of-living increase(s) received by the individual and his/her financially responsible spouse since the individual was last eligible for and achieved SSI and Title II concurrently, were deducted from countable income.

4. **COBRA Widow(er)s (42 CFR 435.137)**

Disabled widow/widowers who lost SSI benefits due to changes in the computation of their 1983 Social Security disability benefits.

5. **DAC Eligibles (P.L.99-643 Employment Opportunities for Disabled Americans Act)**

Disabled adult children who become ineligible for SSI after July 1, 1987 because of entitlement to, or an increase in, Title II disabled adult child (DAC) benefits.

6.	**OBRA-87 Widow(er)s (42 CFR 435.138)**	Effective 07-01-88, individuals age 60-65 who are eligible for Social Security Widow(er) Insurance benefits, who have not become eligible for Medicare, and who are ineligible for SSI benefits because of the receipt of Social Security benefits.
7.	**OBRA-90 Widow(er)s (P.L. 101-508 OBRA 1990)**	Effective 01-01-91, individuals who lose SSI because of receipt of Social Security benefits resulting from the change in definition of disability for widow(er)s provided they are not entitled to Medicare, Part A.
8.	**QMB's (P.L. 100-360 Medicare Catastrophic Coverage Act of 1988)**	Effective 07-01-89, Qualified Medicare Beneficiaries (QMB's) who are entitled to Medicare, Part A, and have income that does not exceed the federal poverty level, and whose resources do not exceed twice the SSI resource limits. QMB's are eligible for Medicare cost-sharing expenses only unless the individual also qualifies for coverage under another Medicaid eligibility group.
9.	**QWDI'S (P.L. 101-239 OBRA 1989)**	Effective 07-01-90, Qualified Working Disabled individuals are eligible for payment of Medicare Part A premiums only provided income does not exceed 200% of the federal poverty level, resources do not exceed twice the SSI resource limits and disability insurance benefits under Title II ended due to earnings.
10.	**SLMB's**	Effective 01-01-93, Specified Low-Income Medicare
	(P.L. 101-508	Beneficiaries (SLMB's), are eligible for payment of Medicare
	OBRA 1990)	Part B premiums only provided income does not exceed 110% of the federal poverty level, resources do not exceed twice the SSI resource limits and the individual is eligible for Medicare Part A. Effective 01-01-95, the income limit increased to 120% of the poverty level.

11.	**Qualifying Individuals (P.L. 105-33 Balanced Budget Act of 1997)**	Effective 01-01-98, Qualifying Individuals with income above 120% of the Federal Poverty Level (FPL) but less than 135% of the FPL are known as QI-1's. Medicaid benefits are limited to full payment of Medicare Part B premiums. QI-2's are Qualifying Individuals with income of at least 135% of the FPL but not exceeding 175% of the FPL. Medicaid benefits are limited to partial payment of Medicare Part B premiums. Both QI-1 and QI-2 Medicaid benefits are paid from 100% federally capped allocated amounts resulting in benefits available on a first come, first serve basis.

F. OPTIONAL COVERAGE OF THE AGED, BLIND AND DISABLED

These are coverage groups that Mississippi has chosen, at option, to cover for the aged, blind and disabled. They are referred to as Optional Categorically Needy:

1. **Long Term Eligible for SSI at Home (42 CFR 435.211)**

   Individuals who would be eligible for SSI their institutional status.

2. **Long Term Care-Eligible Under 300% Cap (42 CFR 435.236)**

   Individuals in institutions who are eligible under a special income level who remain institutionalized for thirty (30) consecutive days or longer.

3. **Disabled Children Living At-Home (42 CFR 435.225)**

   Effective 07/01/89, Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid Medicaid if in a medical institution and who are receiving medical care at home that would be provided in a medical institution.

4. **PLAD Eligibles (P.L. 99-509, SOBRA 1986)**

   Effective 07/01/89, Poverty Level Aged and Disabled individuals whose income does not exceed the federal poverty level and whose resources do not exceed the SSI resource limit.

5. **Hospice Eligibles (P.L. 99-272 COBRA 1985)**

   Effective 04/01/93, individuals who have elected to receive hospice care benefits and who are eligible using the same criteria and special income limit as those in institutions.

6.	**HCBS Waiver for the Physically Handicapped (Section 1915(c) of Social Security Act)**	Effective 07/01/93, individuals who meet the qualifications for participation in the Home & Community Based Services Waiver for the Physically Handicapped. Eligibility is determined using the same criteria and special income limit as those in institutions.
7.	**Working Disabled (WD) Eligibles (PL-105-32 BBA-1997)**	Effective 07/01/99, disabled individuals who would be eligible for SSI except for their earned income are eligible for Medicaid if earned income does not exceed 250% of the poverty level. Certain individuals are subject to a premium if earned income is between 150%-250% of the poverty level.
8.	**Breast and Cervical Cancer Eligibles (P.L. 106-354 BCCPTA of 2000)**	Effective 07/01/01, women under the age of 65 who have no other creditable health insurance and have been screened for breast and cervical cancer by the Centers for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program. Income must be under 250% of the federal poverty level.

G. OPTIONAL COVERAGE OF HOME & COMMUNITY BASED SERVICES (HCBS) WAIVER PROGRAM

Section 1915(c) of the Social Security Act permits States to offer, under a waiver of statutory requirements, an array of home and community based services that an individual needs to avoid institutionalization. The following outlines the different HCBS Waiver Programs currently available under Mississippi's Medicaid Program and the coverage groups eligible for participation in each program.

1. HCBS for the Elderly & Disabled

Through Medicaid, the Elderly & Disabled Waiver provides services to individuals who, but for the provision of services would require the level of care provided in a nursing facility. Beneficiaries of this waiver initially had to qualify for Medicaid as Supplemental Security Income (SSI) beneficiaries or meet the income and resource eligibility requirements for Poverty Level Aged and Disabled (PLAD) program. The PLAD coverage group was added to the HCBS Waiver effective July 1, 1999, and discontinued effective 12/31/05. Effective July 1, 2000, beneficiaries of this waiver can have income up to 300% of the SSI Federal Benefit Rate, which is the institutional income limit. Individuals who apply to participate in this waiver must also have deficits in at least three of their activities of daily living.

The waiver services currently available in addition to all regular Medicaid services are:

- case management
- adult day care
- home delivered meals
- institutional respite
- in-home respite care
- homemaker services
- escorted transportation
- extended home health visits

Referrals for the program can be made through the Community Long Term Care Division of DOM or the waiver case managers located at each Area Agency on Aging.

2. **HCBS Waiver for the Physically Handicapped (Independent Living Waiver**

This waiver program is commonly referred to as the Independent Living Waiver. This waiver was created to assist severely orthopedically and neurologically impaired individuals live independently through the services of a personal care attendant. Beneficiaries of this waiver must be able to communicate effectively with the care giver and service provider. There is no age restriction for participation. Participants in this waiver are limited to:

- SSI recipients
- Individuals determined eligible by Medicaid Regional Offices for the Independent Living Waiver that have income up to 300% of the SSI Federal Benefit Rate.

The waiver services currently available in addition to the regular Medicaid services are:

- personal care attendant services
- case management

Referrals for this statewide program may be made through the Community Long Term Care Division of DOM or through the Department of Rehabilitation Services.

3. **HCBS Waiver for the Mentally Retarded/ Developmentally Disabled (MR/DD Waiver)**

The MR/DD Waiver provides services to individuals who, but for the provision of such services, would require the level of care found in an ICF-MR (Intermediate Care Facility for the Mentally Retarded).

Participants in this waiver are limited to those covered under Medicaid as:

- SSI recipients
- Disabled Child Living At Home recipients
- PLAD - Effective 07/01/99
- Effective 07/01/00, beneficiaries of this waiver can have income up to 300% of the SSI Federal Benefit Rate, which is the institutional income limit.

The waiver services currently available in addition to the regular Medicaid services are:

- in-home respite care
- community respite care
- ICF-MR respite care
- residential habilitation
- attendant care aide
- day habilitation
- pre-vocational services
- supported employment
- physical therapy
- occupational therapy
- speech, language & hearing services
- behavioral support & intervention
- specialized medical supplies

Referrals for this statewide program may be made through the Community Long Term Care Division of DOM, the Bureau of Mental Retardation with the Department of Mental Health or the waiver case managers located at each of the Regional ICF-MR's operated by the Department of Mental Health.

4. **Assisted Living Waiver**

Effective 10/01/00, the Assisted Living provides services to individuals who, but for the provision of home and community-based services, would require replacement in a nursing facility. Assisted living services can be provided in licensed personal care homes, community residential care facilities, or in a congregate housing services program that are approved Medicaid providers.

GENERAL PROVISIONS
COVERAGE GROUPS

Participants in this waiver are limited to:

- Individuals 21 years of age or older

- Individuals that must require assistance with at least three activities of daily living, or

- Individuals that have a diagnosis of Alzheimer=s Disease or another type of dementia and require assistance with two or more activities of daily living.

- Beneficiaries of the waiver can have income up to 300% of the SSI Federal Benefit Rate, which is the institutional income limit.

In addition to the regular Medicaid services, the following services are available to eligible beneficiaries.

- case management
- personal care
- homemaker services
- chore services
- attendant care
- medication oversight
- medication administration
- therapeutic social and recreational programming
- intermittent skilled nursing services
- transportation
- attendant call system

This waiver is limited to the following seven counties:

Bolivar	Hinds	Sunflower
Forrest	Lee	
Harrison	Newton	

Referrals for this program may be made through the Community Long Term Care Division of DOM.

5. **Traumatic Brain Injury and Spinal Cord Injury (TBI/SCI)**

This waiver program was created to assist individuals who have a traumatic brain or spinal cord injury, who but for the provisions of this service, would require the level of care provided in a nursing facility.

Effective July 1, 2001, individuals must meet the following criteria:

- Have a diagnosis of a traumatic brain injury or spinal cord injury
- Must be medically stable
- Cannot have an active life threatening condition that would require systematic therapeutic measures, IV drip to control or support blood pressure, intercranial pressure or arterial monitoring

Services offered through the TBI/SCI Waiver include:

- Case management
- In-Home Nursing Respite
- In-Home Companion Respite
- Institutional Respite
- Attendant Care Services
- Environment Accessibility Adaptations
- Specialized Medical Equipment and Supplies

Participants in this waiver age limited to those covered under Medicaid as:

- Low Income Families with Children
- SSI recipients
- Children under age 19
- Foster Care Children
- Disabled Children Living at Home
- 300% FBR income (nursing home limit)

Referrals for this program may be made through the Mississippi Department of Rehabilitation Services.

GENERAL PROVISIONS
MEDICAID SERVICES

A. COVERED SERVICES AND CO-PAYMENTS

The State Medicaid Agency provides the following services to Medicaid recipients on a fiscal year basis (July 1 - June 30). Cost-sharing payments, or co-payments, are specified where applicable. In order to receive the covered benefits described below, an individual must be eligible for full Medicaid coverage. These covered benefits do not apply to individuals eligible for Medicare cost-sharing services only or to individuals eligible in the Healthier Mississippi Waiver or Family Planning Waiver.

1. **Inpatient Hospital Care**

Up to 30 days of hospital care may be covered annually. Children can get more with a plan of care.

There is a $10.00 co-payment per day.

2. **Emergency Room Visits**

Up to 6 visits are covered. Children can get more with a plan of care.

There is a $3.00 co-payment per visit unless the visit is a true emergency.

3. **Nursing Home Care**

Nursing facility care, intermediate care facility services for the Mentally Retarded and psychiatric residential treatment facility care for children under age 21 is provided under Medicaid. Individuals contribute toward the cost of their care based on their monthly income.

4. **Physician Visits**

Up to 12 visits are covered at a doctor's office or rural health clinic (pre-natal visits do not count against the 12 visit limit). Thirty-six visits are covered for nursing home recipients.

There is a $3.00 co-payment per visit.

5.	**Prescription Drugs**	Up to five (5) prescriptions per month are covered. No more than two (2) of the five may be name brand including refills. Children under 21 may get more with a plan of care. Individuals with Medicare receive their pharmacy benefit through Medicare, Part D. There is a $3.00 co-payment per prescription.
6.	**Laboratory Services**	Lab services are covered when ordered by a doctor and performed by an approved independent laboratory.
7.	**Transportation Services**	Transportation services as medically needed are provided for the recipient's health care, such as ambulance service. There is a $3.00 co-payment per trip. Prior to 05/01/02, the co-payment was $2.00.
8.	**Emergency Dental Extractions**	Emergency Dental Extractions are covered, and if medically necessary, treatment for acute dental conditions (fillings, crowns, bridges and dentures are <u>not</u> covered). There is a $3.00 co-payment per visit.
9.	**Home Health Visits**	Up to 25 visits are covered when ordered by a doctor plus certain medically necessary durable equipment and supplies when furnished by the Home Health Agency or Durable Medical Equipment supplier. There is a $3.00 co-payment per visit.
10.	**Eyeglasses**	One pair of eyeglasses is covered every five (5) years. There is a $3.00 co-payment.
11.	**Hospice**	Hospice services are available for full service Medicaid beneficiaries.

12.	**Child Health Services**	All children and youth under age 21 who are eligible for full Medicaid are eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services. These services include a comprehensive physical and referrals to a doctor for any health problems.
13.	**Limited Coverage for Women Eligible Solely Due to Pregnancy**	Effective September 1, 2002, the Division of Medicaid will not provide eyeglass or dental coverage to women eligible for Medicaid solely because they are pregnant.

B. EXCEPTIONS TO PAYMENTS

The following Medicaid recipients do not pay co-payments:

- Children under 18
- Pregnant women
- Patients in nursing homes
- Patients under family planning

GENERAL PROVISIONS
REGULATIONS SAFEGUARDING CONFIDENTIAL INFORMATION

A. LEGAL BASE & PURPOSE

Title XIX, Section 1902(a)(7), of the Federal Social Security Act requires that the Mississippi Medicaid Agency's State Plan provide safeguards which restrict the use or disclosure of information concerning applicants or recipients of Medicaid to purposes directly connected with the administration of the Plan (Medicaid). The Federal Regulations, 42 CFR 431.300, specifies the State Plan requirements, the types of information to be safeguarded, the conditions for release of safeguarded information, and the restriction on the distribution of other information.

Section 43-13-121(3) of the Mississippi Code of 1972 authorized and empowered the Agency to provide safeguards for preserving the confidentiality of records.

B. ADMINISTRATION OF THE PROGRAM - DEFINITION

For purposes of complying with the Federal and State laws and program regulations, "administration of the program" encompasses those administrative activities and responsibilities which the Agency is required to engage in to ensure effective program operation. Such activities include determining eligibility and methods of reimbursement, processing claims, conducting fair hearings, arranging for inter-agency agreements, ensuring the availability of transportation, conducting outreach, screening, and other similar activities.

Additionally, administration of the Program includes conducting or assisting in investigation, prosecution, or civil or criminal proceedings deemed to be related to the administration of the Plan.

Also, identifying potential third party liability and seeking recourse against legally liable third parties constitute purposes directly related to the administration of the State Plan.

GENERAL PROVISIONS
REGULATIONS SAFEGUARDING CONFIDENTIAL INFORMATION

C. TYPES OF INFORMATION TO BE SAFEGUARDED

The information which shall be considered confidential about applicants and recipients which shall be safeguarded except in the administration of the State Plan shall include:

1. Names and addresses;

2. Medical services provided;

3. Social and economic conditions or circumstances;

4. Agency evaluation of personal information;

5. Medicaid data, including diagnosis and past history of disease or disability.

6. Any information received for verifying income eligibility and amount of medical assistance payments. Income information received from SSA or the Internal Revenue Service must be safeguarded according to the requirements of the agency that furnished the data.

7. Any information received regarding the identification of legally liable third party resources.

D. RELEASE OF INFORMATION

The Medicaid Agency has established criteria specifying the the conditions for release and use of information about applicants and recipients as follows:

1. Information concerning applicants or recipients is subject to disclosure to agencies authorized under Titles IV-A, IV-B, IV-C, IV-D, XX, XVI and other agencies which are Federal or Federally assisted programs which provide assistance, in cash or in-kind, or services, directly to individuals on the basis of need pursuant to appropriately executed data exchange agreements. Access to such information is restricted to those persons or agency representatives who are subject to standards of confidentiality that are comparable to those as set by the Agency.

2. The applicant or recipient or his authorized representative shall have access to certain information in the applicant's or recipient's case record as set out herein below.

3. Information with regard to absent and putative parents in a medical support case may be subject to disclosure for purposes directly connected with obtaining or enforcing medical support.

4. Information necessary in identifying third party liability and for securing recourse against a legally liable third party whether through settlement efforts with the recipient's attorney, insurance carrier, or the legally liable third party may be made available to the recipient, the recipient's attorney, the recipient's insurance carrier, or to providers of services for the recipient. Any other release for TPL purposes should be cleared through the Legal Unit.

5. Information shall be provided to county and district attorneys or the U. S. prosecuting attorney or the Medicaid Fraud Control Unit of the Attorney General's Office in conducting or assisting in an investigation, prosecution, or civil or criminal proceedings relating to abuse, suspected fraud, or the fraudulent receipt of Medicaid, and in connection with the location of non-supporting parents, the establishment of paternity, and the obtaining of medical support.

6. Information provided to an outside source in matters not relating to the administration of the State Plan, upon the execution of written consent for the release of such information. If, because of an emergency situation, time does not permit obtaining written consent before release, the Agency will notify the family or individual immediately after supplying the information.

E. OTHER INFORMATION TO BE DISCLOSED

The Medicaid Agency is required under Federal and State requirements to publish regularly statistical data about the Medicaid Program. State and Regional staff are authorized to release and to interpret the following information:

1. The number of recipients, the total amount paid for Medicaid services, the total number of applications, the total number of applicants approved, the total number of applications denied, and similar data, compiled monthly, quarterly, or annually.

2. Services available from the Medicaid Agency and the conditions under which the services can be reimbursed, medical support activities and information concerning the collection and distribution of records summarized.

F. DISCLOSURE TO ASSISTANCE AGENCIES

Agencies which have standards of confidentiality comparable to those of Medicaid and which provide assistance or services applicants and recipients, and with whom information is exchanged for the purpose of the administration of the Medicaid Program are:

1. Department of Human Services

2. The Medicaid Agency's fiscal agent

3. Division of Vocational Rehabilitation, State Department of Education

4. The Social Security Administration and its District Offices

5. The Mississippi State Department of Health and their County Health Offices (only if they are a provider of medical services for which the information is requested).

6. State Department of Mental Health and the Regional Mental Health Centers (only if they are a provider of medical services for which the information is requested).

7. State Mental Hospitals and general hospitals, the Social Service Department and the reimbursement offices for providers (only as to services each provider rendered to a specific Medicaid recipient).

8. Veterans Administration (only if they are a provider of services and then only for those recipients for whom they provided the service or to confirm benefits).

Generally, the list of names of applicants or recipients shall not be released to these or other agencies, except as specified, but the release of information shall be on request from the agency and the purpose must reasonably relate to the function of the Agency's programs and to the function of the agency requesting the information. When an agency makes a request for information which that agency normally would be ascertaining for itself and which is not in behalf of applicant or recipient, the request will be denied.

G. PUBLIC AGENCIES WITH WHOM LISTS ARE EXCHANGED

Formal arrangements have been made for the Agency to supply a printed list of names and addresses or specific information to other public agencies as follows:

1. To the State Department of Human Services and its county offices, to the Disability Determination Services, and to the Vocational Rehabilitation Division of the State Department of Education.

2. Data information exchanged between the Agency, its fiscal agent, State Department of Human Services, the Social Security Administration, including, without limitation through the inclusion, new case cycle data for AFDC, monthly AFDC case data, quarterly reconciliation information, enumeration data, Buy-In data, Bendex data, and SDX data.

H. DISCLOSURE TO APPLICANT, RECIPIENT OR REPRESENTATIVE

An applicant's or recipient's case record is available for examination by the applicant or recipient or his duly authorized representative in the following situations:

1. In connection with a request for a hearing as otherwise provided in the regulations relating to administrative hearings. Refer to Section J, Hearings, "Rights of the Claimant".

2. Information as to the receipt of amounts of Medicaid received by a recipient when requested by a person filing a Federal or State income tax return and when authorized, in writing, by the recipient. Release of information to the Internal Revenue Service shall be granted only upon a signed authorization of the recipient.

3. Information supplied by the applicant or recipient or obtained by the worker that the applicant or recipient needs in order to be able to qualify for benefits which he has requested. This includes medical reports, as the examining physician must release this information to his patient. It includes proof of age, documents relating to real and personal property, and other factual material that will assist an applicant or recipient in obtaining a service or a benefit.

4. The applicant's or recipient's statement of income and resources and other forms which the applicant or recipient has signed which are contained in the case record.

5. Budgets worked to determine eligibility for programs for which the department is responsible.

6. Any case information when the applicant or recipient presents a written request which specifies the material desired and the purpose for which the material will be used.

When the request is made by a person other than the applicant or recipient, the information will not be made available without the applicant's or recipient's written permission prior to releasing the information. The written statement will be made a permanent part of the case record. The Regional Office will advance the information from the case record or provide copies of the material requested.

I. DISCLOSURE TO PROSECUTING ATTORNEYS

The county or district prosecuting attorneys or the U. S. prosecuting attorneys shall have access to information from the case records for the following purposes:

1. Making an audit or investigation of an alleged violation of the provisions contained in the State or Federal statutes or regulations touching on abuse, fraud, or suspected fraud in the receipt of Medicaid.

2. The locating of deserting or putative parents, establishing paternity, and securing medical support.

When acting in the official capacity in behalf of the Agency, the county and district attorneys or the U. S. prosecuting attorneys are authorized to review without written request, case record material in the case record of the individual involved and other material relating to the individual's case, such as medical assistance records, computer printouts, medical support, fiscal and bookkeeping records.

Before releasing any case record information to a county, district or U. S. prosecuting attorney, contact the Legal Unit of the Division of Medicaid for official clearance in releasing case record material.

J. COURT SUBPOENAS

Any and all court subpoenas for a case record or for any agency representative to testify concerning an applicant or recipient must be issued in the name of the Executive Director of the Division of Medicaid and routed to the Director's office immediately upon receipt. The Regional Office will be notified of appropriate action to take.

K. PERSONS AUTHORIZED TO DISCLOSE INFORMATION

Disclosure of all information, including records of every kind, should be governed by these regulations:

The release of information upon request, unless previously authorized by the Mississippi Medicaid Agency, can be authorized by:

1. The Director of the Mississippi Medicaid Agency or the Deputy Director in his absence the Director's absence.

2. The Regional Office Supervisor, if the information is contained in the Regional Office records.

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STATE RELATIONSHIP WITH SSI AND MEDICARE
SSI ELIGIBILITY

A. BACKGROUND

Effective January 1, 1974, the SSI Program, the new Title XVI, replaced Titles I, X, XIV, and XVI in all states. Receipt of SSI did not give automatic Medicaid eligibility and the Social Security Administration (SSA) was allotted no general responsibilities for the administration of the Medicaid Programs. However, to simplify administration and avoid duplicate eligibility procedures, Section 1634 of the Social Security Act provides that the Secretary of Health and Human Services may enter into an agreement, upon a State's request, under which SSA determines Medicaid eligibility for aged, blind and disabled individuals on behalf of a State.

The 1634 Agreement signed between SSA and the Mississippi Medicaid Agency was effective July 1, 1981. Under this agreement, the SSI application is also an application for Medicaid. Eligibility for Medicaid begins with the first day of the month in which eligibility for SSI begins and continues for the same period of time in which the individual remains eligible for SSI payments.

B. SSI DETERMINATIONS OF MEDICAID ELIGIBILITY

An SSI eligible is also eligible for Medicaid if the individual:

- Assigns rights to medical support and payments for medical care from any third party payor; and
- Provides third party liability (TPL) information; and
- Receives an SSI payment or is considered to be receiving an SSI payment for Medicaid purposes. Refer to Section A, "Individuals Receiving SSI," for the definition of "receiving an SSI payment."

C. SDX Medicaid NOTIFICATION

Notification of SSI eligibility or ineligibility is transmitted to electronically through the State Data Exchange (SDX). The SDX transmits to the State assignment of rights information as well as accretions, deletions and changes in the Supplemental Security Record (SSR).

STATE RELATIONSHIP WITH SSI AND MEDICARE
SSI ELIGIBILITY

D. STATE NOTIFICATION PROCEDURES

SDX transmissions are submitted to Medicaid's fiscal agent who issues computer-generated notices in the following instances:

1. SSI Approvals

A "Notice of Approval and Retroactive Medicaid" is issued indicating the beginning date of Medicaid eligibility for SSI purposes and advises the client of the availability of retroactive Medicaid. A copy of this notice is shown on Page 2020.

A "Notice of Approval of Retroactive SSI-Related Medicaid" is issued whenever SDX transmits a "closed" period of SSI eligibility. This means the client is not currently SSI eligible but was eligible for one or more prior months. This notice indicates the beginning and ending date of SSI-related Medicaid eligibility and explains retroactive Medicaid coverage as well as coverage groups available for possible current Medicaid eligibility. A copy of this notice is shown on Page 2025.

2. SSI Denial

A "Notice of Denial and Retroactive Medicaid" is issued that explains possible Medicaid-only coverage groups and the availability of retroactive Medicaid. A copy of this notice is shown on Page 2030.

3. SSI Terminations

There are two separate SSI Notices of Termination for all SSI terminations due to factors other than excess income or resources, the "Notice of Termination of Medicaid" designated as RS-0-27-4 is issued. This notice explains possible Medicaid-only coverage groups and the availability of retroactive Medicaid and is issued with no attachment. A copy of this notice is shown on Page 2040.

The "Notice of SSI Termination of Medicaid" designated as RS-0-27-8 (shown on Page 2050) is issued to all SSI individuals terminated from SSI due to excess income or resources. An SSI Redetermination Form (DOM-300B) is attached to this notice with instructions for the client to complete and return to the appropriate Regional Office within 10 days in order to determine continuing Medicaid eligibility.

STATE RELATIONSHIP WITH SSI AND MEDICARE
SSI ELIGIBILITY

4.	**Medicaid Denial for Failure to Assign Rights**	A "Notice of Denial of Medicaid" is issued that explains mandatory assignment of TPL and the individual's right to an appeal. A copy of this notice is shown on Page 2060.
5.	**Medicaid Termination for Failure to Assign Rights.**	A "Notice of Termination of Medicaid" is issued that explains failure to cooperate in assigning TPL and the individual's right to an appeal. A copy of this is shown on Page 2070.
6.	**SSI Request for Medicaid Information**	SSI-eligibles who are the beneficiary of a trust, as determined by SSI, are issued this notice. SSI/Medicaid eligibility will be discontinued until the State reviews the trust. A copy of this notice is shown on Page 2080. Policy is discussed in "Special Handling of SSI Cases".

STATE RELATIONSHIP WITH SSI AND MEDICARE
SSI ELIGIBILITY

E. RETROACTIVE MEDICAID FOR SSI APPLICANT COVERAGE OF INTERIM MONTH(S) BETWEEN THE DATE OF SSI APPLICATION & SSI PAYMENT

Medicaid eligibility for SSI applicants is possible as of the first day of the third month preceding the month an application for SSI is filed. A separate application is required for retroactive benefits and is filed with the Medicaid Regional Office that serves the county in which the SSI applicant lives. Retroactive benefits are possible regardless of whether the SSI application is approved or denied. There is no time limit established for applying for the retroactive SSI period.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) requires that SSI payments begin as of the first day of the month following the date SSI application is filed, or if later, the date the individual first meets all eligibility factors. If the individual meets the eligibility requirements for any MAO coverage group during the period of time between the date of application for SSI and the month the SSI payment begins, Medicaid coverage must be provided to the individual for this interim period of time. A separate application is required for determining eligibility for this interim period and is filed with the Medicaid Regional Office that serves the county where the SSI individual lives. There is no time limit established for applying for Medicaid for the interim months of missing SSI eligibility. The individual may apply at the time of application for SSI retroactive Medicaid benefits or at any given time.

1. SDX Verification

The month of SSI application must be verified with SSA in order to establish the correct retroactive and interim or "missing" SSI month(s). The SDX verifies the application date for SSI and identifies any month(s) of non-payment for SSI between the month of application for SSI and the month the SSI payment begins. A copy of the SDX or SVES screen from MEDS will document the time period of possible coverage.

Note: The SSI Application month is usually shown as a Payment Status Code of "E02."

DIVISION OF MEDICAID **RB283**

NOTICE OF APPROVAL AND RETROACTIVE MEDICAID

ID#:
SSN:
SSI APPLICATION DATE:
(taken from SDX)

The Division of Medicaid has been informed by the Social Security Administration that you are eligible for Supplemental Security Income (SSI). Individuals who are eligible for SSI are also eligible for Medicaid. Your eligibility for Medicaid begins (date)_____. You will receive a plastic Medicaid card soon. The card is good for each month you are eligible.

If you have medical bills in the three months prior to your application for SSI, **or for the month(s) between your application for SSI and the month your SSI payment began**, notify the regional office shown below and show them this letter to verify receipt of SSI/Medicaid. If you are found eligible for Medicaid during any of these months, some or all of your medical bills may be paid.

Medicaid Regional Office

Telephone Number

Your eligibility for Medicaid will continue as long as you remain eligible for SSI. It is important that you notify your local Social Security Office in _____ (town) of any change in address or circumstances as soon as possible.

2. Medicaid ID Number

The Medicaid ID number assigned for the retroactive determination of a SSI approved applicant will be the same number issued via SDX for ongoing eligibility purposes. The number assigned via SDX may be verified by inquiring into the Recipient Eligibility History File (REHF), viewing the SSI/Medicaid approval notice issued by the fiscal agent or by viewing the Medicaid Card issued to the SSI eligible. If the SSI application is denied, the Regional Office must assign the Medicaid ID number for the retroactive period via MEDS.

3. Incorrect Medicaid Beginning Date

The SSI beginning date of Medicaid eligibility as shown on the "Notice of Approval and Retroactive Medicaid" and/or and/or another source can be adjusted if in error. Verification of the correct beginning SSI/Medicaid eligibility date must be obtained from SSA and referred to the State Office for correction.

4. Budgeting

The budgeting procedure for retroactive applications is explained in Section G.

F. REPORTING CHANGES FOR SSI

SSI recipients must report all changes affecting SSI eligibility to their SSA District or Branch Office. This includes address changes since Medicaid Cards issued to the address shown on the SDX.

When necessary, it is possible for the Medicaid Agency to notify the SSA District Office of changes that will affect SSI eligibility for an SSI recipient. Form DOM-319, Report or Referral to District or Branch Social Security Office, is used for reporting various changes. Refer to the instructions for the form for the appropriate use of DOM-319.

G. REPORTING NON-RECEIPT (OR DUPLICATE) MEDICAID CARDS

Questions or problems regarding non-receipt of a Medicaid card or receipt of duplicate cards should be referred to the Medicaid fiscal agent, communications unit.

The telephone numbers are:

Statewide Toll Free Number: 1-800-884-3222
Jackson (local): (601) 960-9200

DIVISION OF MEDICAID **RB291**

NOTICE OF APPROVAL OF RETROACTIVE SSI-RELATED MEDICAID

ID#:
SSN:
SSI APPLICATION DATE:

The Division of Medicaid has been informed by the Social Security Administration that you were eligible for Supplemental Security Income (SSI) in the past. Individuals who are eligible for SSI are also eligible for Medicaid. Your eligibility for SSI Medicaid begins (date) _____ and ends _____. You will not receive a Medicaid card for this prior period so you will need to show this notice to any providers of medical services, such as doctors or hospitals, if you have medical bills from this period of time. Your Medicaid ID# for this period is shown above.

If you have medical bills in the three months prior to your application for SSI, notify the regional office shown below and show them this letter to verify receipt of medical assistance. If you are found eligible for medical assistance during any of those three months, some or all of your medical bills may be paid.

Medicaid Regional Office

Telephone Number

Although you are no longer eligible for Medicaid as a recipient of SSI, you may continue to be eligible for Medicaid under one of the following groups if you have Medicare or you are disabled. Medicaid disability rules are the same as SSI and Social Security.

1. You have Part A Medicare Hospital Insurance and your income does not exceed $917 for an individual/$1217 for a couple. There is no resource test for this coverage. edicaid will pay Medicare cost-sharing expenses only for this coverage group.

2. You have Part A Medicare your income does not exceed $1220 for an individual/$1625 for a couple. **Medicaid will pay your Medicare Part B premiums only under this coverage group.** There is no resource test for this coverage.

3. You are a disabled child age 18 or under and receiving medical care at home that would be provided in a medical institution.

4. You are in a nursing home or hospital for 31 consecutive days or longer and your total income is below $1911 per month. Your resources must not exceed $4000 for an individual.

5. You were terminated from SSI for one of the following reasons but would still be eligible for SSI if we disregard the income that made you ineligible such as:

   a. a cost-of-living increase in Social Security.
   b. entitlement to or an increase in Social Security disabled adult child benefits after July 1, 1987.
   c. entitlement to Social Security widow(er) benefits for those between age 50-65 who are not eligible for Medicare.

6. You are disabled and working at least 40 hours per month. Your total monthly earned income is less than $4399 for an individual and $5899 for a couple and your total unearned income is less than $1220 for an individual and $1625 for a couple. Resources can not exceed $24,000 for an individual and $26,000 for a couple.

7. You are disabled and not eligible for Medicare. Your income must not exceed $1220 for an individual/$1625 for a couple. Your resources must not exceed $4000 for an individual and $6000 for a couple.

8. You are a pregnant woman.

If you believe that you may be eligible under one of the groups described above, you should contact:

Medicaid Regional Office Telephone Number

within thirty (30) days for a redetermination of eligibility.

DIVISION OF MEDICAID **RB284**

NOTICE OF DENIAL AND RETROACTIVE MEDICAID

ID#:
SSN:
SSI APPLICATION DATE:

I. In Mississippi, individuals who are eligible for Supplemental Security Income (SSI) are automatically eligible for Medicaid. However, the Division of Medicaid has been advised by the Social Security Administration that your application for SSI _____ (Date) has been denied. Therefore, you are not eligible for Medicaid as an SSI recipient.

If you disagree with the decision on your application for SSI and Medicaid, you should immediately contact your local Social Security Office as directed on the Supplemental Security Income notice of disapproved claim which you recently received. Your local Social Security Office is located in _____ (town).

If you have medical bills in one or more of the 3 months before you applied for SSI and you believe you would have been eligible for SSI at the time, you should apply for Medicaid at the Medicaid Regional Office listed at the end of this notice.

Although you are not eligible for Medicaid as a recipient of SSI, you may be eligible for Medicaid under one of the following Medicaid-only groups if you have Medicare or you are disabled. Medicaid disability rules are the same as SSI and Social Security.

1. You have Part A Medicare Hospital Insurance and your income does not exceed $917 for an individual/$1217 for a couple. There is no resource test for this coverage. Medicaid will pay Medicare cost-sharing expenses only for this coverage group.

2. You have Part A Medicare and your income does not exceed $1220 for an individual/$1625 for a couple. **Medicaid will pay your Medicare Part B premiums only under this coverage group**. There is no resource test for this coverage group.

3. You are a disabled child age 18 or under and receiving medical care at home that would be provided in a medical institution.

4. You are in a nursing home or hospital for 31 consecutive days or longer and your total income is below $1911 per month. Your resources must not exceed $4000 for an individual.

5. You once received SSI and were terminated for one of the following reasons but would still be eligible for SSI if we disregard the income that made you ineligible such as:

   a. a cost-of-living increase in Social Security.
   b. entitlement to or an increase in Social Security disabled adult child benefits after July 1, 1987.
   c. entitlement to Social Security widow(er) benefits for those between age 50 - 65 who are not eligible for Medicare.

6. You are disabled and working at least 40 hours per month. Your total monthly earned income is less than $4399 for an individual and $5899 for a couple and your total unearned income is less than $1220 for an individual and $1625 for a couple. Resources can not exceed $24,000 for an individual and $26,000 for a couple.

7. You are disabled and not eligible for Medicare. Your income must not exceed $1220 for an individual/$1625 for a couple. Your resources must not exceed $4000 for an individual and $6000 for a couple.

8. You are a pregnant woman.

If you believe that you are eligible under one of the groups described above, you should contact:

Medicaid Regional Office Telephone Number

or present this letter of denial to that office.

DIVISION OF MEDICAID **RB290**

NOTICE OF TERMINATION OF MEDICAID

ID#:
SSN:

I. The Division of Medicaid has been notified by the Social Security Administration that your Supplemental Security Income (SSI) payment has been terminated or suspended. Since the receipt of SSI was the basis of your entitlement to Medicaid, your Medicaid benefits will be terminated effective _____ (Date).

If you disagree with the decision made to terminate your SSI check and Medicaid, you should immediately contact your local Social Security Office in _____ (town) as directed in the Supplemental Security Income notice of change which you recently received.

II. **Although you are no longer eligible for Medicaid as a recipient of SSI, you may continue to be eligible for Medicaid under one of the following groups if you have Medicare or you are disabled. Medicaid disability rules are the same as SSI and Social Security.**

1. You have Part A Medicare Hospital Insurance and your income does not exceed $917 for an individual/$1217 for a couple. There is no resource test for this coverage. Medicaid will pay Medicare cost-sharing expenses only for this coverage group.

2. You have Part A Medicare and your income does not exceed $1220 for an individual/$1625 for a couple. **Medicaid will pay your Medicare Part B premiums only under this coverage group**. There is no resource test for this coverage group.

3. You are a disabled child age 18 or under and receiving medical care at home that would be provided in a medical institution.

4. You are in a nursing home or hospital for 31 consecutive days or longer and your total income is below $1911 per month. Your resources must not exceed $4000 for an individual.

5. You were terminated from SSI for one of the following reasons but would still be eligible for SSI if we disregard the income that made you ineligible such as:

   a. a cost-of-living increase in Social Security.
   b. entitlement to or an increase in Social Security disabled adult child benefits after July 1, 1987.
   c. entitlement to Social Security widow(er) benefits for those between age 50 - 65 who are not eligible for Medicare.

6. You are disabled and working at least 40 hours per month. Your total monthly earned income is less than $4399 for an individual and $5899 for a couple and your total unearned income is less than $1220 for an individual and $1625 for a couple. Resources can not exceed $24,000 for an individual and $26,000 for a couple.

7. You are disabled and not eligible for Medicare. Your income must not exceed $1220 for an individual/$1625 for a couple. Your resources must not exceed $4,000 for an individual and $6,000 for a couple.

8. You are a pregnant woman.

If you believe that you may be eligible under one of the groups described above, you should contact::

Medicaid Regional Office Telephone Number

within thirty (30) days for a redetermination of your eligibility.

DIVISION OF MEDICAID

RB293
Sent with SSI
Redetermination
Form Attached

NOTICE OF TERMINATION OF MEDICAID

CLIENT'S NAME/ADDRESS:
ID#:
SSN:

I. The Division of Medicaid has been notified by the Social Security Administration that your Supplemental Security Income (SSI) payment has been terminated or suspended. Since the receipt of SSI was the basis of your entitlement to Medicaid, your Medicaid benefits will be terminated effective _____ (Date).

If you disagree with the decision made to terminate your SSI check and Medicaid, you should immediately contact your local Social Security Office in _____ (town) as directed in the Supplemental Security Income notice of change which you recently received.

II. Although you are no longer eligible for Medicaid as a recipient of SSI, you may continue to be eligible for Medicaid under one of the following groups if:

1. You have Part A Medicare Hospital Insurance and your income does not exceed $917 for an individual/$1217 for a couple. There is no resource test for this coverage. Medicaid will pay Medicare cost-sharing expenses only for this coverage group.

2. You have Part A Medicare and your income does not exceed $1220 for an individual/$1625 for a couple. **Medicaid will pay your Medicare Part B premiums only under this coverage group**. There is no resource test for this coverage group.

3. You are a disabled child age 18 or under and receiving medical care at home that would be provided in a medical institution.

4. You are in a nursing home or hospital for 31 consecutive days or longer and your total income is below $1911 per month. Your resources must not exceed $4000 for an individual.

5. You were terminated from SSI for one of the following reasons but would still be eligible for SSI if we disregard the income that made you ineligible such as:

   a. a cost-of-living increase in Social Security.
   b. entitlement to or an increase in Social Security disabled adult child benefits after July 1, 1987.
   c. entitlement to Social Security widow(er) benefits for those between age 50 - 65 who are not eligible for Medicare.

6. You are disabled and working at least 40 hours per month. Your total monthly earned income is less than $4399 for an individual and $5899 for a couple and your total unearned income is less than $1220 for an individual and $1625 for a couple. Resources can not exceed $24,000 for an individual and $26,000 for a couple.

7. You are disabled and not eligible for Medicare. Your income must not exceed $1220 for an individual/$1625 for a couple. Your resources must not exceed $4,000 for an individual and $6,000 for a couple.

8. You are a pregnant woman.

If you believe that you may be eligible under one of the groups described above, you should contact:

Medicaid Regional Office Telephone Number

within ten (10) days for a redetermination of your eligibility.

FOR AGED AND DISABLED ONLY

If you believe that you would continue to be eligible for Medicaid under one of the Medicaid groups described above, complete the attached SSI Redetermination Form and take or mail it in to the Medicaid Regional Office shown above within 10 days.

DIVISION OF MEDICAID **RB285**

NOTICE OF DENIAL OF MEDICAID

ID#:
SSN:
SSI APPLICATION DATE:

In Mississippi, individuals who are eligible for Supplemental Security Income (SSI) are automatically eligible for Medicaid. However, the Division of Medicaid has been advised by the Social Security Administration that you failed to assign your third party medical payments, and your Medicaid coverage has been denied.

If you disagree with the decision to deny your Medicaid based on the above cited reason, you may notify us immediately in writing to request a hearing in this matter.

Per Federal (P.L. 98-39, Section 2367) and State laws, it is now mandatory that you assign your third party medical payments (medical insurance) to the Medicaid agency in order to be eligible for Medicaid benefits.

Eligibility Division
Division of Medicaid
550 High Street, Suite 1000
Jackson, MS 39201-1399

DIVISION OF MEDICAID **RB287**

NOTICE OF TERMINATION OF MEDICAID

ID#:
SSN:

I. The Medicaid State Agency has been notified by the Social Security Administration that you failed to cooperate in assigning your Third Party medical payments to the Medicaid Agency. Therefore, your Medicaid benefits will be terminated effective_____.

If you disagree with the decision made to terminate your Medicaid based on the above-cited reason, you may notify us in writing to request a hearing in this matter. We must be notified within ten (10) days of the date of this notice, in order for your Medicaid benefits to continue through the hearing process.

II. Per Federal (P.L. 98-39; Section 2367) and State laws, it is now mandatory that you assign your third party medical payments (medical insurance) to the Medicaid Agency in order to remain eligible for Medicaid benefits.

Eligibility Division
Division of Medicaid
550 High Street, Suite 1000
Jackson, MS 39201-1399

_____
Date of Notice

DIVISION OF MEDICAID **RB289**

REQUEST FOR MEDICAID INFORMATION

(Recipient's Name) ID#:
(Recipient's Address) SSN:
SSI Application Date:

Section 1902(K) of the Social Security Act establishes the Medicaid Qualifying Trust provision that makes certain trust agreements a countable resource for Medicaid purposes but not for SSI purposes.

The Division of Medicaid has been notified by the Social Security Administration that you are the beneficiary of a trust agreement or similar legal device. You cannot be eligible for Medicaid until we review your trust agreement (or conservatorship papers or similar legal papers) to determine whether you have resources or income available to you that may affect your eligibility for Medicaid.

Please mail or take all trust documents to the following Medicaid Regional Office:

(Medicaid Regional Address/Telephone Number)

After we have reviewed your trust, you will be notified of your eligibility for Medicaid. If you have questions, you may contact Medicaid at 1-800-421-2408, and ask for the Eligibility Division.

STATE RELATIONSHIP WITH SSI AND MEDICARE

EMERGENCY MEDICAID CARD CERTIFICATION

A. PURPOSE/ PROCEDURE

SSI approvals are transmitted to Medicaid's fiscal agent on a weekly basis and approval notices and Medicaid Cards are issued accordingly. A new SSI approval will usually appear on SDX within two to three weeks after the SSI approval has been processed by SSA. If emergency medical assistance is needed, the local Social Security Office can expedite the issuance of a Medicaid Card via the Emergency Medicaid Card Certification procedure which is processed by the State Office, Eligibility Division. Before this procedure can be initiated, the Social Security Office must certify to the Eligibility Division that the individual is SSI eligible and in need of emergency medical services which cannot be obtained without the Medicaid Card.

1. Emergency Form

The Social Security Office must also provide all the necessary identifying information needed to issue a Medicaid Card. A form for this purpose has been provided to all local Social Security Offices.

2. Retroactive Medicaid

When an individual is certified through the emergency certification process, he may still request a SSI retro determination and a determination of eligibility for the interim month(s) between the month of SSI application and the month the SSI payment begins through the Regional Office. The 3-month period for the retroactive determination will be the three months prior to the date of the SSI application. The date of the SSI application as verified by SSA is the determining date to use in establishing the 3-month period for an SSI eligible. The interim months are determined as the missing months of an SSI payment beginning with the month of SSI application and the month the SSI payment starts.

It is not possible for the "interim" months to be covered via the Emergency process because SSI eligibility for these interim month(s) is not verified.

3. **Notice of Approval** — In instances where a Medicaid Card will not be issued through the use of the emergency procedure, the Eligibility Division will issue a Notice of Approval specifying the month(s) of eligibility, the month of SSI application, the Medicaid ID number assigned and that retroactive benefits are available. The Regional Office will receive a copy of the notice.

B. SYSTEMS LIMITATIONS CASES — The emergency certification procedure through the State Office Eligibility Division may also be used when an individual is determined eligible for a prior period but is not ongoing SSI eligible and due to systems limitations Medicaid eligibility cannot be established.

1. **Presumptive Disability** — Presumptive disability decisions by SSI are allowed up to 6 months of SSI/Medicaid eligibility while awaiting a final DDS decision. These approvals do not always appear on the SDX so it is usually necessary for SSA to prepare an Emergency Form to establish Medicaid eligibility.

2. **Death of SSI Applicant** — When an SSI approval is rendered after the death of the applicant, it is usually necessary for SSA to submit an Emergency Form in order to establish Medicaid eligibility for the period of SSI eligibility. Refer to the "Special Handling of SSI Cases" for eligibility determinations for SSI applicants who die prior to an SSI decision.

3. **ALJ Reversal** — In instances of an ALJ reversal of an SSI denial or termination through the SSI hearing process, it is usually necessary for SSA to submit an Emergency Form to establish Medicaid eligibility for a prior period of SSI eligibility.

4. **Other Limitations** — In any instance of a systems limitations case whereby SSI eligibility will not appear on SDX for a reason other

than one cited above, the only mechanism in place for Medicaid eligibility to be established for a period of SSI eligibility is via the Emergency Certification process.

STATE RELATIONSHIP WITH SSI AND MEDICARE
SPECIAL HANDLING OF SSI CASES

A. ELIGIBILITY DETERMINATIONS FOR DECEASED APPLICANTS

In cases where the SSI applicant dies before the eligibility decision is rendered on the SSI application, the following procedure is followed in order for the deceased applicant to establish Medicaid eligibility.

1. Disability Applications

Currently, SSA is required to complete all disability applications, establishing Medicaid eligibility via the Emergency Medicaid Card Certification procedure which is handled through the State Office. Therefore, the Regional Offices will not handle SSI disability applications for deceased applicants unless a retroactive application is filed, whereby the Regional Office would determine eligibility under ongoing policy.

2. Aged or Blind Applications

SSA is not required to complete the SSI application on an aged or blind applicant who dies prior to the eligibility decision. Of course, if SSA has already determined all factors of eligibility, request SSA to establish Medicaid eligibility by preparing an Emergency Medicaid Card Certification. However, if SSA does not have sufficient information in the SSI record to make a decision, Medicaid eligibility can be established only by the filing of a MAO application. Handle a deceased SSI applicant as a retroactive application and determine eligibility from the month of application for SSI to the month of death as well as determine retroactive eligibility for the 3 months prior to the month of application for SSI if requested by the applicant's representative.

B. POTENTIAL SSI ELIGIBLES IN A TITLE XIX FACILITY

Usually, an individual with income less than the FBR for an individual in a Title XIX institution is referred to SSI for for application and handling. However, SSI cannot consider consider someone in a public institution eligible unless substantial Medicaid payments (more than 50% of the cost of care) are to be made for the individual. If the institution is receiving or will receive more than 50% of the cost of care from a source other than Medicaid, the individual is not eligible for SSI benefits.

If SSI will not complete or accept an SSI application on an institutionalized individual due to the substantial Medicaid payment provision, a MAO application must be processed instead. An application for MAO cannot be refused because an individual appears to be SSI eligible in an institution.

C. SSI ELIGIBLES IN A TITLE XIX FACILITY

Individuals who receive SSI while institutionalized are divided into two categories:

1. SSI Only

These are individuals who remain SSI eligible while institutionalized who receive an SSI payment based on their "D" living arrangement. The handling of SSI only cases by the Regional Office is explained in Section I, Institutionalization.

2. SSI to MAO

These are individuals whose income exceeds the institutional SSI FBR (LA-D) who must apply for MAO in order for Medicaid to continue. Although these individuals have SSI eligibility upon entry into the facility their SSI eligibility will not continue. The handling of SSI to MAO cases is explained in Section I, Institutionalization.

D. SSI RECIPIENT MOVES OUT OF STATE

When a SSI recipient moves out of Mississippi, he/she may continue to receive a Mississippi Medicaid Card for several months after actually moving out of state. This is due to time lapses in processing SSI actions and receipt of SDX reports from SSA and the requirement for advance notice before the closure of Mississippi Medicaid. The termination notice is issued to the Mississippi address and if the client has not left a forwarding address with the Post Office, it will be returned to the Medicaid fiscal agent. The client must call the fiscal agent and provide the new address to obtain the card.

When the SSI recipient moves from Mississippi to another state which covers all SSI recipients, the SDX information reporting the change of address is transmitted to both states simultaneously with the former state terminating and the new state approving Medicaid automatically.

When the SSI recipient moves from Mississippi to another state which does not automatically cover all SSI recipients, it is necessary that the recipient make application for Medicaid in that state. In some instances those states will request verification of termination of Mississippi Medicaid before approving in the new state. Request for this verification should be referred to the Eligibility Division of the State Office.

E. SSI COVERAGE OF CERTAIN DISABLED CHILDREN LIVING-AT-HOME

Section 8010 of Public Law 101-239 amended the Social Security Act to waive the SSI income and resource deeming rules for severely disabled children who were eligible for SSI benefits while in a medical institution, and who qualify for the Home and Community Based Services Program, and who would not be eligible for SSI under the parental deeming rules. These children are eligible to receive a $30 SSI payment as if they were institutionalized. This provision of federal law is effective June 1, 1990.

There is no direct Division of Medicaid involvement with these children; however, if a disabled child applies with the Regional Office for Medicaid at-home, a referral to SSI may be appropriate if the child has been SSI eligible in an institution and is returning home.

STATE RELATIONSHIP WITH SSI AND MEDICARE
SPECIAL HANDLING OF SSI CASES

F. SSI TRANSFER OF RESOURCES FOR MEDICAID PURPOSES

Transfer for less than fair market value authorized after June 1988 do not affect SSI eligibility. However, since transfers could result in Medicaid ineligibility for nursing home services, SSI must notify the State Medicaid agency of any transfers by an SSI recipient made known to SSI. This notification is required in the event the recipient enters a nursing home whereby the Medicaid transfer penalty could apply.

SSI will notify the Medicaid State Office of any known transfers. This information will be forwarded to the appropriate Regional Office for future reference if a nursing home application is filed within 36 months from the date of the transfer.

G. TRUSTS - SSI ELIGIBLES

When SSI discovers a trust or similar legal device which is not a resource for SSI purposes but may affect Medicaid eligibility, the trust must be referred to the State for a Medicaid determination.

SSI will identify SSI recipients who are the beneficiary of a possible trust by an indicator on the SDX. When this code appears, a notice entitled "Request for Medicaid Information" will be generated by the fiscal agent. While this code appears on the SDX, the SSI eligible will not be eligible for Medicaid.

The notice instructs the individual to take all legal documents pertaining to the trust to the Regional Office shown on the notice. When the Regional Office receives any such documents, they should be forwarded to the State Office Eligibility Division for review along with the copy of the "Request for Medicaid Information." If the letter to the recipient is not available, the Regional Office must obtain identifying information on the SSI recipient and include this with the trust.

If the trust or similar legal device results in the SSI eligible not being eligible for Medicaid, the individual will be so notified. If the trust does not result in ineligibility for Medicaid, the State Office will notify the appropriate SSA Office to change the indicator on the SDX so as to allow Medicaid eligibility retroactive to the appropriate begin date.

H. 12 MONTHS CONTINUOUS ELIGIBILITY

The Balanced Budget Act of 1997, P.L. 105-33, gives states the option to provide continuous eligibility to children under age 19 as follows:

1. After eligibility for Medicaid is determined or redetermined, eligibility will continue for 12 months regardless of changes in circumstances. The only exceptions to the 12 months of continuous eligibility would be

    - child reaches age 19
    - child moves out of state or is admitted to a public institution
    - child dies
    - family requests voluntary closure

STATE RELATIONSHIP WITH SSI AND MEDICARE
RELATIONSHIP BETWEEN MEDICAID AND MEDICARE

A. MEDICARE

Medicare is a health insurance program under Social Security which is generally available for the following groups:

- Persons age 65 or older.

- Disabled persons who have been entitled to Social Security disability benefits or Railroad disability benefits for at least two consecutive years.

- Persons insured under Social Security or the Railroad Retirement System who need dialysis treatments or a kidney transplant because of permanent kidney failure.

Medicare is divided into two parts -- hospital insurance (Part A) and medical insurance (Part B).

- The hospital insurance, Part A, helps pay for inpatient hospital care and for certain follow-up care after release from the hospital.

- The medical insurance, Part B, helps pay for doctor's services, out-patient hospital services, and many other medical items and services not covered under hospital insurance.

Due to the complexity of the Medicare program, individuals with specific questions on their eligibility for Medicare should be referred to the Social Security Administration.

B. MEDICAID

The Medicaid program coordinates some benefits with Medicare as follows:

- On Part A, the Medicaid program can pay the hospital deductible and Medicare co-insurance for skilled nursing care. Medicaid will also pay Part A premiums for certain recipients, as outlined in the following discussion of Buy-In.

- On Part B, the Medicaid program can pay the deductible and the 20% co-insurance if the provider of service is willing to file for both Medicare and Medicaid. Medicaid can also pay for the monthly Medicare premium, as outlined in the following discussion of Buy-In.

C. BUY-IN

The Medicaid State Agency has contracted with the Social Security Administration to pay the premiums for coverage under Part B Medicare for Medicaid recipients who are eligible for Part B and the premiums for Part A for certain Medicaid recipients. This arrangement is called the Buy-In. To carry out the terms of this agreement, the Medicaid State Agency must:

- Transmit monthly to the Social Security Administration a listing of the Medicaid eligibles who qualify for Parts A and B.

- Enroll monthly all Medicaid recipients who qualify for Parts A and B as newly approved applicants are added to the assistance rolls.

1. Securing Information Buy-In

Information for the Buy-In is secured at the same time that the individual's eligibility for Medicaid is determined. The worker will:

- Photocopy the individual's Medicare card for the case record. When this information is entered into MEDS, be sure that the individual's name and Social Security claim number are identical to the information on the Medicare card.

- For the client who does not have a Medicare card, ask that he apply for Medicare at the District Office of SSA and follow up on his enrollment. If the individual has Part B only, the Medicaid Agency will automatically enroll the individual in Part A if the individual is dually eligible as a QMB.

2. Buy-In Coverage Beginning Date

The Social Security Administration has set rules governing the beginning date for Buy-In as follows:

- For money-payment recipients (SSI or AFDC), the buy-in coverage period for Part B begins with the month reported by the State agency as the date the individual is eligible for both Medicare and cash assistance.

- For Medicaid-only recipients who are not dually eligible as QMB, buy-in coverage for part B begins the first day of the month after the month in which the State agency determines the individual eligible. For example, an MAO applicant approved during the month of November will have a buy-in effective date of December 1. The exception to this rule is that buy-in coverage is continuous for an individual who loses eligibility for cash assistance but whose Medicaid eligibility continues without interruption.

- For SLMB's (Specified Low-Income Medicare Beneficiaries), buy-in coverage for Part B begins with the first month of Medicaid eligibility.

- For QMB's (Qualified Medicare Beneficiaries) and those determined dually eligible, buy-in for Parts A and B are effective with the month after the month in which the individual is determined to be a QMB or a dually eligible recipient. For example, a QMB approved during the month of November will have a buy-in effective date of December 1.

3. **Buy-In Coverage and/or Ending Date**

Buy-In coverage terminates on the last day of the month which a recipient is no longer eligible for Medicaid Medicare. When SSA is notified by Medicaid that a recipient is no longer eligible for Medicaid, SSA will continue Parts A and B Medicare coverage and either begin deducting the monthly premiums from the recipient's Social Security check or send a notice of premiums due if the recipient does not receive Social Security.

Buy-In problems should be referred to the State Office for clearance on how to handle.

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APPLICATION AND REDETERMINATION PROCESSING
APPLICATION PROCESS

A. OPPORTUNITY TO APPLY

The Division of Medicaid must afford an individual wishing to do so the opportunity to apply for Medicaid without delay.

B. PERSONS WHO CAN FILE

Medicaid requires that a written application form be filed by:

1. **Applicant**

The individual in whose behalf the application is filed.

2. **Legal Guardian or Conservator**

The application must be made in the name of the applicant but the guardian or conservator must give eligibility information and sign the Application Form. Proof of legal guardian or conservatorship will be required in the form of court papers.

3. **Authorized Representative**

This is a person who has been authorized in writing by the applicant to act in behalf of the applicant. An application must be filed in the name of the applicant and the Application Form will be completed from information provided by the authorized representative who will sign the Application. Proof of authorized representative status is required in writing. DOM-302 is used for this purpose.

4. **Designated Representative**

This is someone acting responsibly for an applicant because the physical or mental condition of the applicant is such that he cannot authorize anyone to act for him nor can he act for himself. The designated representative must be someone who is knowledgeable of the applicant's financial affairs and will usually be a close relative or friend. The designated representative will be required to sign DOM-302, Designated Representative Statement to document his status. The application will be made in the name of the applicant with the designated representative providing the eligibility information and signing the Application Form.

APPLICATION AND REDETERMINATION PROCESSING
APPLICATION PROCESS

C. APPLICATION DEFINED

An application is the action by which an individual indicates to the Regional Office on the agency Application Form, DOM-300, his desire for medical assistance. The DOM-300 must be completed by one of the persons described above.

1. Application Date

The application date is the date the DOM-300 was completed in the presence of a Regional Office staff member by one of the persons who can file or the date a signed application is received by mail. Applications received by mail which arrive after the end of the month, but which were postmarked on the last day of the month or a prior date will be considered to have an effective date of the last day of the month in which they are postmarked.

2. Assistance With Application

The agency must allow an individual or individuals of the applicant's choice to accompany, assist, and represent the applicant in the application process or a redetermination of eligibility.

3. Where the Application Shall be Filed

The application must be filed with the Regional Office responsible for the county in which the applicant is currently residing. However, due to the circumstances of a client unable to act for himself, a person authorized to act for the client who lives in another region's area may request assistance from the Regional Office nearest him in completing the Application Form, etc. In such instances, the staff in the Regional Office where the authorized person is located will give assistance in completing the application form, making copies of any necessary documents, etc., and assist the authorized representative in forwarding the application to the Regional Office where the applicant is located. The Regional Office where the applicant is located will be responsible for accepting, registering, and completing the application.

In instances where the applicant is in one Regional Office area when he applies and moves to a second Regional Office area before the application is completed, the first Regional Office will complete the application and then transfer the record to the second Regional Office after final disposition of the application has been made.

APPLICATION AND REDETERMINATION PROCESSING
APPLICATION PROCESS

D. METHODS OF MAKING APPLICATION

The right to apply for Medicaid is a basic right under State and Federal law. The Regional Office accepts applications for aged, blind and disabled applicants who do not receive SSI benefits and applications for illegal aliens who have received emergency services covered by Medicaid. The Regional Office hours are 8:00 a.m. to 5:00 p.m., Monday through Friday, except for holidays.

The methods of applying are:

1. Visit to a Regional Office (RO)

An applicant or representative must be given the opportunity to apply without delay when an individual visits a Regional Office in order to apply for Medicaid, he/she will be given the opportunity to complete the DOM-300.

2. Contact With RO Outside the RO

Regional Office eligibility staff are authorized to accept applications while on official duty outside the Regional Office. Such contacts may occur while the staff member is at a contact center, nursing home, hospital or other public facility.

3. Applications Received by Mail

The DOM-300 may be completed and mailed to the Regional Office. The date of application is the date the DOM-300 is received in the Regional Office or the date postmarked, whichever is earlier.

4. Applications Received by Fax

Regional Office eligibility staff are authorized to accept applications by fax. The application with the original signature should be mailed in and filed in the case record. The date of the application will be the date that it was faxed to the Regional Office.

APPLICATION AND REDETERMINATION PROCESSING
APPLICATION PROCESS

5. **Inquiry or Referral**

Anyone who inquires about eligibility requirements should be told of the opportunity to apply. If an application is desired, the Regional Office must mail out the DOM-300 if one is requested. The application will not be considered filed until received back in the Regional Office. An application can be completed by telephone with the worker using the DOM-300. The signature page can be mailed out. The date of the application will be the date the signed signature page is returned.

If another person or agency refers the name of an individual in need of medical assistance to the Regional Office, the Regional Office will mail an application to the individual if sufficient information regarding a mailing address is provided.

6. **Requests for Application**

By Out of State Applicant

Applications for Mississippi residents who are temporarily out of State may be accepted but the applicant must return to State before the application processing period ends. Exception: If the applicant is hospitalized in another State but plans to return to Mississippi upon discharge, then the application may be processed in the usual manner.

E. DETERMINING INITIAL ELIGIBILITY

To determine eligibility each eligibility factor must be established and the case record documented with verification of each factor. The technical and financial factors of eligibility are set out in Sections D-H. The steps in determining initial eligibility are as follows:

1. Interview

There is no requirement for an in-person interview. If a client specifically request an in-person interview, an interview will be granted. If anyone wants to come into the office to apply and requests assistance with completing the form, an in-person interview would be appropriate. Mail-in applications are accepted with telephone contact if the application is not complete. Telephone interviews are conducted on any application if information given is questionable or unclear.

2. Explanations Required At The Interview

The following items must be explained if an interview is conducted:

- the applicant may be assisted by the person of his/her choice.
- the eligibility factors pertinent to the coverage group under which the applicant is applying.
- the use and purpose of the DOM-300 including the fact that the applicant is agreeing to all of the rights and responsibilities specified on the application by signing the form.
- the Quality Control review process as stated on the DOM-300.

- that coverage is limited to only one source of eligibility, i.e., AFDC, SSI or MAO. If the individual is eligible under another source, that source must terminate prior to MAO eligibility beginning.

- the standard or promptness applicable to the case (outlined in the following discussion).

- the assignment of rights requirement as stated on the DOM-300.

- the use of SSN's in computer matching programs as stated on the DOM-300.

- that verification of eligibility factors is required and that the applicant must provide all information requested.

- the right to a local or state hearing (with a hearing pamphlet provided).

- the Medicaid services available to all eligibles (with a Services pamphlet provided).

3. Conclusion of Interview

The applicant or representative must have an understanding of:

- what the applicant must provide for eligibility to be determined,

- what the agency must do to determine eligibility, and

- what the end result will be, i.e., written approval or denial and the issuance of Medicaid cards and/or the right to appeal any decision.

The worker will also explain that, if approved, a redetermination of eligibility is conducted annually or more frequently if necessary.

F. STANDARDS OF PROMPTNESS

Federal regulations at 42 CFR 435.911 define timely determinations of eligibility. The time standards set cover the period from the date of application to the date the agency mails notice of the decision to the applicant. These standards may not exceed:

1. Aged or Blind Applications

45 days.

2. Disabled Applications

90 days. Exception: If a separate DDS decision is not required because the applicant draws RSDI disability benefits, the 45 day standard applies to the application.

3. Exceptions for Agency Delay

These standards do not apply when a decision cannot be reached because of:

a. Failure or delay on the part of the applicant.

b. Administrative or other emergency delay that could not be controlled by the agency such as:

- Staff vacancies or illness of eligibility staff members lasting two months or more.

- Wholesale desk reviews on active cases mandated by court order, or Federal regulations of wholesale increase in benefits such as Social Security, VA etc., which require extensive staff time.

- Computer problems arising from control of machines by an outside agency.

DOM-303 is used to notify the applicant of any agency delay in processing. The Notice of Delay will clearly state the reason for the agency delay.

G. REVIEW AND EVALUATION OF ELIGIBILITY INFORMATION

The worker must determine eligibility based on information secured during the initial interview and information contained on DOM-300. Appropriate DOM Forms must be present in the case record as the basis for the determination along with other legal or official documents secured which documents and supports the eligibility decision.

In addition to the completion of the appropriate DOM Forms, there are other supporting documents that the worker must obtain, if applicable, before eligibility can be determined. Documents such as legal deeds, wills, tax receipts, statements from knowledgeable sources, etc., are also required in cases involving resources. Refer to Sections D-H, for specifics.

After all applicable forms are completed and other required documents obtained, an eligibility decision is reached and the client is notified. No application will be held after the Regional Office has made the eligibility decision unless awaiting termination of Medicaid eligibility through another source. If, however, the needed information is not received after issuing DOM-307, 309, and, if applicable, DOM-303, the application must be denied.

1. Regional Office Supervisor Responsibility

After the worker makes the eligibility decision, the case is submitted to the Supervisor for review. The Supervisor is responsible for the accuracy, completeness, and consistency of information contained in the case record. The Supervisor attests to the validity of the information when signing off on the case in MEDS.

2. Concept of the Prude Man

This term is sometimes called the "reasonable man"and is taken from the practice of law. It refers to the element of judgement that is exercised by persons in making choices, determining goals and in evaluating statements of others.

Although all factors of eligibility must be verified, the concept of the prudent man must be used in evaluating and questioning information which the applicant has given which is not logical, consistent nor reasonable. Examples of use of the concept are:

- The worker must seek a reasonable explanation when a person has recently sold property or has owned other types of assets and suddenly becomes dispossessed of his holdings. It may be that the applicant has become senile, been cheated, or met with some other disaster, but the worker must gather as many facts as possible and then use reason and judgement in assessing the facts before making a decision as to the veracity of the explanation.

- The worker should seek further information or a logical and reasonable explanation of the circumstances when the applicant declares no income or resources but states that his payment for shelter, utilities, food, etc., are all current. The worker will ask the applicant to explain how he has managed to pay his expenses when he has no income or how he has managed to pay his expenses when he has no income or resources. There may be a logical and reasonable explanation for this, such as: (1) he has had income in the past which was recently terminated as in the case of loss of employment; (2) he had resources or cash savings which he has now exhausted; or (3) he has paid his past living expenses by incurring debts, establishing credit at a store, obtaining loans, etc. When the applicant or recipient can offer and substantiate no logical and reasonable explanation as to how he had paid his past living expenses with no income or resources, and offers vague explanations such as" "I just get by," etc., then eligibility cannot be determined and the application must be denied or assistance terminated for this reason.

H. DENIAL OF ELIGIBILITY DUE TO FAILURE TO PROVIDE INFORMATION

Medicaid eligibility cannot be determined solely on the basis of declarations of information by applicants or clients or representatives. It is necessary to verify information through independent or collateral sources and obtain additional information necessary to be sure that only eligible individuals are enrolled in the Medicaid Program. The authority for obtaining this verification is found in 42 CFR 435.721 which specifies that Medicaid must use SSI eligibility requirements and Section 1631(e) of the Social Security Act.

Applicants and their representatives must provide information about each factor of eligibility. Medicaid will verify the information provided through documents, records and statements from third party sources, such as governmental or nongovernmental agencies, businesses and individuals. When documents are available from the applicant, they are asked to provide such proof.

If circumstances warrant it, information is obtained direct from third parties. The general rule for verification is to verify information which is material to an individual's eligibility. Refer to the section explaining each eligibility factor for specific verification and development requirements.

1. Competence of Applicant

When the worker observes that the applicant is mentally and physically competent to understand his role in establishing eligibility, or has a family member or close friend who can and will assist in this process, the worker will:

a. Be clear during the application interview about the steps which the applicant is to take.

b. Confirm these steps in writing via DOM-307, Request for Information.

2. Make one follow-up at the end of 10 days via DOM-309 when the applicant does not supply the necessary information or take the necessary action to determine eligibility.

When the worker determines that the applicant is mentally or physically incompetent or is unable to read and write when these activities are required, a designated representative must be found. The worker will determine whether there is some family member or close friend who can understand the steps normally required of the applicant and who will become his designated representative. The person who signs DOM-300 or DOM-300A must be competent and knowledgeable enough to attest to the accuracy of the information supplied on the form.

If the applicant fails to respond to the Second Request for Information, reject the pending application at the end of the standard of promptness because of the refusal of the applicant, or his failure after due notice to take any of the necessary steps to establish his eligibility or ineligibility. When this occurs, the application is rejected because the agency is unable to establish eligibility or ineligibility.

2. Reasonable Effort to Assist Applicant

It is required that the worker make a reasonable effort to assist the applicant in order to have the applicant's eligibility determined determined. This includes:

- help with completion of DOM-300,
- help with securing a representative, if needed,
- assisting the applicant in obtaining necessary information/evidence from third parties,
- provide information that will assist the applicant in making informed decisions about Medicaid eligibility. Medicaid program policies are public information and the applicant has a right to know the policies that will impact his/her eligibility.

APPLICATION AND REDETERMINATION PROCESSING
COVERAGE PERIODS FOR MEDICAID

A. BEGINNING DATES OF ELIGIBILITY

An applicant for Medicaid, including one who dies prior to fiing an application or dies prior to completion of the application, may qualify for Medicaid on one of the following dates:

- The first day of the month of the application provided all eligibility factors are met for the first day of the month.
- The first day of the month after the month of application in which all eligibility factors are met.
- The first day of the first, second, or third month prior to the month of application when the conditions set out below for retroactive Medicaid are met.

B. RETROACTIVE ELIGIBILITY FOR MEDICAID

In accordance with 42 CFR 435.914, an applicant for Medicaid may qualify for Medicaid coverage for a three-month period prior to the month of the application. Retroactive eligibility can cover all three months of the prior period, or any month(s) in this three-month period, provided the following conditions are met:

The provision of retroactive medical assistance for up to three (3) full months prior to the month of the application is mandatory for all applicants who:

- have received services covered by Title XIX (Medicaid) during any of the three-month period; and
- meet all eligibility criteria in the retro-active month(s) when the service was provided.

An individual who is not eligible at the time of the application may be eligible for retroactive medical coverage. An application for retroactive eligibility may be made on behalf of a deceased individual.

NOTE: SSI eligibles may be eligible for additional months of eligibility beyond the SSI retroactive period. This period of coverage is the month of application for SSI and any other missing months of SSI eligibility that exists until the month the SSI payment begins. The SSI eligible must apply for and be determined eligible for MAO coverage for this "interim" period of missing SSI eligibility.

C. BEGINNING DATE OF ELIGIBILITY FOR MEDICAID ELIGIBLES WHO MOVE TO MISSISSIPPI

When a Medicaid eligible moves to Mississippi from another state, it is possible for the individual to be considered a resident of Mississippi in the month of the move, provided the individual intends to reside in Mississippi. There are no durational limits on residency requirements; however, no individual is entitled to a duplication of Medicaid services from the state of former residence and Mississippi.

In the event an individual who is receiving Medicaid from another state moves to Mississippi and applies for Mississippi Medicaid, the following guidelines are to be followed:

1. Nursing Home Eligible

When an individual transfers from an out-of-state nursing home to a Mississippi nursing home, the issue regarding payment of nursing home claims must be resolved by contact with the Medicaid Agency in the former state of residence. The Regional Office handling the application must contact the Medicaid Agency by telephone or letter to determine if that state will pay the Mississippi nursing home claim for the month of the move and any subsequent months prior to termination of that state's Medicaid eligibility. If the state of former residence refuses payment, i.e., they do not pay out of state claims, then there will be no duplication of services and Mississippi Medicaid eligibility can potentially begin with the month of the move.

If the former state of residence will pay for the partial month or any subsequent months, eligibility for Mississippi Medicaid cannot begin until the state of former residence specifies their payment(s) will stop.

The case record must be documented with the out-of-state contact and the response concerning payment.

2. At-Home Eligible

If a Medicaid client living at home in another state enters a a Mississippi nursing home, the same procedures as outlined in 1 above applies. An individual living at home, who applies for Medicaid, must have the beginning date of eligibility coordinated with the former state of residence. The same procedure outlined in 1 above is necessary regarding contact with the state of former residence to determine when Medicaid will terminate and whether out-of-state payment of claims is customary. If no out of State payment is anticipated, eligibility can begin with the month of the move to Mississippi if eligible on all other factors.

D. TERMINATION DATES FOR MEDICAID

Medicaid coverage for a recipient will end on one of the following days of the month:

- The last day of the last month in which the client was eligible.
- The death date of the recipient.

APPLICATION AND REDETERMINATION PROCESSING
REDETERMINATIONS

A. PURPOSE

Redeterminations on Medical Assistance Only cases must be performed on a regular basis to determine if a client remains eligible for Medicaid benefits. The redetermination process is essentially the same as the application process in that the client's entire situation must again be reviewed for regular redeterminations. Special reviews require that only the reported change be considered rather than all eligibility factors.

1. **Factors That Do Not Require Reverification during redetermination**

Certain technical factors of eligibility which are verified and/or during the application process need not be reverified a redetermination unless a change has occurred or a discrepancy exists

- Age.
- Disability. However, if DDS has requested on the most recent DOM-325 that a re-examination is necessary, the case will be resubmitted to DDS on the date requested by DDS.
- Citizenship and Residency.
- Physicians Certification approving need for long-term-care clients.
- Social Security Number of client.

2. **Factors That Require Reverification**

Other technical factors such as living arrangements, utilization of other benefits, or any other factor that has changed since the last application/redetermination process must be reverified.

Note: It is mandatory to verify the current living arrangement of each recipient at each redetermination, i.e., verify that the recipient continues to reside in the same type of living arrangement or nursing facility as previously reported.

Financial factors of eligibility are the most likely to change. For this reason, income and resources must be carefully reviewed at each regular redetermination.

Obtain a tax receipt each year for nursing home cases.

Obtain one bank statement or other means of documenting bank balances. A verified balance from the bank is acceptable. Give the client the 330 to take to the bank or ask the client to get a statement or receipt from the bank. Only one verified balance, with date, is needed. If a bank statement is received that shows odd deposits, use the prudent man concept to determine if this is on going income.

APPLICATION AND REDETERMINATION PROCESSING
REDETERMINATIONS

B. TYPES AND FREQUENCY OF REDETER-MINATIONS

Redeterminations are classified as either regular or special reviews of a client's case.

1. Regular Reviews

A regular review must be performed on each MAO client's case at intervals not to exceed 12 months. A regular review is a complete redetermination whereby DOM-300A is completed by the client or representative and each eligibility factor is examined.

Note: SSI Nursing Home cases are redetermined each 12 months to recalculate Medicaid Income only and issue an updated DOM-317.

No designated time limit exists for completion of regular redetermination since eligibility does not expire at the end of 12 months. Cases which are not current simply become overdue. The regular redetermination process should begin two months prior to the end of the review due date, meaning DOM-300A should be issued at this time, thereby allowing time for completion before the case becomes overdue.

1. **Telephone Redeter-minations**

A telephone redetermination can be completed using the DOM-300A Form. The client's signature is not needed. Document the Household Composition for nursing home cases. Also, document what was verbally requested during the telephone redetermination. Set a ten (10) day manual tickler for information needed. After 10 days, send a Second Request (309) if the information has not been received.

3. Exception Telephone Interviews

When it is impossible to contact a client by telephone, the Redetermination Form, DOM-300A, should be issued along with DOM-307, Request for Information. DOM-307 must specify the types of verification known to be needed upon return of the completed DOM-300A. A time limit of 10 days is allowed for completion of Form-300A and the submission of requested information.

DOM-309, Second Request for Information, must be issued at the end of 10 days if the information requested via DOM-307 is not timely submitted. Note, however, the instructions to DOM-307 which specify that if new or additional information is required upon return of the completed DOM-300A, and this information was not included on the first DOM-307, it is necessary to issue another DOM-307 requesting information for the first time.

DOM-306, Notice of Adverse Action, must be issued to close the case if required information is not received after DOM-307 and DOM-309 have been issued and the appropriate 10-day notices have expired.

Do not close a case for failure to return the needed redetermination information without a documented telephone contact that effort(s) were made to contact the client prior to closing the case. This means an additional telephone contact is required, other than the redetermination interview.

4. Special Reviews

Special redeterminations can occur, as outlined below, whereby a complete review is not required nor due; however, a portion of the case must be reworked.

Special determinations of eligibility are necessary when:

- the client reports a change in his circumstances which could affect eligibility or level of benefits,
- information from any other source is received which could affect eligibility or level of benefits,
- potential changes in eligibility are indicated by information already available,
- it is necessary to transfer the case record to another Regional Office.

If additional information is needed to act on reported charges, then the client must be notified in writing via the use of DOM-307 and DOM-309 Forms allowing the client sufficient time to provide the information.

C. SSI REDETERMINATIONS

Individuals terminated from SSI due to income and/or resources are issued an SSI Termination Notice (Section B) and an SSI Redetermination Form, DOM-300B, by the fiscal agent upon receipt of the SDX notification of termination. This form is to be completed and returned to the appropriate Regional Office if the client desires continued Medicaid and is eligible under one of the coverage groups described in the SSI Termination Notice. SSI clients who are terminated from SSI and receive this form do not require an in-person interview but all necessary factors of eligibility must be verified; i.e., disability, residency, utilization of other benefits, etc. Needed information must be requested in writing to the client including DOM-TPL Form 406, Third Party Liability Information, since this form is not part of the SSI Redetermination Form issued by the fiscal agent with the SSI Termination Notice.

APPLICATION AND REDETERMINATION PROCESSING
NOTIFICATION PROCESS

A. NOTICE TO CLIENT

The client must be notified in writing, via the appropriate DOM Form, of any action taken on the client's application or active case which affects eligibility or level of benefits. The appropriate notice to use depends on the type of action taken on the case as outlined below:

1. DOM-305, Notice of Action

This notice to the client is used when the action taken on an application or active case involves any of the following:

- Approval of application. This form is used to approve retroactive benefits, ongoing eligibility, or a combination of the two. The effective date of approval and the amount of Medicaid Income, if any, will be shown on the form. DOM-305 is used when approving only a portion of the benefits applied for, e.g., when the applicant applied for 3 months retroactive benefits but can only be approved for 1 month. If a portion of the benefits applied for are to be denied or if eligibility will expire at a predetermined time, an explanation must be provided in the remarks section of the form.

- Approval of redetermination. For nursing home clients this form is used to approve the redetermination or special review of a case, provided benefits remain the same or increase, meaning the client's Medicaid Income is reduced. If Medicaid Income increases, this is considered a reduction in benefits and, thus, results in an adverse action. Refer to the following subsection for policy outlining the effective date of action for changes.

- Transfer of case to another Regional Office. This form is used to notify the client when the case record is transferred to another Regional Office. The address of the Regional Office that will handle the case will be posted on the form.

The Notice of Action includes a statement concerning the client's right to a fair hearing. However, the fair hearing statement does not include the 10-day advance notice for continuation of benefits, as this provision is not applicable to approval of applications or an increase in benefits. The applicant or client has 30 days from the date of mailing posted on the form to request a hearing if dissatisfied with the action taken on the case.

2. **DOM-306, Notice of Adverse Action**

This notice is used when the action taken on an application or active case involves any of the following adverse actions:

- Denial of application. This form is used when all benefits applied for must be denied. The reason for the denial will be clearly stated in the space provided on the form. Although a denial is an adverse action, there is no need to hold the denial for 10 days, since the continuation of benefits provision does not apply.

- Closure of active case. This form is used to close a client's case. The effective date and reason for the closure will be clearly stated in the space provided and the continuation of benefits provision applies as outlined below. Refer to the following subsection for policy outlining the effective date of closure.

- Increase in Medicaid Income. This form is used to report an increase in Medicaid Income for nursing home/hospital clients. The effective date and reason for the increase will be clearly stated in the space provided and the continuation of benefits provision applies outlined below. Refer to the following subsection for policy outlining the effective date of increases in Medicaid Income.

- Termination of Nursing Facility vendor payment. This form must be used to terminate a client's vendor payment in instances where a transfer penalty is to be applied or a nursing facility level of care is denied or terminated. Advance notice to terminate the vendor payment is required for MAO and SSI-only clients

- Conversion to a reduced services coverage group. This form is used to notify the client that eligibility for full Medicaid services is being terminated and eligibility will continue for reduced services only, such as QMB or SLMB.

B. ADVANCE NOTICE PERIOD

Federal regulations mandate that the agency mail a notice of of adverse action 10 days before the date of action to reduce or terminate Medicaid benefits, except for situations classified as "Exceptions to Advance Notice." The required advance notice period is 10 calendar days beginning with the day after the date of mailing which is posted on the DOM-306. However, for MEDS purposes the actual advance notice period is 12 calendar days from the end of a month to allow for notice processing and mailing. It is mandatory that the Notice is mailed out on the date posted as the date of mailing so that the client is allowed the maximum advance notice time in order to timely request a hearing whereby continuation of benefits applies.

During the 12-day advance notice period, the agency cannot authorize any action to reduce or terminate benefits. If action is erroneously taken to reduce or terminate benefits during the advance notice period and the client requests a hearing during the advance notice period, benefits must be reinstated as discussed in the following subsection.

1. Continuation of Benefits

This provision applies to any action taken to reduce or terminate Medicaid benefits. Form DOM-306, Notice of Adverse Action, contains space for the worker to enter the date which represents the last day of the advance notice period. This is the 12th calendar day from the day after the date of mailing which is posted on the notice. If a client requests a fair hearing during the 12-day advance notice period, the agency may not reduce or terminate benefits until the final hearing decision is rendered. For a detailed discussion on how to determine if a hearing is requested timely in order for continuation of benefits to apply, refer to the Hearings Section.

2. Exceptions to Advance Notice

The following situations represent exceptions to advance notice whereby the action does not have to be held; however, the DOM-306 must be issued:

- The agency has factual information confirming the death of a client.
- The client submits a voluntary request for closure of his/her case. This request must be in writing, signed by the client or his/her designated representative.
- The client is admitted to a public institution, e.g., prison or a State hospital in a non-Title XIX facility.
- The recipient's whereabouts are unknown and the Post Office returns agency mail indicating no forwarding address. If the client's whereabouts become known during the time the client is eligible for services, the case must be reinstated.
- The agency establishes the fact that the client has been accepted for Medicaid services by another State.

APPLICATION AND REDETERMINATION PROCESSING
AUTHORIZING CHANGES

A. TIMELY ACTION ON CHANGES

The worker must follow up on any information resulting in a change in a client's circumstances which is reported or becomes known to the agency. Changes affecting eligibility should be processed as soon as the change becomes known to the agency. Action must be taken to initiate the change no later than 10 working days from the date the change becomes known. The case record must reflect that action was initiated to process a change within this 10-day time period.

Changes include:

- closures
- increases or decreases in Medicaid Income
- procedural changes such as transfer between programs, etc.

Changes require that the client be notified of the change via the appropriate notice to the client and that the medical facility be notified, if appropriate, via DOM-317. The following policy discussion specifies the effective dates to use in notifying the client and medical facility.

B. CLOSURES

Advance notice is always required before a case can be closed. This means that there must be 12 days left in the current month in order to close a case for the following month. This allows for the 10-day advance notice period plus 2 days mailing time. During the advance notice period the client has the right to request a fair hearing and has the right to continuation of benefits pending the hearing decision if timely requested.

APPLICATION AND REDETERMINATION PROCESSING
AUTHORIZING CHANGES

1. **Death Closures**

If a client's death has been verified, the case will be closed as of the actual death date. Advance notice is not required.

The date of death must be established and date and source of verification recorded in the case folder. The following sources of verification are acceptable:

- viewing death certificate
- contact with the funeral home or attending physician
- signed statements from two (2) persons who can attest to the date of death
- dated newspaper clippings
- contact with the hospital or nursing home where patient died

2. **Temporary Closure of Two Months Or Less**

In situations where it is known that a client will be ineligible for two months or less, the closure will be processed in the normal manner; however, at the end of the temporary ineligibility period the case may be reinstated without completing new eligibility forms necessary for reapplication. The case record will show:

- the exact length of time during which the ineligibility will exist
- the date the recipient will again be eligible
- the reason for the temporary ineligibility

C. CHANGES IN MEDICAID INCOME (MI)

Changes in a client's income, marital status or non-covered medical expenses will impact the amount of income the client must pay toward the cost of his/her care, known as Medicaid Income. These changes will result in either a decrease or increase in Medicaid Income. The effective dates of these changes are determined as follows:

1. Decrease in MI

A change which results in a decrease in Income is effective the month in which the change is reported or becomes known to the agency. For example: A decrease in income reported at any time during the month of June will be effective as of June 1. Notice to the client (DOM-305) and notice to the medical facility (DOM-317) will specify June 1.

2. Increase in MI

A change which results in an increase in Medicaid Income requires advance notice to the client advising of the increase. However, advance notice for Medicaid Income increases is based on issuing notice 10 days before the date Medicaid makes its payment to the facility. A nursing home cannot submit a claim for any month until the first day of the following month. Payment is then made to the facility on the first Monday following receipt of the claim. This means that the worker has 10 days before Medicaid makes its payment to a facility to increase Medicaid Income for the current month. Since payment schedules to nursing homes may vary, policy governing increasing Medicaid Income in the current month is based on whether advance notice can be issued 10 calendar days before the first of the following month.

For example, if an increase in the client's income is discovered on October 10, an increase in Medicaid Income can be effective October 1 provided advance notice is issued regarding the increase by October 21.

NOTE: If a State or local hearing is requested within the advance notice period, the increase cannot be effected until the final hearing decision is rendered.

When Medicaid Income is temporarily decreased due to the allowance of a deduction, i.e., a health insurance premium or other non-covered medical expense, and Medicaid Income is subsequently returned to an amount previously in effect, this action is not considered an increase in Medicaid Income subject to advance notice. When the client is notified of the allowance of a deduction, the notice should advise that Medicaid Income will return to the previous amount and specify the previous amount and date Medicaid Income will resume.

In any instance where Medicaid Income does not revert back to the amount in effect prior to allowance of a deduction, an increase would require advance notice.

3. Increase in MI Combined With A Closure

In instances where income is counted in the month received but receipt of the income also renders the client ineligible, the excess income is counted in the Medicaid Income computation in the month of receipt provided there are 10 calendar days remaining in the month of receipt to allow for advance notice. In addition to increasing Medicaid Income for the month of receipt, the case is also scheduled for closure for the following month. Both actions are accomplished by use of one DOM-306, Notice of Adverse Action, explaining the increase and the closure.

Example: A client receives a lump sum VA payment of $4000 on December which is reported to the Regional Office on December 12. Action is taken to include the $4000 as income for December for Medicaid Income purposes. DOM-306 is issued December 19 which allows advance notice prior to January 1. DOM-306 shows a Medicaid Income increase for December and a closure for December 31 due to excess resources for January.

APPLICATION AND REDETERMINATION PROCESSING AUTHORIZING CHANGES

The amount of the excess income will be shown on the DOM-306 and DOM-317 Forms; however, the client/representative should be advised that the amount due for the month will be the actual income shown or the Medicaid reimbursement rate for the particular facility, whichever is less. The client/representative must contact the facility to obtain the lesser of the two amounts.

D. CHANGES TO REDUCED SERVICES COVERAGE GROUPS

Changes from a full services coverage group to a reduced group, such as QMB or SLMB, require advance notice before the change can be effected in the following month. It is not possible to change an active case to a reduced services coverage group unless there are 12 days remaining in the current month.

E. PROCEDURAL CHANGES

The types of changes discussed below are considered procedural since Medicaid benefits are continued at the same level. Procedural changes are reported via MEDS and include the following:

- Change of address (Notice to the client is not required.)
- Change in name due to:
- error made in the original listing of the name
- change in marital status
- change or appointment of guardian/conservator

Changes in name should also be posted on all other permanent records which carry the client's name, such as master card(s), case record, etc. (Notice to the client is not required.)

- Transfer between programs. MEDS should be corrected to change category when a disabled or blind client turns 65 years of age and becomes an aged client. (Notice to the client is not required.)
- Transfer between Regional Office. (Notice to the client is required).

F. CORRECTIVE ACTION

At the time the Regional Office becomes aware of an error present in the case record which affects eligibility or level of benefits, action must be initiated to correct the error. Immediate corrective action is handled as a change, outlined in the preceding policy discussion, and prevents further error. However, in some instances, it is also necessary to correct the error retroactively into prior months.

When corrective action into prior months adversely affects the client, meaning that the client was ineligible or eligible for fewer benefits, DOM-354 is prepared. Refer to Section K, "Improper Medicaid Benefits."

When corrective action into prior months favorably affects the client, meaning that the client was eligible or eligible for more benefits, the corrective action is handled as a reinstatement as outlined below.

G. REINSTATEMENTS

Certain situations require a reinstatement of services which means that either eligibility is restored or Medicaid Income is corrected for a prior period. Either type of reinstatement is accomplished without requiring that a new application be filed on behalf of the recipient. A reinstatement of services is in order in the following situations:

1. Hearing Decision

A hearing decision is rendered as a result of a State or local hearing which grants eligibility or increased benefits. Based on the findings of a State or local hearing, the Regional Office may be required to reinstate eligibility or correct Medicaid Income, whichever is appropriate, retroactive to the date decided by the hearing official.

Note: If benefits were continued pending the hearing decision on an active case, reinstatement may not be required unless the decision at the hearing is to increase the level of benefits in effect prior to the hearing.

2. Advance Notice Period

Proper advance notice policy is not followed as outlined in the "Notification Process" subsection for adverse actions. This includes situations where:

a. Appropriate advance notice is issued; however, the client timely request a hearing during the advance notice period.

b. Advance notice to reduce or terminate benefits is not issued as required; therefore, benefits must be reinstated at the time the error is discovered, regardless of whether the client is currently eligible. Benefits must be reinstated and the appropriate advance notice issued.

3. Client's Whereabouts Become Known

A client's whereabouts are unknown as indicated by the return of unforwardable agency mail directed to him/her. Any discontinued Medicaid must be reinstated if his whereabouts become known during the time he/she is eligible for Medicaid. To do this the worker must determine

eligibility for each month that the client's whereabouts were unknown and reinstate for any period of time he/she would have been eligible.

4. Temporary Case Closure

A case is closed temporarily for 2 months or less.

Note: Although no new application is required for temporary closures of 2 months or less, a break in the client's eligibility correctly exists. Therefore, it is necessary to adjust the client's beginning Medicaid date via MEDS to reflect the most recent beginning Medicaid date.

5. Reapplication

A second application is requested on an application that has been in rejected status for less than 2 months. The rejected application can be updated and signed by the applicant or representative thereby establishing a new application date that supersedes the initial application date. However, all factors of eligibility that are not subject to change need not be reverified, i.e., disability, physician certification. Income and resource factors may require further verification, depending on the types involved.

The beginning date of eligibility is controlled by the second or updated date of application.

6. Agency Error

The agency discovers that eligibility was denied or terminated in error or that benefits were reduced in error due to agency failure to act on information present in the case record or information that was presented within the advance notice period that established eligibility.

The discovery of erroneous action may come about through:

- a review of the case or application,
- a complaint made by or for the applicant or client,
- recognition of the error by the worker, or

- other sources having knowledge of the error.

When the agency fails to act on information provided during the application/redetermination process or during the advance notice period, action must be initiated to reinstate benefits retroactive to the month in which the erroneous action took place. No corrective action to reinstate benefits is required when the information establishing eligibility was not provided to the agency either prior to or during the advance notice period; instead a new application must be filed.

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NONFINANCIAL ELIGIBILITY FACTORS
BASIC POLICY

A. INTRODUCTION

Title XIX of the Social Security Act specifies who is eligible to receive Medicaid benefits. Eligibility for Medicaid is determined using both SSI and Medicaid policy, as specified in federal law and federal regulations.

Basic non-financial requirements under SSI and Medicaid policy are explained in this section and are outlined below.

B. POLICY PRINCIPLES

Basic eligibility requirements are:

- an eligible individual must be either aged (65 or over) or blind or disabled; and,
- a citizen of the United States or an alien lawfully admitted for permanent residence in the U. S. or an alien permanently residing in the U. S. under color of law; and,
- a resident of Mississippi; and,
- have income and resources within specified limits; and,
- file an application.

1. Definition of Eligible Individual

A person who meets all of the basic requirements shown above. This includes a person who meets the definition of a "child."

2. Definition of Eligible Spouse

A person who meets all of the basic requirements shown above and is the husband or wife of an eligible individual with whom he or she lives (including a man/woman who hold themselves out as husband/wife).

An individual and spouse must each file an application and meet all of the criteria shown above to establish eligibility as an eligible couple.

NONFINANCIAL ELIGIBILITY FACTORS

BASIC POLICY

3. **Eligibility Exceptions**

Despite meeting all of the above criteria, an individual is not eligible for Medicaid if the person:

- fails to apply for any and all other benefits for which he/she may be eligible.
- is a resident of a public institution.
- refuses to accept vocational rehabilitation services.
- fails to assign rights to any third party medical support or cooperate with Medicaid in obtaining third party payments.

NONFINANCIAL ELIGIBILITY FACTORS
MARITAL & PARENT/CHILD RELATIONSHIPS

A. MARITAL RELATIONSHIPS

Whether a man and woman are married for SSI/Medicaid purposes governs whether:

- couple budgeting rules apply; or
- spousal or parental deeming applies.

In addition, someone who is married cannot be considered a child.

1. Marital Criteria

For SSI/Medicaid purposes, a marital relationship is one in which members of the opposite sex are:

- married under State law (common law marriage is recognized in Mississippi if the couple began holding out prior to April 1, 1956); or,
- married for title II purposes; or,
- living in the same household and holding themselves out to the community as husband/wife.

2. When a Martial Relationship Ends

A man and woman are no longer considered married as of the date that:

- either dies;
- a final decree of divorce or annulment is issued;
- either begins living with another as that person's spouse;
- they are determined not to be married for title II purposes if this was the basis for considering the couple married;
- they begin living in separate households.

3. Evidence of Marriage or Termination of Marriage (Including Living Apart

A marital relationship must be documented with proof that the marriage exists or has been terminated. Photocopy marriage records or SSA records showing entitlement on a spouse's record or divorce or separation papers for the case record.

If a married couple claims to be living apart, obtain as many items of evidence as possible to make a determination as to the couple's relationships and living arrangement. Evidence such as:

- mortgages, leases, rent receipts, property deeds, bank accounts, tax returns, credit cards, etc.
- information from other government programs (SSA, Food Stamps, public housing, etc.)
- statements from relatives, friends or neighbors.

If a couple is determined to be living apart, each is treated as an individual. If evidence does not substantiate that a couple lives apart, then couple rules/deeming may apply.

C. HOLDING -OUT RELATIONSHIPS

A man and a woman who live in the same household are married for SSI/Medicaid purposes if they hold themselves out as husband and wife to the community in which they live.

If a couple lives together but denies "holding out," obtain as many of the following items of evidence as possible to make a determination of the couple's status:

- mortgages, leases, property deeds, bank accounts, insurance policies, passports, tax returns, credit cards;

- information from other government programs, such as SSA, Food Stamps, public housing, etc.

- statements from relatives, friends or neighbors.

It is possible for a couple to live together and not be "holding out" as man/wife depending on their circumstances (economic/social), but the only way to make a determination of marital status is to examine how the couple holds themselves out to the community. If the couple is determined to be living apart, each is treated as an individual. If evidence does not substantiate that a couple lives apart, then couple rules and deeming applies.

Note: A man and woman who are still legally married and resume living together after having lived apart are a married couple, regardless of the reason for having resumed living together. If a divorced couple resume living together, develop whether they are "holding out."

NONFINANCIAL ELIGIBILITY FACTORS
MARITAL & PARENT/CHILD RELATIONSHIPS

D. INDIVIDUAL IS A CHILD

A child is defined as someone who is neither married nor head of a household and:

- Under age 18; or
- Under age 21 and a student regularly attending school or college or training that is designed to prepare him/her for a paying job.

An individual who does not meet the definition of a child (e.g., age 17 but married) may meet the definition of an eligible individual.

1. Definition of Parent

A natural or adoptive parent or stepparent who lives in the same household as the child.

- The stepparent must be the present husband or wife (including a holding out relationship) of the natural or adoptive parent living in the same household as the child.
- A person is not the stepparent if the natural or adoptive parent has died, been divorced from the stepparent, or had the marriage annulled.

2. Child Status Ends

Do not consider an individual a child effective with the month the child becomes age 18 or age 21 if a student or the month he/she last meets the definition of a child.

3. Evidence of Child Status

Obtain proof of age or marital status, if married, for the child. Use the birth or baptismal record to verify proof of age and the parent/child relationship.

E. STUDENT CHILD

A student child is someone who is under age 21 and regularly attends school of college or training designed to prepare him/her for a paying job.

1. Student Requirements

Regular attendance means the individual takes one or more courses of study and attends classes:

- In a college or university for a least 8 hours a week under a semester or quarter system; or
- In grades 7-12 for at least 12 hours a week; or
- In a course of training to prepare him/her for a paying job for at least 15 hours a week if the course involves shop practice or 12 hours a week if it does not involve shop practice. This kind of training includes anti-poverty programs, such as the Job Corps and government-supported course in self-improvement; or
- For less than the time indicated above for reasons beyond the student's control, such as illness, if the circumstances justify the reduced credit load or attendance. **EXAMPLE:** School Attendance Less Than Required Hours

  A paraplegic is forced to limit vocational school attendance to one day a week due to the unavailability of transportation. Although the student is enrolled for attendance of less than 12 hours a week, he qualifies as regularly attending school because lack of transportation is a circumstance beyond his control.
- Student status is also granted to homebound students who have to stay home due to a disability. Student status is granted if the child studies courses given by a school (grades 7-12), college, university or government agency and a home visitor or tutor directs the study or training.

2. Vacation

A child remains a student when classes are out if he/she attends classes regularly prior to school vacation and intends to return when school reopens.

3. Evidence of School Attendance

Develop school attendance whenever an applicant/recipient between ages 18-21 alleges being a student. This individual may meet the definition of a child if he/she qualifies as a student. No development is necessary for a child under age 18 who does not expect to earn over $65 in any month.

Obtain the following information:

- Name and address of the school or institution furnishing the training;
- Name of the person to contact for verification, if necessary; and
- Information on the course or courses of study, dates of enrollment, number of hours of attendance, other activities of the child.
- Verify enrollment by examining a student record such as an ID card, tuition receipt or contact with the school.

NONFINANCIAL ELIGIBILITY FACTORS

AGE

A. DEFINITION

To be considered "aged" an individual must be age 65 or older. According to SSI policy, a given age is attained on the first moment of the day preceding the anniversary of the individual's birth. For example, an individual born January 1, 1929 is considered to be age 65 as of December 31, 1993, and could file an application as an aged individual as an aged individual in the month of 12/93.

B. VERIFICATION

The age of an individual must be verified in the following situations:

- an applicant applies for benefits based on age.
- a disabled or blind applicant under age 21 applies and any of the following conditions exists:
  a. deeming.
  b. student earned income exclusion.
  c. support from absent parent exclusion.
- there are ineligible children in a deeming household.

1. Acceptable Evidence

Acceptable evidence for establishing age consists of the following:

- The original birth record. This is a birth certificate or hospital birth record established during the first 5 years of life and certified by the custodian of record. This could include a statement signed by the physician or midwife who was in attendance at the birth who attests to the date of birth.
- Social Security records when application has been made for a Social Security number.
- School records.

- Church records.
- Family Bible or other family record. (Must examine the entire publication)
- State or Federal census records established near date of birth.
- Insurance policy which shows age or date or birth.
- Marriage record which shows age or date of birth.
- Passport.
- Employment records.
- Military records.
- Child's birth certificate which shows age of parent.

2. **Evidence For Those Born In Foreign Countries**

Records which might be available to those born in foreign countries are those listed above plus the following:

- A foreign passport.
- An immigration record established upon arrival in the U.S.
- Naturalization papers.
- An alien registration card.

NONFINANCIAL ELIGIBILITY FACTORS
BLINDNESS AND DISABILITY

A. BACKGROUND

Under the provisions of sections 1902(a)(10) and 1905(a) of the Social Security Act, individuals who meet certain income and resource requirements and other general eligibility requirements and who are disabled, as defined under the Social Security Act, are eligible for Medicaid. The law requires that the SSI definition of disability set forth in section 1614 of the Social Security Act must be satisfied, at a minimum, in order for an individual to be eligible for Medicaid based upon disability.

B. DEFINITION OF DISABILITY (20 CFR 416.905)

The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. This means an individual unable to do his/her previous work or any other substantial gainful activity which exists in the national economy. In making this determination, an individual's residual functional capacity, age, education and work experience are considered.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) changed the definition of childhood disability to specify:

1. An individual under the age of 18 shall be considered to be disabled under SSI if that child has a medically determinable physical or mental disability, which results in marked and severe functional limitation, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of at least 12 months, and

2. No individual under the age of 18 who engages in substantial gainful activity may be considered disabled.

In addition to the new definition of disability for children, the law mandates two changes to current evaluation criteria in SSA/SSI regulations:

1. The discontinuation of individualized functional assessment (IFA) for children, and

2. The elimination of maladaptive behavior in the domain of personal/behavioral function in determining whether a child is disabled.

The new definition applies to all applications filed on or after August 22, 1996 (and to applicants whose claims were not finally adjudicated as of that date) and to all redeterminations of childhood disability.

C. DEFINITION OF BLINDNESS

Statutory blindness is central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which has a limitation in the field of vision so that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered to have a central visual acuity of 20/200 or less.

An individual's ability to work will not affect eligibility based on blindness.

Note: Blindness alone precludes eligibility under the Poverty Level Aged and Disabled coverage group. An individual must be determined "disabled," as described above, in order to qualify for coverage under the poverty level group. (Blindness does not meet the medical criteria for disability under the PLAD coverage group.)

D. DISABILITY DETERMINATIONS IN 1634 STATES

Under contract with the Medicaid State Agency and the Social Security Administration, the Disability Determination Service (DDS) makes all decisions relating to disability or blindness.

In cases in which a State has a section 1634 agreement with SSA (as does Mississippi) and an individual files an application only with SSA for SSI, the Medicaid Agency is not required to make a Medicaid disability determination for the period starting on the effective filing date of the SSI application. This is because an application for SSI is also an application for Medicaid in such States. An applicant is required to wait until SSA makes an SSI eligibility determination.

Note: This does not mean that a separate MAO application cannot be filed. This means that Medicaid is not required to make a separate disability decision for any months of potential SSI eligibility.

1. Circumstances Which Warrant A Separate Medicaid Application

The circumstances under which the State Medicaid Agency is required to make an independent determination of disability by way of a separate MAO application are as follows:

a. An individual has not applied for SSI or has applied for SSI and been denied for a reason other than disability.

b. An individual applies both to SSI and to Medicaid and SSI fails to make a disability decision within 90 days. In such an instance DDS must provide Medicaid with a decision prior to the SSI decision.

Note: If DDS provides a Medicaid approval prior to an SSI decision, a tickler must be set to check on the final SSI decision. If the SSI decision is a disability denial, the case must be closed for Medicaid purposes and the case referred to State Office (along with all medical information in the case record) for routing to DDS for a final decision.

c. An individual applies for Medicaid and alleges a disabling condition that is different from or in addition to that considered by SSA.

d. An individual applies for Medicaid more than 12 months after SSA last made a final determination that the individual was not disabled and the individual alleges his/her condition has deteriorated since that final decision and the individual has not reapplied for SSI.

2. Circumstances Which Warrant a Referral to SSA

If the above conditions do not exist and the individual is potentially eligible for SSI, he/she must be advised to file or refile with SSA for SSI benefits; however, this does not mean an MAO application cannot be filed. For example: An individual applied for SSI and was denied due to disability in October, 1989. In March, 1990, the individual applies for Medicaid only but alleges no change in his physical condition since his SSI application was denied. In this case, the SSI disability denial controls the Medicaid decision and the individual must be denied eligibility based on the previous SSI denial and referred to SSA to refile for SSI.

In addition, any allegation of a deterioration of the condition for which SSA made a determination that is filed less than 12 months after the most recent final SSI determination must be submitted to SSA for reconsideration or reopening. Under SSA rules, an individual may request a reconsideration within 60 days of receipt of the notice denying SSI disability. If the individual does not appeal the decision within 60 days, he/she may still request reopening of the determination within 1 year for any reason and within 2 years for good cause, such as new or material evidence.

3. Disability Questionnaire (for PLAD applicants)

An individual who wishes to file an MAO application must be allowed to do so. However, a separate DDS decision is not required if an SSI medical decision has been rendered within the previous 12 months or is currently pending with SSA.

In order to assist a worker in deciding whether a DDS decision is required, a Poverty Level Disability Questionnaire and instructions have been developed for this purpose. It is designed to be used for an applicant with no income or income below the SSI FBR appropriate for the individual to determine if a previous SSI medical denial exists. The Questionnaire is not necessary for someone who currently receives title II disability benefits.

E. EXCEPTIONS TO OBTAINING DDS DISABILITY APPROVALS

A separate Medicaid determination of disability is not require in certain instances where DDS has already determined determined disability using SSI criteria for the same period of time to be covered by a MAO application. If the date disability began, as established by SSA, does not include all months of requested Medicaid eligibility, a separate DDS decision is required. The exceptions are as follows:

1. Applicant Receives Title II Disability

If an applicant receives title II disability benefits (for a disability other than blindness for PLAD applicants) on an ongoing basis based on his/her own disability and the date disability began is verified to include all months to be covered by the Medicaid application, i.e., the month of application and any retroactive month(s), then a separate DDS decision for Medicaid is not required. The "Date Disability Began" will appear on the applicant's TPQ response from SSA. The receipt of title II disability must be reverified at each redetermination.

2. ALJ Reversal

If you have evidence of an ALJ (Administrative Law Judge) reversal that establishes disability (other than blindness for a PLAD applicant) and the date of onset of disability, this evidence can be used provided the onset of disability encompasses all months of the Medicaid eligibility request.

3. Deceased Applicants

A verified death date is sufficient to establish disability for a deceased applicant provided the disability which resulted in death existed in all months that Medicaid eligibility is requested. For example, if a traumatic onset of disability such as an accident occurred which resulted in death, eligibility could only be established under this exception for the month of the accident forward.

4. Disabled Adult Child(ren)

If an applicant is: over 18, entitled to Medicare, and receives title II benefits as a C1-C9 beneficiary, then no separate DDS decision is required as disability has previously been established by SSA.

F. OBTAINING DDS DISABILITY DECISIONS

When an applicant under age 65 applies for Medicaid on the basis of disability or blindness and a DDS decision is required, follow the procedure outlined below:

1. Complete the Appropriate Forms

The worker will complete, with the applicant's assistance, Form DOM-323, Disability or Blindness Report. This form is completed based on the applicant's responses and worker observations. If the applicant is a child, Form DOM-323A must also be completed.

Note: If applicant is currently employed, DDS needs detailed information regarding work hours, income, name and type of employer, etc. included on DOM-323. Also include whether applicant has been examined by a physician within the last 3 months and specify the physician.

Form DOM-324, Vocational Report, will be completed by the worker only if the applicant has a communication problem due to language, speech or hearing difficulties which would make it difficult for DDS to contact the applicant.

The applicant must sign the appropriate number of Form DOM-301A, Authorization to Release Medical Information, based on the number of medical sources identified on DOM-323 plus 2 additional signed forms. (Note: Leave the "Date" space blank.) DDS will use the signed forms to obtain necessary medical information from each provider. If the applicant is a child, the parent or representative must sign the 301A Forms. Note: If the applicant is unable to sign DOM-301A and the designated representative signs in the applicant's place, the authorized representative must state why the applicant is unable to sign his/her name, e.g., "patient unconscious," "Patient senile," etc. If a representative signs DOM-301A, attach a copy of DOM-302 Designated Representative Statement. If DOM-302 is signed as a self-designation, there must be an explanation as to why applicant did not sign the 302 before medical information is released.

Complete Form DOM-325, Disability Determination and Transmittal. This form serves as the transmittal form for submitting DOM-323, DOM-324, if applicable, and prior medical information from the case record. Note: if the applicant is applying under the Poverty Level coverage group, indicate this in the "Remarks" section of DOM-325 to alert DDS to the fact that a disability other than blindness must exist.

If the applicant is a child, put the parent or representative's name on the DOM-325 in the same space with the case name. For example, enter Jane Doe (parent) for Janie Doe.

2. **Submit a File Folder to DDS and Set a Tickler**

Include all material cited in item 1 in a file folder labeled with the client's name, Social Security number and case number. For example:

Brown, Samuel T. 425-76-8320

104-24-3467

Mail the folder to DDS. The mailing address is:

Disability Determination Service
P. O. Box 1271
Jackson, MS 39205

At the time the Regional Office submits the medical information folder to DDS for a disability decision, whether it is an initial submission or a resubmission, the worker will set a tickler for 75 days. If the Regional Office has not received a disability decision within 75 days or if any problem occurs pertaining to the medical decision, the Supervisor should mail a copy of the DOM-325 to the State Office. The State Office will in turn contact DDS.

3. Receipt of the DDS Decision and Reevaluations

DDS will return the medical information file and a disability or blindness decision to the Regional Office. The decision will be recorded on the lower portion of DOM-325. Any 325 that does not have a physician's signature should have a physician's rating referenced in the "Remarks" section. DDS will attach this cross-referenced documentation to the 325. Each Regional Office will make sure DDS sends all relevant material for a decision. When Disability Determination Services sends an approved DOM-325, the need for a re-exam and date is indicated. If no re-exam is needed, the DOM-325 is valid indefinitely or until the recipient is determined "no longer disabled". If a re-exam date is given, the DOM-325 is valid until that re-exam date. The valid DOM-325 can be used for reapplications when the closure was due to a reason other than disability. Note: Do not send a case in for reevaluation prior to the date specified by DDS in item 15 on DOM-325. The worker must set a tickler for a date prior to the due date to ensure the medical information is resubmitted following the procedure outlined above on the specified due date.

Upon receipt of the decision from DDS, the Regional Office will initiate appropriate action on the case and notify the applicant of the decision regarding his eligibility.

Note: SSI retro approvals for the retroactive period yet denied ongoing SSI benefits due to a medical denial must be submitted to the State Office for review. The case will be resubmitted to DDS for an explanation.

4. DDS Telephone Numbers

The DDS toll free # is 1-800-962-2230.
The local DDS # is 853-5100.

5. **SSI Temporary Closures**

Cases that are SSI eligible but terminate up to once per quarter (usually due to earned income in a 5-week month) and are then reinstated as SSI are referred to as "ping-pong" cases. The individual can apply for MAO coverage during these missing SSI months by filing a separate MAO application. If a DDS decision is required in these types of cases, the initial DDS decision remains valid during the intervening SSI months of eligibility unless a re-exam is specified by DDS.

NONFINANCIAL ELIGIBILITY FACTORS
CITIZENSHIP/ALIEN ELIGIBILITY

A. CITIZENSHIP

An eligible individual must be a resident of the United States and a citizen of the United States or a qualified alien as discussed below.

For purposes of qualifying as a United States citizen, the United States as defined in the Immigration and Nationality Act includes the 50 States, the District of Columbia, Puerto Rico, Guam, Virgin Islands, and the Northern Mariana Islands. Nationals from American Samoa or Swain's Island are also regarded as United States citizens for purposes of Medicaid.

Effective 02/27/01, the Child Citizenship Act of 2000 (HR 2883) amended the Immigration and Nationality Act to grant automatic citizenship to children born abroad who are: (1) under 18 years of age; (2) admitted to the U. S. as a lawful permanent resident; and, (3) in the legal and physical custody of at least one parent who is a U. S. citizen. Under this Act, children adopted from abroad by U. S. citizens receive the same treatment as children born abroad to U. S. citizens.

1. Verification of Citizenship

Citizens and nationals who apply for Medicaid must provide Medicaid with documentation of citizenship and sign a declaration under penalty of perjury that the applicant is a citizen or national (or qualified alien). This statement is included on the Application for Medicaid. Citizenship must be verified only at the time of application (do not reverify at redetermination).

2. Acceptable Documentation

The following are examples of acceptable documentation of U.S. citizenship for all Medicaid applicants.

- Birth certificate showing birth in the U.S. If a birth certificate is available, it must be provided as the preferred method of verification,

- Religious record of birth recorded in the United States or its territories within 3 months of birth, which indicates a U.S. place of birth. The document must show either the date of birth or individual's age at the time the record was made

- United States passport (not limited passports, which are issued for periods of less than 5 years)

- Report of Birth Abroad of a Citizen of the U.S. (Form FS-240)

- Certification of Birth (INS Form FS-545)

- U.S. Citizen I. D. Card (INS Form I-197)

- Naturalization Certificate (INS Forms N-550 or N-570)

- Certificate of Citizenship (INS Forms N-560 or N-561)

- Northern Mariana Identification Card (issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before 11/03/86)

- American Indian Card with a classification code "KIC" and a statement on the back (issued by the INS to identify U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border)

- Contemporaneous hospital record of birth in one of the 50 States, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam (on or after April 10, 1899), the U.S. Virgin Island (on or after January 17, 1917), American Somoa, Swain's Island, or the Northern Mariana Islands (unless the person was born to foreign diplomats residing in such a jurisdiction).

3. Liberalized Citizenship Verification

Effective 08/01/98, the following liberalized verifications are allowable:

1. Obtain a birth certificate showing birth in the U. S. only if one is in their possession. Do not require that a birth certificate be obtained from the Bureau of Vital Statistics.

2. Use prior receipt of SSI as citizenship verification. The SSA obtains a birth certificate or other birth verification on all SSI recipients. We will not require a separate verification of citizenship if prior SSI eligibility can be documented for our record.

3. If an applicant or recipient receives Title II benefits on their own number (A), accept this as verification of citizenship. The SSA obtains a birth certificate or other birth verification for their records. We will not require a separate verification of citizenship for those who receive benefits on their own record, either alone or in a dual entitlement case.

4. If item 1, 2 or 3 is not available, accept a secondary verification such as a child's birth certificate or other document that shows the recipient's place of birth.

Document on the DOM-367 regarding the method used to verify citizenship.

4. Exemption for Certain Non-Citizen Indians

Noncitizen members of Federally recognized Indian tribes, and certain American Indians born in Canada are treated as though they are U.S. citizens, as mandated by the Balanced Budget Act of 1997 (P.L. 105-33). Canadian born Indians with "one-half American Indian blood" are considered in this group. Also, non-citizen members of a Federally-recognized Indian tribe (determined by the Bureau of Indian Affairs) are exempted from citizenship requirements. Tribal membership must be confirmed by a tribal membership card or other tribal document confirming membership.

NONFINANCIAL ELIGIBILITY FACTORS
CITIZENSHIP/ALIEN ELIGIBILITY

B. ALIEN ELIGIBILITY

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P. L. 104-193) changed Medicaid eligibility for individuals who are not citizens of the United States. Medicaid must be provided to eligible citizens or nationals of the United States. Individuals who meet the eligibility requirements of Medicaid but are not citizens or nationals of the United States are Medicaid eligible based on whether the alien is a qualified or non-qualified alien. Non-qualified aliens may be eligible to receive treatment for an emergency medical condition as defined in "Emergency Medicaid Services For Aliens."

The Balanced Budget Act (BBA) of 1997 (P.L. 105-33) mandated additional categories of eligible aliens, permitted longer periods of Medicaid eligibility for certain categories of aliens, and provided that most aliens receiving Medicaid on August 22, 1996, will be "grandfathered" and allowed to have Medicaid benefits continued provided all other eligibility requirements are met.

1. Grandfathered Aliens (Receiving Benefits on 08/22/96) Mandated by BBA of 1997

Aliens who received Medicaid benefits on 08/22/96 and who are lawfully residing in the U.S. will remain eligible for Medicaid provided they meet all other Medicaid eligibility requirements. These aliens are referred to as "grandfathered aliens." These aliens remain eligible under alien policy in effect before 08/22/96.

A grandfathered alien retains his/her grandfathering rights if benefits terminate but are later reestablished.

2. Qualified Aliens

To be eligible for Medicaid under federal statutes, an alien who was not receiving Medicaid on 08/22/96 must be both a "Qualified Alien" AND in one of the "Eligible Categories of Qualified Aliens" described in 3. below.

There are 8 qualified alien categories. Seven categories are based on INS alien status and one is based on battery or extreme cruelty and INS alien status.

A "Qualified Alien" based on alien status is an alien who, at the time of application for a Federal public benefit, is:

- lawfully admitted for permanent residence in the U.S. under the INA (Immigration and Nationality Act),

- a refugee admitted to the U. S. under section 207 of the INA,

- granted asylum under section 208 of the INA,

- paroled into the U. S. under section 212(d)(5) of the INA for a period of at least 1 year,

- an alien whose deportation is being withheld under section 243(h) of the INA or whose removal has been withheld under section 241(b)(3) of the INA,

- granted conditional entry pursuant to section 203(a)(7) of the INA as in effect prior to April 1, 1980,

- an alien who is a Cuban/Haitian entrant under section 501(e) of the Refugee Assistance Act of 1980.

- a qualified alien based on battery or extreme cruelty who meets the following requirements:

  - the alien must not be residing in the same household with the one responsible for the battery, and

  - the alien must be the one battered or the parent of a child who is battered, or a child whose parent has been battered,

- the alien is the beneficiary of a petition for (1) immediate relative status, (2) classification to immigrant status based on relationship to a lawful permanent residence alien, or (3) suspension of deportation and adjustment to lawful permanent residence status.

3. Eligible Categories of Qualified Aliens

Qualified aliens are eligible only if they also meet one or more of the following additional requirements. Aliens who are qualified solely based on battery or extreme cruelty are eligible only if they also meet one of the categories related to veterans and active duty military.

a. Refugee

A qualified alien who was admitted to the U.S. as a refugee under section 207 of the INA may be eligible for 7 years after the date of admission, even if his/her immigration status has changed.

b. Asylee

A qualified alien who was granted asylum under section 208 of the INA may be eligible for 7 years after the date asylum is granted, even if his/her immigration status has changed.

c. Deportation or Removal Withheld

A qualified alien whose deportation has been withheld under section 243(h) of the INA (as in effect before 04/01/97) or removal withheld under section 241(b)(3) of the INA (after 03/31/97) may be eligible for 7 years after the date deportation or removal is withheld.

d. Cuban & Haitian Entrants

An alien who is a Cuban/Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980) may be eligible for 7 years after the date Cuban/Haitian entrant status is granted.

e. Aliens Who Are Blind or Disabled and Lawfully Residing in the U.S. on 08/22/96

An alien who was lawfully residing in the U.S. on August 22, 1996, who is blind or disabled, and who is a qualified alien can be eligible for Medicaid benefits, regardless of the alien's age and regardless of whether onset of blindness/disability occurs before, on or after 08/22/96.

If a qualified alien meets this exception, the 7-year time limit on eligibility **does not apply.**

f. Lawfully Admitted to the U.S. for Permanent Residence (LAPR)

(1) Aliens who enter the U.S. on or after 08/22/96 and have lived in the U.S. at least 5 years in any qualified alien status since the date of entry (or date qualified alien status was granted, if later), AND

(2) Who has, or can be credited with, 40 Qualifying Quarters (QQ's) of Earnings under Social Security law.

g. LAPR Aliens Admitted As Amerasian Immigrants

Lawfully admitted aliens who were admitted to the United States within the last 7 years as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as contained in section 101(e) of Public Law 100-202 and amended by the 9th proviso under "Migration and Refugee Assistance" in title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1989, Public Law 100-461, as amended.

Eligibility is limited to the 7 year period.

h. Veteran

A qualified alien who is a veteran of the Armed Forces of the U.S. may be eligible if he/she lawfully resides in Mississippi and is a veteran (as defined in section 101,1101, or 1301, or as described in section 107 of title 38, Unites States Code) who received a discharge characterized as honorable and not on account of alienage, and who fulfills the minimum active-duty service requirements of section 5303A(d) of title 38, USC.

If a qualified alien meets this exception, the 7-year time limit on eligibility **does not apply.**

i. Active Duty Military

A qualified alien who is an active duty member of the Armed Forces of the U.S., and who is not on active duty for training purposes only, may be eligible.

If a qualified alien meets this exception, the 7-year time limit on eligibility **does not apply.**

j. Spouse of a Veteran or Active Duty Military Personnel

A qualified alien who is the spouse of a veteran or an active duty member of the Armed Forces may be eligible. An unremarried surviving spouse of a deceased veteran may also be eligible if the marriage fulfills the requirements of section 1304 of title 38, USC. This does not include divorced spouses.

If a qualified alien meets this exception, the 7-year time limit on eligibility **does not apply.**

k. Child of a Veteran or Active Duty Military Personnel

A qualified alien who is the unmarried dependent child (biological, legally adopted or stepchild) of a veteran or an active duty member of the Armed Forces may be eligible. A child of a deceased veteran may also be eligible if he/she was a dependent child of the veteran at the time of the veteran's death.

If a qualified alien meets this exception, the 7-year time limit on eligibility **does not apply.**

4. Loss of Eligibility Due to Alien Status Change

The following circumstances will result in the loss of Medicaid eligibility:

- Change in Alien Status - INS can rescind an alien's status, not renew a time-limited status, or adjust the alien's status. A qualified alien in an eligible category who ceases to meet those requirements because of a change in alien status will lose Medicaid eligibility the month after the month the change occurs.

- Separation From the Armed Forces - a qualified alien who is eligible based on active military duty by the alien, alien's spouse or alien's parent will lose eligibility if the discharge is not honorable or is based on alienage.

- Change in Status of Spouse of Veteran or Active Duty Military Member - eligibility as a spouse ends the month after the month of divorce or remarriage of a surviving spouse.

- Change in Status of Unmarried Dependent Child of Veteran or Active Duty Military Member - eligibility as a dependent child ends the month after the month the child marries or is no longer "dependent."

- Battered Alien and Battered Resume Living in Same Household - eligibility of a "battered" alien ends the month after the month the two resume living together.

5. Time Limited Eligibility of Certain Aliens

Aliens in "time-limited" status of refugee, asylee, deportation withheld, a Cuban/Haitian entrant and an Amerasian immigrant may adjust to another "qualified alien" status during the 7-year period; however, eligibility in the time-limited status will continue for the 7-year period (provided all factors of eligibility continue to be met).

At the end of the 7-year period, eligibility can continue if the status has changed to a non-time limited status, i.e., LAPR, and the alien meets an eligible category of qualified aliens. For example, the alien is LAPR with 40 QQ's of coverage under Social Security or the alien is a spouse of a veteran, etc.

Otherwise, eligibility in a time-limited category ends with the first month after the 7th anniversary of admission.

6. Non-Qualified Aliens

Non-qualified aliens do not meet the requirements of "Qualified Aliens". If otherwise eligible for Medicaid, a non-qualified alien is eligible only for treatment of emergency medical conditions. These aliens must provide their SSN(s) if available or apply for an SSN if the applicant does not have one. It is not necessary to verify the alien status of non-qualified aliens through SAVE.

7. Illegal Aliens

The term "non-qualified alien" also includes illegal aliens. These aliens either were never legally admitted to the United States for any period of time or were admitted for a limited period of time and did not leave the United States when the period of time expired. These individuals, if they are otherwise eligible for Medicaid, may be eligible for Medicaid for treatment of any emergency medical condition. However, unlike other non-qualified aliens, they are not issued SSNs. Therefore, such aliens do not have to provide an SSN.

8. Ineligible Aliens

Some aliens may be lawfully admitted to the United States but only for a temporary or specified period of time as legal non-immigrants. These aliens are never qualified aliens. However, in some cases an alien in a currently valid non-immigrant classification may meet the State residence rules. When this is the case, such an alien is eligible for Medicaid for the treatment of emergency medical conditions if the individual meets the other eligibility criteria of an MAO coverage group. Such individuals may possess valid employment authorization documents (Form I-688B or Form I-766).

Among otherwise ineligible aliens are visitors, tourists, some workers, and diplomats who are currently lawfully admitted as legal non-immigrants. These aliens would have the following types of INS 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; or Form I-95A, Crewman's Landing Permit. These aliens are not eligible for Medicaid because of the temporary nature of their admission status. The following categories of individuals are ineligible aliens:

- Foreign government representatives on official business and their families and servants,

- Visitors for business or pleasure, including exchange visitors,

- Aliens in travel status while traveling directly through the U.S.,

- Crewman on shore leave,

- Treaty traders and investors and their families,

- Foreign students,

- International organization representation and personnel and their families and servants,

- Temporary workers including agricultural contract workers, and

- Members of foreign press, radio, film or other information media and their families.

C. DOCUMENTATION & VERIFICATION OF ALIEN STATUS

All non-citizen applicants for Medicaid who declare they are qualified aliens must provide Immigration and Naturalization Service (INA) documents to establish immigration status. Noncitizens must also sign a declaration under penalty of perjury that the applicant is a qualified alien. This statement is included on the Application for Medicaid.

If the alien does not provide requested INS documentation, eligibility must be denied. If the alien does provide INS documentation, the INS documents must be verified with the INS using SAVE (described below).

1. INS Documentation That Alien is a Qualified Alien

Lawful Permanent Resident--INS Form I-551, or for recent arrivals, a temporary I-551 stamp in a foreign passport or on Form I-94.

NOTE: Expired or Absent Documentation: If an applicant presents an expired INS document or is unable to present any document demonstrating his or her immigration status, refer the person to the local INS district office to obtain evidence of status unless he or she can provide alien registration number. If the applicant provides an alien registration number, refer all information the State Office to verify alien status using SAVE.

Refugees--INS Form I-94 annotated with stamp showing entry as refugee under section 207 of the INA and date of entry to the United States; INS Forms I-688B annotated "274a.12(a)(3)", I-766 annotated "A3", or I-571. Refugees usually adjust to Lawful Permanent Resident status after 12 months in the U.S. But for purposes of establishing eligibility are still considered refugees. Therefore, check the coding on Form I-551 for codes RE-6, RE-7, RE-8, or RE-9.

Asylees--INS Form I-94 annotated with stamp showing grant of asylum under section 208 of the INA; a grant letter from the Asylum Office of the INS; Forms I-688B annotated "274a.12(a)(5)" or I-766 annotated "A5".

An alien who has had deportation or removal withheld under section 243(h) as in effect prior to April 1, 1997 or removal withheld under section 241(b)(3). Derive date deportation or removal withheld from date of court order from Immigration Judge; or INS Forms I-688B annotated "274a.12(a)(10)" or I-766 annotated "A10".

Cuban/Haitian entrants - Obtain a Form I-94 with a stamp showing parole as "Cuban/Haitian Entrant" under section 212(d)(5) of the INA.

Amerasian Immigrants - Obtain the immigrants Form I-551 with the code AM1, AM2 or AM3 or passport stamped with an unexpired temporary I-551 showing a code AM6, AM7 or AM8.

2. Determining 7-Year Limit

Determine 7-year limitation as follows:

- Form I-94, the date of admission should be found on the refugee stamp. If missing, refer the information to State Office to contact INS to verify the date of admission.

- If an alien presents INS Forms I-688B (Employment Authorization Document), I-766, or I-571 (refugee travel document), ask the alien to present Form I-94. If not available, refer the information to State Office to contact INS.

- If an alien presents a grant letter or court order, derive date status granted from the date of the letter or court order. If missing, refer the information to State Office to contact INS.

In general, if an applicant presents a receipt indicating that he or she has applied to INS for a replacement document for one of the documents identified above, refer the information to State Office for referral to INS. INS must be contacted at any time if there is any reason to question the authenticity of a document presented or the information on the document is insufficient to determine whether the alien status requirements are met.

3. **Evidence of Honorable Discharge or Active Duty Status**

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

- For discharge status, an original, or notarized copy, of the veteran's discharge papers issued by the branch of service in which the applicant was a member;

- For active duty military status, an original, or notarized copy, of the applicant's current orders showing the individual is on full-time duty in the U.S. Army, Navy, Air Force, Marine Corps, or Coast Guard (full-time National Guard duty is excluded), or a military identification card (DD Form 2 (active));

- Other documentation acceptable under Department of Defense or VA.

4. **Qualifying Quarters (QQ's) of Coverage Under Social Security Law**

A lawfully admitted permanent resident who enters the U.S. on or after 08/22/96 cannot be eligible based on having 40 qualifying quarters (QQ's) of coverage for a 5 year period beginning on the alien's date of entry into the U.S. as a qualified alien. A lawfully admitted permanent resident must have or be credited with 40 QQ's to meet the eligibility requirements for this category.

A qualifying quarter means a quarter of coverage that is credited for covered and/or noncovered earnings for the purpose of determining eligibility for a LAPR alien, and/or,

- All the qualifying quarters worked by the spouse of such alien during their marriage and the alien remains married to such spouse or such spouse is deceased, and

- All of the qualifying quarters worked by a parent of such alien while the alien was under age 18.

Any quarter of coverage, beginning after December 31, 1996, in which the alien or spouse or parent of the alien applicant received any Federal means tested public benefit (SSI, Medicaid, Food Stamps and/or TANF) cannot be credited to the alien for purposes of meeting the 40-quarter requirement for eligibility for Medicaid.

QQ's will be verified via SVES in the near future; however, until this feature is available in SVES it will be necessary to verify through SSA contact whether or not 40 QQ's are credited to the alien.

NONFINANCIAL ELIGIBILITY FACTORS
CITIZENSHIP/ALIEN ELIGIBILITY

D. CHART OF ALIEN STATUS & POTENTIAL ELIGIBILITY

If the individual is:	**Then he/she is:**
U. S. citizen or national or American Indian born in Canada or member of federally recognized Indian tribe.	always potentially eligible
lawfully admitted permanent resident	potentially eligible only if: - lawfully residing in the U.S. on 08/22/96 and is blind or disabled, or - meets 40 QQ's requirement, or - entered U.S. as Cuban/Haitian entrant within last 7 years, or - entered U.S. as an Amerasian immigrant within last 7 years, or - entered U.S. as refugee within last 7 years, or - granted status as asylee or deportation withheld within last 7 years, or - veteran/active duty military, or - spouse/dependent child of living or deceased veteran/military member. - **5-year ban for those entering U.S. on or after 08/22/96**

NONFINANCIAL ELIGIBILITY FACTORS
CITIZENSHIP/ALIEN ELIGIBILITY

If the individual is:	Then he/she is:
refugee (Section 207)	potentially eligible only if: - entered U.S. within last 7 years, or - veteran/active duty military, or - spouse/dependent child of living or deceased veteran/military member, or - lawfully residing in U.S. on 08/22/96 and is blind or disabled.
asylee (Section 208)	potentially eligible only if: - granted asylum within last 7 years, or - veteran/active duty military, or - spouse/dependent child of living or deceased veteran/military member, or - lawfully residing in U.S. on 08/22/96 and is blind or disabled.
deportation withheld (Section 243(h)) or removal withheld (section 241(b)(3) after 03/31/97)	potentially eligible only if: - granted status within last 7 years, or - veteran/active duty military, or - spouse/dependent child of living or deceased veteran/military member, or - lawfully residing in U.S. on 08/22/96 and is blind or disabled.

NONFINANCIAL ELIGIBILITY FACTORS
CITIZENSHIP/ALIEN ELIGIBILITY

If the individual is:	Then he/she is:
Amerasian immigrant	potentially eligible only if: - admitted in immigrant status within last 7 years, or - veteran/active duty military, or - spouse/dependent child of living or deceased veteran/military member, or - individual is blind or disabled and was lawfully residing in the U.S. on 08/22/96
Cuban and Haitian entrant	potentially eligible only if: - granted status within last 7 years, or - veteran/active duty military, or - spouse/dependent child of living or deceased veteran/military member or - individual is blind or disabled and was lawfully residing in the U.S. on 08/22/96
parolee (sec.212(d)(5)) (status granted for one year minimum)	potentially eligible only if: - veteran/active duty military, or - spouse/dependent child of living or deceased veteran/military member, or - individual is blind or disabled and was lawfully residing in the U.S. on 08/22/96

NONFINANCIAL ELIGIBILITY FACTORS
CITIZENSHIP/ALIEN ELIGIBILITY

If the individual is:	Then he/she is:
battered spouse or child	potentially eligible only if: - veteran/active duty military, or - spouse/dependent child of living or deceased veteran/military member, or - individual is blind or disabled and was lawfully residing in the U.S. on 08/22/96
other status	ineligible except for Emergency Services

E. THE SAVE SYSTEM

Beginning October 1, 1988, State Medicaid agencies must verify with the Immigration Naturalization Service (INS) the immigration status of all alien applicants for benefits. INS verification is established through the "Systematic Alien Verification for Entitlements" (SAVE) Program. The statutory basis for this requirement is section 121 of the Immigration Reform and Control Act of 1986 (P. L. 99-603).

Mississippi has not implemented the automated portion of SAVE since so few aliens apply for assistance. Instead, the SAVE system is accessed by secondary verification procedures. This consists of the use of an INS G-845 Form submitted to INS for verification of alien status. Photocopies of original immigration documentation provided by the applicant must accompany the form submitted to INS.

The procedure for verifying the status of all aliens who apply for Medicaid is as follows:

- Request that the alien produce immigration documents provided by INS that reflects his/her alien status.

- Photocopy the INS document (both front and back of document) and submit the photocopy to the State Office Eligibility Division.

- If the alien alleges to be a legal alien and has the appropriate INS identification, proceed with determining eligibility on all factors.

State Office will:

- Submit the G-845 Form to INS for verification and respond to any additional questions the INS may want answered.

- Notify the Regional Office when the alien verification process is complete.

Once an applicant's alien status has been verified by INS, it is not necessary to reverify status at the time of redetermination unless the individual is not in lawful permanent residence status. In this case, the Regional Office will be advised to resubmit the alien's INS documentation at the appropriate time.

F. EMERGENCY MEDICAID SERVICES FOR ALIENS

Non-qualified aliens, illegal aliens and ineligible aliens who meet the residence and all other financial/non-financial eligibility criteria (except alien status) of a full-service MAO coverage group will be eligible for Medicaid only for treatment of medical conditions meeting the following definition:

- Such care and services are necessary for the treatment of an emergency medical condition of the alien provided such care and services are not related to either an organ transplant procedure or routine prenatal or post-partum care; and

- The alien has, after sudden onset, a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

    - Placing the patient's health in serious jeopardy,

    - Serious impairment to bodily functions, or

    - Serious dysfunction of any bodily organ or part.

If an inquiry and application is filed in the Regional Office and the only factor of ineligibility is citizenship, the case must be referred to the State Office Eligibility Division for handling. It will be the Regional Office's responsibility to determine eligibility on all factors other than citizenship for any available full service MAO coverage group, including MAO groups normally handled by DHS. The State Office will handle the eligibility input into the system. When the eligibility determination is finalized, refer the case to State Office for notification to the alien and input of eligibility dates.

NONFINANCIAL ELIGIBILITY FACTORS

STATE RESIDENCE

A. STATE RESIDENCE REQUIREMENTS (42 CFR 435.403)

An eligible individual must be a resident of the State of Mississippi. A resident is someone who is:

- voluntarily living in Mississippi with the intention to remain permanently or for an indefinite period; or
- living in Mississippi having entered with a job commitment or for the purpose of seeking employment (whether or not currently employed).

1. Intent to Reside

Residence is based on the concept of intent to reside. An individual must be capable of indicating intent. An individual would be considered incapable of stating intent if the individual:

- Has an IQ of 49 or less or has a mental age of 7 or less on tests acceptable to the Department of Education; or,
- Is judged legally incompetent; or,
- Is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist, or other person licensed by the State in the field of mental retardation.

2. Exceptions

To determine whether an applicant is a resident of Mississippi or whether a recipient continues to be a resident of Mississippi, apply one of the rules listed below based on the client's age and living arrangement. The exception to the rules listed below are as follows:

- An individual who is receiving a state supplementary payment (optional or mandatory) is considered a resident of the state making the payment.
- For individuals of any age who are receiving Federal payments for foster care under title IV-E and individuals with respect to whom there is an adoption assistance agreement in effect under title IV-E, the state of residence is the state where the individual is living.

NONFINANCIAL ELIGIBILITY FACTORS
STATE RESIDENCE

3. **Individuals Under Age 21**

For any individual who is emancipated from his/her parents or who is married and capable of stating intent, the state of residence is the state where the individual is living with the intention to remain permanently or for an indefinite period.

For any individual in a private living arrangement whose Medicaid eligibility is based on blindness or disability, the state of residence is the state in which the individual is living.

For any institutionalized individual who is neither married nor emancipated, the state of residence is:

a. The parent's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent); or,

b. The current state of residence of the parent who files the application if the individual is institutionalized in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian who files the application is used); or,

c. The state of residence of the individual or party who files an application is used if the individual has been abandoned by his/her parent(s), does not have a legal guardian and is institutionalized in that state.

4. **Individuals Age 21 and Over - In a Private Living Arrangement**

For any individual in this category the state of residence is the state where the individual is living with the intention to remain permanently or for an indefinite period or the state where the individual is living which the individual entered with a job commitment or seeking employment (whether or not currently employed).

If the individual in this category is incapable of stating intent, the state of residence is the state where the individual is living.

NONFINANCIAL ELIGIBILITY FACTORS
STATE RESIDENCE

5. **Individuals Age 21 and Over - In Institutions**

For an institutionalized individual who became incapable of indicating intent before age 21, the state of residence is:

a. That of the parent applying for Medicaid on the individual's behalf (if the parents reside in separate states). If a legal guardian has been appointed, the state of residence of the guardian is used; or,

b. The parent's state of residence at the time of placement (or if a legal guardian has been appointed, the state of residence of the guardian is used); or,

c. The current state of residence of the parent who files the application if the individual is institutionalized in that state (or if a legal guardian has been appointed, the state of residence of the guardian is used); or,

d. The state of residence of the individual or party who files an application is used if the individual has been abandoned by his/her parent(s), does not have a legal guardian and is institutionalized in that state.

For any institutionalized individual who became incapable of indicating intent at or after age 21, the state of residence is the state in which the individual is physically present, except where another states makes a placement. A state agency that arranges for an individual to be placed in an institution located in another state is recognized as acting on behalf of the state in making a placement. The state arranging or actually making the placement is considered as the individual's state of residence.

For any other institutionalized individual, the state of residence is the state where the individual is living with the intention to remain there permanently or for an indefinite period.

B. DURATIONAL REQUIREMENTS PROHIBITED

Medicaid eligibility may not be denied because an individual has not resided in Mississippi for a specified period or because the individual did not establish residence in Mississippi before entering an institution. An individual determined to be a resident of Mississippi as set forth in one of the residency rules established above must have eligibility determined as a Mississippi resident.

1. Temporary Absence

A resident of Mississippi does not lose residency due to temporary absence from the State. Medicaid eligibility may not be denied or terminated because of an individual's temporary absence from the State if the person intends to return when the purpose of the absence has been accomplished, unless another state has determined that the individual is a resident there for purposes of Medicaid.

A Medicaid recipient is responsible for reporting his absence from Mississippi and for giving information as to his purpose, plans, dates of departure, and return.

For the recipient who does not notify the agency of his departure, an attempt will be made to determine the address in the other state so that information can be secured from the recipient regarding whether his absence is temporary in nature, its purpose, and date of return.

No limit is placed on the length of an out-of-state visit, but the recipient's eligibility must be reviewed every three (3) months to determine the recipient's intent of residence and necessary action taken on the case as a result of the eligibility determination.

The recipient who leaves the State with no declared intent to return is determined to have given up his Mississippi residency and his case is closed after advance notice. (If a recipient's whereabouts are unknown, advance notice is not required as specified in Section C, "Exceptions to Advance Notice.")

2. Homeless Eligibility

The Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) specified that states are prohibited from posing any residence requirements which excludes from Medicaid any qualified individual who resides in the State, regardless of whether the residence is maintained permanently or at a fixed address. In other words, a "homeless" individual or one who frequently moves from one address to another can qualify for Medicaid if otherwise eligible.

In addition, Medicaid cards must be made available to individuals with no fixed home or mailing address. This can be accomplished by having the card mailed to a specific shelter or similar facility or to the Regional Medicaid Office or county Human Services Office. Whatever method works best for the Medicaid recipient and is agreeable to the agency or group receiving the card is permissible. The recipient should be advised of the time and place that the card will be available.

C. DISPUTED RESIDENCY

Where two or more states cannot resolve which state is the state of residence, the state where the individual is physically located is the state of residence.

NONFINANCIAL ELIGIBILITY FACTORS
UTILIZATION OF OTHER BENEFITS

A. REQUIREMENT TO APPLY (42 CFR 435.603)

As a condition of eligibility, an applicant or recipient must take all necessary steps to obtain any annuities, pensions, retirement and disability benefits to which they are entitled, as explained below:

1. Other Program Benefits

An individual must apply for another benefit if the other benefit is classified as:

- an annuity or pension, such as private employer pensions, Civil Service pensions, union pensions, Railroad Retirement annuities and pensions, municipal, county or State retirement benefits;
- Social Security retirement, survivors and disability insurance benefits, early retirement at age 62;
- retirement or disability benefits, including veterans' pensions and compensation (VA Aid & Attendance benefits are not a required benefit under this provision);
- Worker's Compensation payments;
- Unemployment Insurance benefits.

An individual potentially eligible for the types of benefits listed above must take all appropriate steps to apply for the benefit(s), and if eligible, accept payment regardless of the impact acceptance will have on Medicaid eligibility. The exception to this rule is that an individual is not required to accept another benefit if the resulting payment would be a reduction in current benefits payable (excluding Medicaid benefits). Election of a lower benefit when the individual has an option between a high or low benefit will result in denial or less of eligibility.

NONFINANCIAL ELIGIBILITY FACTORS
UTILIZATION OF OTHER BENEFITS

2. Exempt Other Program Benefits

Types of other benefits exempt from the filing requirements are:

- Aid to Families With Dependent Children (AFDC),
- General Public Assistance
- Bureau of Indian Affairs General Assistance,
- Victims' Compensation payments,
- Other Federal, State, local or private programs which make payments based on need,
- Earned Income Tax Credits.

3. Applying the Provision

The utilization of other benefits requirement is applicable at the time of application as well as throughout the time a client receives Medicaid. Applicants, recipients, and the Medicaid agency assume responsibilities in connection with this provision of the law. It is the client's responsibility to supply information about possible eligibility for some other benefit, to file for such benefits when informed by the Medicaid Regional Office of potential eligibility for these benefits, and pursue such benefits. It is the Regional Office's responsibility to judge the likelihood of such eligibility and inform the client in writing of the possible eligibility for other benefits. The client's pursuit of other benefits to award or denial must be documented in the case record.

4. Ineligible and Community Spouses Exempt

The requirement to apply for other benefits applies only to the eligible individual (applicant or recipient). It does not apply to an ineligible spouse or a community spouse (who is ineligible).

5. Lump Sum or Annuity

When a client can choose payment of an "other benefit" as a lump sum or an annuity, advise him/her that he/she must choose the annuity. A one-time total withdrawal of pension plan funds in this situation does not comply with the statutory requirements that mandate application for the annuity or pension (i.e., money payment at some regular interval)

With the focus on maximizing the use of other benefits to provide ongoing benefits, recommend conversion of lump-sum applications in appropriate situations.

NONFINANCIAL ELIGIBILITY FACTORS
UTILIZATION OF OTHER BENEFITS

B. DETERMINATION OF POTENTIAL ELIGIBILITY FOR OTHER BENEFITS

The Regional Office has the responsibility for determining the likelihood of potential eligibility for other benefits, providing the written notice and referral to the proper agency, and assisting the individual, as necessary, in complying with the requirements that he or she file for certain other benefits. Awareness of potential eligibility for other benefits is elicited from:

- Responses to lead questions on DOM-300/DOM-300A
- Information received from the initial interview;
- Inquiries with other agencies; and,
- Knowledge of governmental and private pension plans and disability programs.

If the Regional Office determines that an application for other benefits would not be beneficial, e.g., proof exists of a prior denial and there has been no change in circumstances, do not require the individual to apply for such benefits. The case record must be documented with the reason for the decision not to refer a client to file for other benefits.

If there is doubt about the possibility of eligibility in a given case, the worker should try to resolve the matter by means of a telephone call or written inquiry to the agency or organization involved. If the issue of potential eligibility is still uncertain, notify the individual of the potential eligibility as outlined below.

1. General

A client may be eligible for more than one type of benefit so care must be taken to identify all potential sources of benefits.

NONFINANCIAL ELIGIBILITY FACTORS
UTILIZATION OF OTHER BENEFITS

2. Social Security/ Railroad Retirement Benefits

Any client who is not already receiving Social Security or Railroad Retirement benefits at the time of application must be referred to apply for either retirement benefits (including early retirement), disability benefits (if under age 65) or survivor's benefits (if a widow(er) or disabled child of a deceased parent). The case record must be documented as to why no benefits are payable if none are awarded.

3. Workers' Compensation Payments

If a client alleges either injury on the job or has what may be may be a work-related impairment, refer the client to apply for such benefits.

4. Veterans' Benefits

Explore the possibility of entitlement to VA benefits if a client is a veteran, the child or spouse of a veteran, a widow(er) or previous spouse of a veteran or the parent of a veteran who died from service connected causes.

5. Private Sector

Explore entitlement for benefits if the client or former/deceased spouse worked for a private employer with a pension plan and is not already receiving or has not received a pension based on that employment.

6. Public Sector

Explore entitlement for benefits if the client or former/deceased spouse (or deceased parent if client is a child) is not already receiving or has not received a pension based on such employment and was employed in one of the following:

a. Federal Civilian Employment for a minimum of 5 years,

b. Federal Uniformed Service (Military) for a minimum of 20 years,

c. State or Local Government Employment.

C. NOTIFICATION REQUIREMENTS

Upon a determination of potential eligibility for another benefit, the worker must furnish the individual a dated written notice explaining the individual's responsibility to apply within 30 days of the notice. DOM-307, Request for Information, will be used to inform the individual of the following:

- The type of benefit for which he/she may be eligible;
- The organization or agency where the application is filed;
- That the individual has 30 days from the date shown on the DOM-307 in which to file application for the potential benefit; and,
- That the individual must provide evidence to the Regional Office that application has been filed.

List the information specified above on DOM-307 and set a tickler for 30 days at which time the client will be contact by use of DOM-309, Second Request for Information, if the client has not already provided evidence within the 30 days that application has been filed. The DOM-309 allows an additional 10 days for the client to provide evidence. If the client has no evidence to present which documents application has been filed, the worker will contact the agency in question to determine whether an application has been filed and the usual processing time involved for the application in question.

NONFINANCIAL ELIGIBILITY FACTORS
UTILIZATION OF OTHER BENEFITS

If application for other benefit(s) is filed within the allowable 30 days, eligibility for Medicaid will continue or an application may be approved while the application is in process for the other benefits. A tickler will be set for the end of the usual processing time for the application for the other benefit(s) so that the worker can contact the individual and/or agency to determine the final decision. The Regional Office must keep a control in this fashion to make a determination at any point in time as to whether the individual has taken all appropriate steps in prosecuting his/her claim for other benefits.

As soon as the Regional Office is notified of the final decision, the case record must be documented with the decision. The individual should receive written notice explaining the decision which should be obtained and photocopied for the case record. If the worker contacts the agency to determine the final decision, document the case record accordingly. Appropriate action will then be taken by the worker to determine the effect the decision has on Medicaid eligibility. If approved for the other benefit, the payment must be included in the budgeting procedure and the client notified of the resulting effect on Medicaid eligibility.

D. FAILURE TO COMPLY AND GOOD CAUSE

The agency must require clients to take all necessary and appropriate steps to obtain "other" benefits, unless good cause can be shown for not doing so. A denial or dismissal of the claim for other benefits because of the failure of the individual to submit requested verification does not satisfy the fulfillment of the requirement to apply.

Good cause for not applying for other benefits may be found to exist if the individual does not apply due to:

1. illness (and there is no authorized representative to apply in the client's behalf); or,

2. the individual previously applied and was denied and the reason for the denial has not changed; or,

3. the individual was unaware of the availability of a benefit and the agency did not advise him/her of its availability.

If good cause does not exist for the failure on the individual's part to take all appropriate steps to obtain an "other" benefit, the worker will take action to deny or terminate Medicaid benefits until such time as the requirement is fulfilled. Agreement to comply with the requirement does not negate any prior action to deny or terminate benefits. The effective month of establishing eligibility is the month in which the individual takes the steps necessary to obtain benefits from the other agency.

NONFINANCIAL ELIGIBILITY FACTORS
USE OF SOCIAL SECURITY NUMBERS

A. SSN REQUIREMENT (42 CFR 435.910)

The Division of Medicaid must require, as a condition of eligibility, that each individual (including children requesting Medicaid benefits furnish each of his/her Social Security Number(s) (SSNs). The statutory requirement to furnish SSNs for Medicaid purposes is found in Section 2651 of the Deficit Reduction Act of 1984 (P.L. 98-369). This law amended the Social Security Act, the Food Stamp Act and the Internal Revenue Code for the purpose of enabling and requiring federally funded public assistance agencies and unemployment agencies to make more accurate eligibility determinations and benefit payments by exchanging information with each other via SSNs of clients receiving assistance.

1. Furnishing SSNs

Before eligibility can be established, an applicant/recipient must provide the Regional Office with each of his/her SSNs or proof that an application for an SSN has been filed with SSA. If an applicant has an SSN, request documentation to show that the number(s) belong to the applicant such as the Social Security card or other official document(s) containing the SSN(s). If an applicant cannot furnish Medicaid with his/her SSNs, the applicant must show proof that he/she has applied for an SSN with the Social Security Administration (SSA) before eligibility can be approved. SSA can provide the applicant with a notice confirming that an application has been filed. This documentation will allow eligibility to be established pending receipt of the number. A tickler must then be set for 90 days, at which time the applicant must be contacted regarding receipt of the SSN.

If an applicant or recipient fails to apply for an SSN or fails to furnish the Regional Office with a valid SSN, then the case will be closed after appropriate notice.

2. Verification of SSNs

Verification of the furnished SSN(s) is necessary to ensure that the SSN used for eligibility purposes is for the applicant/recipient. In addition, all furnished SSNs must be verified so that the agency will maintain and exchange information on correct SSNs as outlined in "Use of SSNs" below.

BENDEX, SDX or TPQY processes will be used to verify SSNs.

NONFINANCIAL ELIGIBILITY FACTORS
USE OF SOCIAL SECURITY NUMBERS

B. USE OF SSNs

Applicants and recipients must be advised of the uses the Medicaid Agency will make of each SSN. Form DOM-300 and 300A, Application and Redetermination Forms, contain statements that inform the applicant/recipient or representative that the client's SSN(s) will be computer matched with other agencies to obtain information about income and resources available to the client and that the information will be used in determining the client's eligibility for Medicaid.

Specifically, all SSNs will be matched with the following:

- Employment Security Commission - to obtain data regarding wages and unemployment compensation.

- Social Security Administration (SSA) - to obtain net earnings from self-employment, wage and retirement income information and title II (RSDI) and title XVI (SSI) benefit information.

- Internal Revenue Service (IRS) - to obtain unearned income information (interest, dividends, etc.)

Within 45 days of receipt of an item of information from the sources listed above, the information must be reviewed and compared against the recipient's case record to determine whether it affects eligibility or Medicaid Income (if applicable). If no action is necessary, the case record must be so documented. If the information would result in an adverse action, the worker must obtain independent verification of the income information before taking acting to terminate eligibility or increase Medicaid Income.

Independent verification includes verification of:

- the amount of the income and resource that generated the income involved;

- whether the client actually has (or had) access to the resource or income (or both) for his or her own use;

- the period of time when the individual had access to the income/resource.

NONFINANCIAL ELIGIBILITY FACTORS
ASSIGNMENT OF RIGHTS

A. ASSIGNMENT OF RIGHTS (AOR) REQUIREMENT (42 CFR 435.604)

Applicants and recipients of Medicaid must, as a condition of eligibility, assign to the Medicaid Agency their rights to medical support or other payments for medical care and cooperate with Medicaid in obtaining third party payments. The Statutory requirement for this provision is in the Deficit Reduction Act of 1984 (P. L. 98-369) mandating assignment of rights to payments for medical support and other medical care owed to recipients. Failure to assign rights or cooperate with Medicaid in obtaining third party payments will result in denial or termination of Medicaid benefits after the appropriate advance notice affording the applicant or recipient the right to appeal.

Application and Redetermination Forms contain the mandatory assignment of rights statement in the section of the form requiring the signature of the applicant, recipient or designated representative. An explanation must be provided to applicants or their representatives at the time of the initial interview that by their signature on the DOM-300 Form they are assigning their rights to third party payments for medical care as a condition of eligibility for Medicaid. This requirement must be reaffirmed by the appropriate signature on the DOM-300A Form at each redetermination of eligibility. In addition, Form-TPL 406, Medical Insurance Form must be completed by the applicant/recipient or representative before an application for eligibility or redetermination of eligibility can be approved.

1. Failure to Cooperate

Section 9503(e) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P. L. 99-272) added a new requirement to the assignment of rights provision regarding cooperation. Federal law requires that all Medicaid applicants and recipients must, as a condition of eligibility, cooperate with the Medicaid Agency in identifying, to the extent they are able, potentially liable insurers and other third parties who may be liable to pay for care and services covered by Medicaid. Cooperation also includes repaying any monies to the Medicaid Agency received from a third party source to the extent that Medicaid has paid for the covered service. The

cooperation aspect of the assignment of rights provision is handled by the Third Party Liability (TPL) Unit of the State Medicaid Agency.

An individual who refuses to cooperate under this provision must be found ineligible for Medicaid. The individual will remain ineligible for future Medicaid benefits until full restitution has been made to the Medicaid Agency. If the TPL Unit determines that there was good cause for failure to cooperate, the applicant/recipient will be excused from the cooperation requirement.

2. Notification Process

The TPL Unit will notify the Eligibility Division of any any instances of failure to cooperate. The Eligibility Division will notify the appropriate Regional Office of the appropriate action necessary to deny or terminate eligibility. Advance notice must be issued to terminate eligibility and the recipient has the right to a hearing as per ongoing policy. However, all appeals regarding failure to cooperate with the TPL Unit must be handled via a State Hearing request. A Hearing Officer from the Eligibility Division will open and conclude the hearing, but the worker handling the case in the Third Party Unit will be present to discuss the issue regarding cooperation.

The Regional Office will be notified of the length of time ineligibility will exist when a case is to be terminated for failure to cooperate. When and if the cooperation issue is resolved, the Regional Office will be notified of the action necessary to restore eligibility.

B. REFERRAL OF ABSENT PARENT INFORMATION

Section 9142 of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) contains a requirement that State Child Support (IV-D) Agencies provide all appropriate child support services available under IV-D of the Social Security Act to families (with an absent parent) who receives Medicaid benefits and who has assigned rights for medical support to the State. State IV-D agencies are required to petition for medical support when health insurance is available to the absent parent at a reasonable cost. In order for the IV-D agency to provide the services required by law, the Division of Medicaid must refer Medicaid recipients who are disabled children in absent parent situations to the Child Support Enforcement Office at the county office of the Department of Human Services located in the county where the child lives. The referral is to be made in writing via Form DOM-TPL-410, Absent Parent Referral.

NONFINANCIAL ELIGIBILITY FACTORS
ESTATE RECOVERY

A. ESTATE RECOVERY REQUIREMENT

Effective July 1, 1994, the Division of Medicaid will begin to seek recovery of payments for nursing facility services and related hospital and prescription drug services from the estate of a deceased Medicaid recipient who was fifty-five (55) years of age or older when Medicaid benefits were received. Estate recovery was mandated by the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) and is now State law located in the Mississippi Code, Section 43-13-317.

Estate recovery applies to all Medicaid recipients in a nursing facility as of July 1, 1994, who:

- Are age 55 or older at the time of death, and
- Own real or personal property at the time of death that can be considered an estate.

1. Estate Property

Estate property includes any real or personal property owned by the recipient in its entirety or by shared ownership. Ownership of Life Estate Interests or ownership of property that has previously been transferred into a trust is <u>not</u> subject to estate recovery.

Real property includes the home and any other real property, including ownership of mineral rights and/or timber rights. Personal property includes ownership of any cash reserves, stocks, bonds, automobiles, RV's, mobile homes or any other type of property with value known to be owned by the recipient in full or in part.

2. Exceptions to Estate Recovery

Estate recovery rules do <u>not</u> apply to a deceased recipient if at the time of death the recipient had a:

a. Legal surviving spouse, or,

b. A surviving dependent child under the age of 21; or,

c. A dependent blind or disabled child of any age. The blind or disabled individual must be dependent on the Medicaid recipient for a home or income, such as a disabled child drawing benefits from the parent's record.

The following assets and resources of American Indians and Alaska Natives are exempt from estate recovery:

- Interest in and income derived from Tribal land and other resources currently held in trust status and judgement funds from the Indian Claims Commission and the U.S. Claims Court

- Ownership interest in trust or non-trust property, including real property and improvements located on a reservation.

- Reparation payments to special populations

3. HCBS Waiver Applicants/ Recipients

Under federal and state law, the Division of Medicaid is required to seek recovery of payments for home and community-based services, related hospital services, and prescription drug services from the estates of deceased Medicaid beneficiaries who were 55 years of age or older when these benefits were received. Effective July 1, 2001, estate recovery applies to persons applying for a HCBS Waiver Program. Any person who entered the HCBS Waiver Program prior to July 1, 2001, will not have their case referred to estate recovery. Those individuals will be "grandfathered"; however, if the individual is discharged from the program and is readmitted after July 1, 2001, the "grandfathered" status is lost. The case will be referred to estate recovery as a new HCBS client

B. REFERRAL TO TPL

TPL has established a $5000 liquid assets threshold for use in determining whether a case record is to be referred to TPL for Estate Recovery purposes. The $5000 threshold is set so that the client will have sufficient funds for burial. When calculating the $5000 threshold, do not include burial or insurance, or life estate property. Life insurance will be referred only when the beneficiary is the estate. Joint bank accounts, annuities, and promissory notes will not be referred to TPL. If a client has countable assets that exceed the $5000 limit, the case must be referred to TPL via Form DOM-TPL-411. If total countable assets is $5000or less, do not refer the case to TPL but complete Form DOM-TPL-412.

Refer cases subject to Estate Recovery as follows:

1. If a client owned real property (regardless of CMV) or personal property totaling more than $5000, the case record is to be referred to TPL via DOM-TPL-411, Estate Recovery Form.

2. If a client owned no real property and the total value of all personal property (liquid assets) is $5000 or less, complete DOM-TPL-412, Non-Referral Estate Recovery Form, and send the form only to TPL. This will let TPL know that the client is deceased but the case record is not being referred to TPL because total assets are below the established threshold.

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INCOME
GENERAL-INCOME RULES

A. WHAT IS INCOME

Income is anything an individual receives in cash (and is cases in-kind) that can be used to meet his/her needs for food, clothing or shelter. Medicaid is required, in accordance with 42 CFR 435.721, to use SSI financial eligibility requirements. SSI income policy applies unless a subsequently issued Medicaid statute or regulation supersedes the SSI policy. The following income rules are based on SSI income policy.

1. SSI Income Rules

- Income is counted on a monthly basis.
- An individual who has too much income in a particular month is not eligible for Medicaid for that month.
- Not all income counts in determining eligibility.
- Income may include more or less than is actually received. For example:
  - Expenses of obtaining income (less)
  - Garnishment (more)
  - Gross earnings, before any deductions (more).

2. Relationship of Income to Resources

In general, anything received in a month, from any source, is income to an individual, subject to SSI's definition of income.

Anything the individual owned prior to the month under consideration is subject to the resource counting rules.

An item received for the current month is income for the current month only. If held by the individual until the following month, that item is subject to resource counting rules. Any exceptions to this rule are noted in the discussion of the particular type of income involved.

3. Types of Income

Income is either earned or unearned, and different rules apply to each. Each type of income is discussed in detail in this section.

INCOME
GENERAL-INCOME RULES

B. WHEN INCOME IS COUNTED

Generally, income is counted at the earliest of the following points:

- when it is received; or,
- when it is credited to an individual's account; or,
- when it is set aside for his or her use.

Income is evaluated on a monthly basis and counted in the month it is received.

1. Advance Dated Checks

When a payor advance dates a check because the regular payment date falls on a week-end or holiday, there is no intent to change the normal delivery date. Whenever such an advance dated check is received, consider it income in the month of normal receipt.

2. Electronic Funds Transfer

When an individual's money goes to a bank by direct deposit, the funds may be posted to the account before or after the month they are payable. Whenever this occurs, threat the electronically transferred funds as income in the month of normal receipt.

3. When a Payment Is Not Income

A payment is not income when the individual is aware that he/she is not due the money and returns the check uncashed or otherwise refunds all of the erroneously received money either in the same month or in a following month. Normally, but not always, this would mean a month or two after the month of receipt. In such situations, verify return of the payment, consider all of the relevant facts, and document the determination for the file. Some of the points to consider are:

- the reason for the payment (i.e., whether it was really erroneous)

- the reason for any delay in returning the payment

- whether he or she made repayment in full or only in part.

INCOME

GENERAL-INCOME RULES

C. INCOME DERIVED FROM JOINT BANK ACCOUNTS

Policy below explains how to charge income in different situations involving joint bank account(s) held by a Medicaid client and other ineligible individuals.

1. Eligible With Ineligible

Deposits made by the ineligible (regardless of the source of deposit) are income to the eligible unless:

a. The ineligible is a deemor (spouse or parent) for income and/or resource purposes in which case the deposits are income to the one actually receiving it (but the ineligible's income or resources will be deemed to the eligible).

b. The ineligible is a legal guardian or conservator of the eligible and legal documents allow deposits to be treated otherwise.

c. The deposit can be excluded under some other provision.

d. Spousal Impoverishment rules apply (see Institutionalization section).

2. Eligible With Other Eligibles

A deposit by one is not income to the other. Deposits are counted as income to the eligible actually receiving the benefit or entitled to the payment. Interest payments are allocated equally among the joint holders.

3. Rebuttal Situations

If an eligible individual or deemor has successfully rebutted ownership of a portion of the funds in a joint account, deposits by the other account holders will not be counted as income, and interest will be charged in proportion to the amount of funds in the account which are owned by the eligible individual or deemor. Refer to the Resources section for policy governing the rebuttal of a joint bank account.

If an eligible individual or deemor has successfully rebutted ownership of all of the funds held in a joint bank account, no deposits by the other account holders nor interest credited to the account are counted as income of the eligible individual or deemor.

D. INCOME FROM TRUSTS/CONSERVATORSHIPS

Generally, if the client/beneficiary has a right to the income from the principal of a trust/conservatorship, it is income to him/her as it becomes available. If the client/beneficiary has no right to the income from the trust/conserved funds, then only the payments actually paid from the trust would be income.

The income/resource rules that apply to a trust or conservatorship depend on when the trust, guardianship or conservatorship was established. Refer to the Resource section for a complete discussion of the income/resource rules that apply to trusts/conservatorships.

E. VERIFICATION OF INCOME

SSI policy requires income to be verified from independent or collateral sources and additional information obtained as necessary to be sure that only eligible individuals qualify for assistance. A person applying or receiving Medicaid must provide Medicaid with any requested income information and show necessary documents or other evidence to establish the amount of an individual's income. Medicaid will assist the individual in obtaining needed verification not in the individual's possession; however, the burden of proof lies with the applicant, recipient or their representative to verify income and to report all changes in income.

See the instructions for the particular type of income involved for additional verification requirements.

1. Projecting Actual Income

Develop and record the best possible estimates of anticipated income (belonging to the eligible and deemor) on a month by month basis. When income fluctuates, use each month's anticipated receipts to estimate income for that month. Do not average income for the purpose of determining eligibility.

Always consider the number of paydays (for earned or unearned income) in any given month. If the amount is the same each payday, multiply the amount by the number of paydays in a given month to obtain the monthly amount. If the amount varies from payday to payday, add the individual amounts to obtain a monthly amount.

Eligibility for the current month, retroactive period and for the next 12 months is based on the monthly amount derived from the above computation. When there is an anticipated change in income, meaning income will start, stop or come in at a different rate, use only that income which the individual is reasonably sure will be received. The exception to this is in the case of self-employment income which is discussed in the Earned Income subsection.

2.	**Use of Tickler File**	The worker will use the Tickler File, either in MEDS or manually, as appropriate, to control cases with income that will affect eligibility or Medicaid Income for a future month. A tickler must be set for the month prior to the month of receipt of the income to handle the case to either adjust Medicaid Income or issue a notice of closure.

INCOME
INCOME EXCLUSIONS

A. WHAT IS NOT INCOME (OR A RESOURCE)

Certain income is excluded by federal statute or excluded under SSI rules and some money received is not considered income because it does not meet the definition of income. Items that are not considered income are discussed below:

1. Medical & Social Services, Related Cash & In-Kind Items

Medical services are those services which are directed toward diagnostic, preventative, therapeutic, or palliative treatment of a medical condition and which are performed, directed or supervised by a State licensed health professional. A social service is any service, other than medical, which is intended to assist a handicapped or socially disadvantaged individual to function in society on a level comparable to that of an individual who does not have such a handicap or disadvantage.

a. Any cash provided by a governmental medical or social services program is not income.

b. Any cash from a nongovernmental medical or social services organization is not income when the cash is for medical or social services already received by the individual and approved by the organization. However, if the individual receives an amount in excess of the medical or social services expenses incurred, the excess cash is unearned income.

A cash payment restricted to the future purchase of a medical or social service is not income.

Cash from an insurance policy, which pays "loss of time" benefits for a certain period of time during the hospital confinement, is treated as a third party liability.

c. In-kind items which meet the definition of medical services, i.e., prescription drugs, eyeglasses, prosthetic devices, etc., are not income regardless of their source.

d. Any in-kind items (including food, clothing or shelter) provided by a governmental, medical or social services program are not income.

e. In-kind items (other than food, clothing or shelter) provided by a nongovernmental medical or social services organization for medical or social services purposes are not income.

A cash payment for medical or social services that is not income is not a resource for one calendar month following the month of receipt.

2. **Food & Shelter Received During a Medical Confinement**

Food and shelter received during a medical confinement are not income. A medical confinement exists when an individual receives medical services in a medical treatment facility.

3. **Personal Services**

A personal service performed for an individual is not income. Examples of personal services for an individual which are not income are mowing the lawn, doing housecleaning, going to the grocery or babysitting.

4. **Conversion or Sale of a Resource**

Receipts from the sale, exchange, or replacement of a resource are not income but are resources that have changed their form. This includes any cash or in-kind item that is provided to replace or repair a resource that has been lost, damaged or stolen.

5. **Rebates & Refunds**

When an individual receives a rebate, refund or other return of money he or she has already paid, the money returned is not income. NOTE: The key idea in applying this policy is a return of an individual's own money. Some "rebates" may not fit this category. If a rebate is a return on an investment, for example, the rebate would be treated as a dividend.

6.	**Income Tax Refunds**	Any amount of income tax refunded to an individual is not income. Because amounts withheld or paid as income tax during the course of a taxable year are included in the definition of income, any later refund of such income taxes by a Federal, State, or local taxing authority is not again treated as income, but is treated as a resource. This is so even if the income from which the tax was withheld or paid was received in a period prior to application and therefore was not actually considered in determining eligibility.
7.	**Credit Life or Credit Disability Insurance Payments**	Both credit life and credit disability insurance may be administered under group or individual policies. These policies are issued by insurance companies to or on behalf of of borrowers, to cover payments on loans, installment purchases, etc., in the event of death or disability. These payments are made directly to loan companies, mortgage companies, etc., and are not available to the individual, either directly or by sale or conversion, for the purposes of meeting his/her basic needs. Therefore, payments made on behalf of an individual under credit life or credit disability policies are not considered income.
8.	Other **Insurance Payments**	Each insurance policy must be examined to determine the type of benefit it provides and the purposes for which it can be used. Cash payments from any insurance policy made directly to the provider would not be income since the beneficiary does not receive the payment. Amounts paid to the facility for purposes other than medical care may be considered income if the facility actually pays the amount to the individual. Cash payments from any insurance policy which are restricted for purchase or reimbursement of medical services covered under the policy are not considered income. This would be a third party resource. Policies that restrict payments to periods of hospital confinement are considered a third party source and is not considered income.

Cash payments from any insurance policy intended for income supplementation for lost income due to a disability is considered income. This includes weekly disability policies, without regard to hospital confinement.

9. Proceeds of a Loan

Money that a person borrows or money received as the repayment of a bona fide loan is not income. However, interest received on money loaned is income. Although the proceeds of a bona fide loan are not income in the month received, if the proceeds are retained into the following month, they become a resource.

A bona fide loan is an agreement that is legally valid and made in good faith. The loan agreement must be in writing and include:

- borrower's acknowledgment of his obligation to repay
- schedule and plan for repayment; e.g., borrower plans to repay when he receives anticipated income in the future; and,
- borrower's express intent to repay by pledging either real or personal property or anticipated income.

If a loan is found not to be bona fide, then any proceeds received in connection with the transaction must be considered as unearned income to the borrower in the month received.

10. Bills Paid by a Third Party

When someone other than the eligible individual or couple makes a payment directly to a vendor, the payment is not income to the individual. This is because the individual does not receive the payment itself. However, a third party vendor payment is a means by which an individual may receive unearned in-kind income.

INCOME
INCOME EXCLUSIONS

11.	**Replacement of Income Already Received**	If an individual's income is lost, stolen or destroyed and the individual receives a replacement, the replacement is not income. Once a payment has been issued and treated as issued and treated as income in determining an individual's eligibility, the reissuance of that same payment is not income.
12.	**Weatherization Assistance**	Weatherization assistance (e.g., insulation, storm doors, windows, etc.) is not income.
13.	**Receipt of Certain Noncash Items**	The value of any noncash items (other than items of food, clothing or shelter) which would become partially or totally excluded nonliquid resources if retained into the month following the month of receipt is not income. Such nonincome items may include, but are not limited to, specially equipped vehicles, household goods, and property essential to self-support. Consider these nonincome items solely under the resource rules.
14.	**Fund Raising Proceeds**	Benefits received through fund raising are a potential Third Party Liability source. The beneficiary must report all sources of income from fund raising to the source of eligibility. The source of eligibility will inform the Third Party Liability unit of the availability of any source of payment for medical services. Donated funds for the purpose of payment of medical services are considered a third party source. In order for donated funds to be excluded as income, the following criteria must be met: - Prior to accepting donations, the beneficiary (or family if a child) must make arrangements to place donations in a trust fund or special account.

- The trust fund or special account must be managed by an administrator (someone outside the family).

- The funds must never be mixed with personal or family money.

- The beneficiary should not have direct access to the trust funds or special account.

- The beneficiary or administrator must be able to produce documentation as to how the funds were spent.

INCOME
INCOME EXCLUSIONS

B. INCOME EXCLUSIONS FOR UNEARNED & EARNED INCOME

An exclusion is an amount of income which does not count in determining eligibility and payment amount. Exclusions never reduce income below zero. Except for the $50 general exclusion, no unused unearned income exclusion may be applied to earned income.

Prior to 07/01/99, the general exclusion was $20.00.

1. $50 Per Month General Exclusion (Effective 07/01/99)

The first $50 of unearned income received in a month is is excluded. Only one $50 exclusion can be applied to the combined income of a couple. Do <u>not</u> apply this exclusion to any income based on need.

The general income exclusion applies only to the individual applicant's or recipient's own income. The recipient's or applicant's own income includes income which has been deemed. Do not apply the $50 general income exclusion to the person's income which is to be deemed.

Apply the $50 exclusion first to unearned income. Any remainder is applied to earned income. If there is no unearned income, then apply the $50 exclusion to the earned income.

2. Earned Income Exclusion

After the $50 general exclusion is applied, $65 plus one-half of remaining earned income is excluded. Couples' earned income is combined and only one earned income exclusion is applied.

3. Income Exclusions for Certain Former SSI Recipients

Social Security Pass-a-Long clients who were former SSI SSI recipients terminated due to certain increases in Social Security benefits are allowed income disregards specific to their coverage group. These disregards are referred to as HR-1, COL, DAC, OBRA, etc. disregards. The eligibility for and amount of the disregard is determined by State Office Eligibility Staff upon Regional Office referral.

4. Student Child Earned Income Exclusion

For a blind or disabled child who is a student regularly attending school, up to $400 per month of earned income (but not more than $1,620 in a calendar year) is excluded. The child must be under age 22 and regularly attending school (in at least 1 month of the current calendar quarter or expects to attend school in at least 1 month in the next calendar quarter). Earnings received prior to the month of eligibility do not count toward the $1,620 yearly limit.

Effective January 1, 2001, the monthly maximum amount has increased to $1,290 and the yearly maximum has increased to $5,200.

Apply the exclusion consecutively to months in which there is earned income until the exclusion is exhausted or the child is no longer a student or under age 22. The exclusion applies only to the child's own earned income. This exclusion is in addition to the $65 plus ½ remainder earned income exclusion.

For example, a student child with a summer job who earns $1,600 per month (only income) beginning in June has countable income computed as follows for June, July, August:

$1,600.00 gross earnings
- 1,290.00 student child exclusion
$ 310.00
- 50.00 general income exclusion
$ 260.00
- 65.00 earned income exclusion
$ 195.00
- 97.50 one-half remainder
$ 97.50 countable income

In this example, the student has used up $3.870 of his $5,200 yearly exclusion and only has $1,330 left to be excluded over the remaining calendar year should he have any other earned income through December of the same calendar year.

INCOME
INCOME EXCLUSIONS

5. Blind Work Expenses Exclusion

Any earned income of a blind person which is used to meet any expenses reasonably attributable to earning the income is not counted if the blind person is under age 64 or 65 or older and and received SSI or Medicaid in the month prior to attaining age 65.

The BWE exclusion applies to earned income only. The exclusion is deducted after applying the $50 general income exclusion and all other earned income exclusions. Before applying a BWE exclusion, contact the State Office Eligibility Division for clearance.

6. Plan for Achieving Self-Support (PASS)

Income, whether earned or unearned, of a blind or disabled recipient may be excluded if such income is needed to fulfill a plan for achieving self-support. Income can be excluded under an approved PASS when the income is set aside for a planned expenditure determined necessary to achieve the individual's occupational objective.

To be eligible for this income exclusion, the individual plan must be submitted to State Office for approval. The plan submitted must:

1. include the objective and time period for achieving
2. include the amount of money involved
3. be currently in use by the individual

INCOME
INCOME EXCLUSIONS

7. Impairment-Related Work Expenses (IRWE)

Any earned income of a disabled individual (not blind) which is used to meet any expenses for items or services which are directly related to enabling a person with a disability to work and which are necessarily incurred by that individual because of a physical or mental impairment is not counted if the disabled person is under age 64 or age 65 or older and received SSI or a disability payment for the month before attaining age 65.

The IRWE exclusion applies to earned income only. The exclusion is deducted after applying the $50 general income exclusion which has not been deducted from unearned income and the $65 earned income exclusion; and immediately before deducting one-half of the remaining earned income. Before applying a IRWE exclusion, contact the State Office Eligibility Bureau for clearance.

8. Irregular & Infrequent Income Exclusion

Apply an exclusion to income which is received either infrequently or irregularly provided the total of such income does not exceed:

- $10 per month of earned income; and/or,
- $20 per month of unearned income.

Infrequent income means the income is received no more than once in a calendar quarter from a single source. Irregular means the income cannot reasonably be expected (unpredictable).

In order to be excluded, the total amount of earned income received cannot exceed $10 in the month. When the exclusion is applied, verify the earned income and document the case record with the basis for the decision that the income is infrequent or irregular.

In order to be excluded, the total unearned income received by the client cannot exceed $20 in a month. The frequency is evaluated for the calendar quarter, but the dollar amount is evaluated for the month.

In determining if unearned income can be excluded as infrequent, identify and categorize by amount, frequency, type and source. Consider each receipt of unearned income separately. Any unearned income of one type received once per quarter from one source is considered infrequent, that is, a person may receive the same type of unearned income from two different sources or two different types of unearned income from the same source if each is received only once during the quarter, and still have the amount excluded if no more than $20 is received in any given month.

C. **OTHER UNEARNED INCOME EXCLUSIONS**

The following is a discussion of additional income exclusions applicable to unearned income.

1. **Home Produce for Personal Consumption**

Home produce is excluded from income if it is consumed by the individual or his/her household.

The proceeds from the sale of home produced may be unearned income if sold but not as a trade or business. If sold as a trade or business, the income may be earnings from self-employment.

2. **Refunds of Taxes Paid on Real Property or Food**

Any amount received from any public agency as a return or refund of taxes paid on real property or on food purchased is excluded from income.

3. **German Reparation Payments**

German reparations payments are made under the Republic of Germany's Federal Law for Compensation of Nationalist Socialist Persecution ("German Restitution Act") to certain survivors of the Holocaust. The payments may be made periodically or as a lump sum. Reparations payments received from the Federal Republic of Germany are excluded from income. **Unspent payments are excluded from resources.**

4. **Austrian Social Insurance Payments**

The nationwide class action lawsuit, Bondy v. Sullivan, involved Austrian social insurance payments which were based, in whole or in part, on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act (GSIA). These paragraphs grant credits to individuals who suffered a loss (i.e., were imprisoned, unemployed, or forced to flee Austria) during the period from March 1933 to May 1945 for political, religious, or ethnic reasons. (The GSIA does not specify what entity, e.g., the government or an employer, must be responsible for the loss in order for the credits to be granted.) Not all Austrian social insurance payments are based on Paragraphs 500-506.

5. **The Nazi Persecution Victims Eligibility Act**

Enacted August 1, 1994, the Nazi Persecution Victims Eligibility Act (P.L. 103-286) excludes from income any payments made to individuals because of their status as victims of Nazi persecution.

This provision supersedes previous provisions for the exclusion of certain payments made by the governments of Germany, Austria, and the Netherlands, insofar as they are made to victims of Nazi persecution.

Austrian social insurance payments based, in whole or in part, on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act are not counted as income. **Unspent payments are excluded from resources.** Austrian social insurance payments not based on age credits granted under Paragraphs 500-506 are counted as income.

6. **Japanese-American & Aleutian Restitution Payments**

Restitution payments made by the U. S. Government to to individual Japanese-Americans or the spouse or parent of individual of Japanese ancestry (or, if deceased, to their survivors) and Aleuts who were interned or relocated during World War II are excluded from income and resources. Also, restitution payments from the Canadian Government to individual Japanese-Canadians who were interned or relocated during World War II are excluded from income **and resources**.

7. **Netherlands WUV Payments to Victims of Persecution**

The Dutch government, under the Netherland's Act on Benefits for Victims of Persecution 1940-1945 (Dutch acronym, WUV), makes payments to both Dutch and non-Dutch individuals who, during the German and Japanese occupation of the Netherlands and Netherlands East Indies (now the Republic of Indonesia) in World War II, were victims of persecution because of their race, religion, beliefs, or homosexuality and, as a result of that persecution are presently suffering from illnesses or disabilities. Payments under this Act began January 1, 1973 and include four categories of benefits: periodic income payments, compensation for non-definable disability expenses (Dutch acronym, NMIK), reimbursement of persecution related disability expenses, and partial compensation for persecution related disability expenses.

WUV payments are excluded from income. **Unspent payments are excluded from resources.**

8. **Agent Orange Settlement Payment**

Agent Orange settlement payments made in connection with the case of **In re Agent Orange Produce Liability Litigation** come from a fund created by manufacturers of Agent Orange who agreed to pay into a settlement fund. Payments began in March 1989. Qualifying veterans will receive at least one payment a year for the life of the program. Qualifying survivors of deceased veterans will receive a single lump sum payment.

Effective January 1, 1989, payments made from the Agent Orange settlement fund or any other fund established pursuant to the settlement in the Agent Orange product liability litigation are excluded from income **and resources.**

9. **Radiation Exposure Compensation Trust Fund Payments**

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 the 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.

Payments from the RECTF are excluded from income. **Unspent payments are excluded from resources.**

INCOME

INCOME EXCLUSIONS

9. **Exclusion of Income from Individual Interests in Indian Trust or Restricted Lands**

Native American income derived from tribal trust lands is lands is excluded by federal statutes. Individual interests of Native Americans in trust or restricted lands are excluded from resources. The Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66), enacted August 10, 1993, further provides for an exclusion of income derived from those individual interest in Indian trust or restricted lands.

This income (often called individual Indian trust or least income) generally comes from interests in lands that were allotted to individual Indians many years ago. The income generated by those interests may be quite small since many of the original interests in allotted lands have fractionated over time, e.g. due to inheritance by multiple heirs over several generations.

Effective January 1, 1994, up to $2,000 per year in payments derived from individual interest in Indian trust or restricted lands is excluded from income. Such payments include any interest which accrues on these funds before being distributed or credited to an individual's account.

This exclusion applies to the income of an ineligible spouse or ineligible parent(s) in the deeming process.

For purposes of applying the $2,000 annual exclusion, for both eligibles and deemors, only payments received in months of eligibility count toward the $2,000 annual exclusion.

If that income exceeds $2,000 per calendar year, determine the month that the $2,000 annual exclusion was exceeded, and count the excess as unearned income in the months received.

10. **HIV/ Hemophiliac Settlement Payments**

Settlement payments received as a result of a class settlement in the case of Susan Walker v. Bayer Corporation, et al, are excluded as income and resources in determining Medicaid eligibility. (This same exclusion does not apply for SSI purposes.) This case involved hemophiliacs who contracted the HIV virus from contaminated blood products. Section 4735 of the Balanced Budget Act of 1997 mandates this income/resource exclusion for Medicaid applicants/recipients.

Interest earned on settlement payments count as unearned income unless the settlement is placed in an approved Special Needs Trust.

D. EXCLUSIONS INVOLVING ASSISTANCE PROGRAMS

The following is a discussion of payments from certain assistance programs and the excludability of the assistance.

1. Low Income Energy Assistance

Through a block grant, the Federal Government provides funds to states for energy assistance (including weatherization) to low income households. The assistance may be provided by a variety of agencies and known by a variety of names. It is most often provided in a medium other than cash but may be in cash.

Home energy assistance payments or allowances provided under subchapter II of chapter 94, title 42 of the U. S. Code are excluded from income and resources.

2. Home Energy Assistance and Support Maintenance

Home energy assistance is any assistance related to meeting the costs of heating or cooling a home. It includes such items as payments for utility service or bulk fuels, assistance in kind such as portable heaters, fans, blankets, storm doors, or other items which help reduce the costs of heating and cooling such as conservation or weatherization materials and services.

Home energy or support and maintenance assistance is excluded from income **and resources** if it is certified in writing by the appropriate State agency to be both based on need and:

- provided **in kind** by a private nonprofit agency; or,
- provided in cash or in kind by a supplier or home heating oil or gas.

3. **Action Programs/ Domestic Volunteer**

The Federal government through the ACTION, the Federal domestic volunteer agency, is involved in a number of volunteer service programs including:

- Volunteers in Service to America (VISTA);
- University Year for ACTION (UYA);
- Special and Demonstration Volunteer Programs;
- Retired Senior Volunteer Program (RSVP);
- Foster Grandparent Program;
- Senior Companion Program.

Payments to volunteers under chapter 66 title 42 of the U. S. Code Domestic Volunteer Services (ACTION programs) are excluded from income and resources.

4. **Disaster Assistance-Presidentially Declared Disaster**

At the request of a State governor, the President may declare a major disaster when the disaster is of such severity and magnitude that effective response is beyond the capabilities of the State and local governments, and Federal assistance is needed. Disasters include such things as hurricanes, tornadoes, floods, earthquakes, volcano eruptions, landslides, snowstorms, drought, etc.

Assistance provided to victims of a presidentially-declared disaster includes assistance from:

- Federal programs and agencies;
- joint Federal and State programs;
- State or local government programs;
- private organizations (e.g., the Red Cross).

The value of support and maintenance in cash or in-kind is excluded from countable income. **If assistance is excluded from income, any unspent assistance is permanently excluded from resources.**

5. **Federal Housing Assistance**

The Federal Government through the Office of Housing and Urban Development (HUD) and the Farmers Home Administration (FMHA) provides many forms of housing assistance including:

- subsidized housing (e.g., public housing, reduced rent, cash towards utilities, etc.)
- loans for renovations;
- loans for construction, improvement, or replacement of farm homes and other buildings;
- mortgage or investment insurance;
- guaranteed loans and mortgages.

This assistance may be provided directly by the Federal Government or through other entities such as local housing authorities, nonprofit organizations, etc.

The value of any assistance paid with respect to a dwelling unit is excluded from income and resources if paid through HUD or FMHA.

6. **Federal Food Programs**

The value of food or assistance provided through the following programs is excluded from income and resources:

- Food Stamp Program
- School Lunch Programs
- Child Nutrition Programs
- Nutrition Programs for Older Americans

7. **Programs for Older Americans**

The Federal Government through the Administration on Aging is involved in a variety of programs for older Americans. The programs may be operated by State of local governments or community organizations. Some types of programs are health services, nutrition services, legal assistance and community service department.

Anything provided under chapter 35 of title 42 of the U. S. Code, Programs for Older Americans, other than a wage or salary is excluded from income.

8. **Relocation Assistance**

Relocation assistance is provided to persons displaced by projects which acquire real property. The following types of reimbursement, allowances, and help are provided:

- moving expenses;
- reimbursement for losses of tangible property;
- expenses of looking for a business or farm;
- displacement allowances;
- amounts required to replace a dwelling which exceed the agency's acquisition cost for the prior dwelling;
- compensation for increased interest costs and other debt service costs of replacement dwelling (if it is encumbered by a mortgage);
- expenses for closing costs (but not prepaid expenses) on replacement dwelling (if it is encumbered by a mortgage);
- rental expenses for displaced tenants;

- amounts for down payments on replacement housing for tenants who decide to buy;

- mortgage insurance through Federal programs with waiver of requirements of age, physical condition, personal characteristics, etc., which borrowers must usually meet; and

- direct provision of replacement housing (as a last resort).

Relocation assistance provided by Federal, State or local funds to persons displaced by any Federal, State or local project is excluded from income. **Unspent payments are excluded from resources for 9 months following the month or receipt.**

9. **Victims' Compensation Payments**

Effective May 1, 1991, any payment received from a fund established by a State to aid victims of crime is excluded from is excluded from income. **Unspent payments are excluded from resources for 9 months following the month of receipt.**

INCOME
INCOME EXCLUSIONS

10. Job Training Partnership Act

The purpose of the Job Training Partnership Act (JTPA) is to prepare individuals for entry into the labor force. JTPA funding is much like a block grant and programs will vary among States and among areas within States. JTPA payments may be called "needs-based" for JTPA purposes but are not "income based on need" or "assistance based on need" for SSI/Medicaid purposes. JTPA payments may be in cash or in kind, and participants in JTPA may receive supportive services in cash or in kind. Usually, adult participants receive only supportive services.

JTPA payments are subject to the general rules pertaining to income and income exclusions.

- Assume that supportive services such as child care, transportation, medical care, meals, and other reasonable expenses, provided in cash or in kind, are social services and not income.

- Items such as salaries, stipends, incentive payments, etc., must be evaluated under the general rules of unearned and earned income.

11. AmeriCorps & National Civilian Community Corps

Part of AmeriCorps, the new National Civilian Community Corps (NCCC) was created in 1993 as a residential service program for young adults between the ages of 18 and 24 in which participants provide work teams for a variety of community service projects.

Participants of AmeriCorps and NCCC receive a stipend or living allowance generally based on minimum wage requirements. Participants also are eligible to receive an educational award made after the completion of a specified term of service. The educational award is for educational assistance only and must be applied to college tuition, vocational training or outstanding college loans. The educational award must be paid by AmeriCorps or NCCC directly to an educational institution or to a loan-holder for repayment of a student educational loan.

Instead of an educational award, AmeriCorps and NCCC participants may, with the approval of the director of CNCS, receive an alternative benefit. The alternative payment for NCCC members is equal to one-half the amount of any educational award and is paid directly to the participant.

The treatment of payments made under AmeriCorps and NCCC is determined by the type of payment.

Stipends or living allowance payments are wages and are subject to the general rules regarding wages and earned income exclusions.

Any food or shelter received by participants is not wages, but is unearned income in the form of in-kind support and maintenance (ISM) subject to the presumed maximum value (PMV), if appropriate.

Any clothing allowance payments are unearned income and subject to the general rules regarding unearned income and exclusions.

Participants are considered to be living in their own household. Temporary absence rules do not apply for living arrangement purposes.

Educational awards are wages when credited to the educational institution or loan-holder for repayment of a student educational loan, and subject to the general rules regarding wages and earned income exclusions.

Any payments made as an alternative to educational awards are wages and are subject to the general rules regarding wages and earned income exclusions.

12.	**Dividends, Interest Royalties**	Effective 07-01-99, up to $5.00 per month is excluded from countable income. The $5.00 exclusion includes either dividends interest, royalties or a combination of the three income types. Not more than $5.00 can be excluded per person.

INCOME
UNEARNED INCOME

A. GENERAL

Unearned income is all income that is not earned income.

The monthly amount of any unearned income must be determined and verified for all applicants and recipients except in cases where ineligibility results from another factor of eligibility. Verification of unearned income will normally be by documentation from the source of the unearned income. Another means of verification may be used only if the source and the amount of unearned income can be clearly established. The case record will clearly show the method and particulars of the verification used to establish the unearned income.

B. AMOUNT OF UNEARNED INCOME

The amount of unearned income which must be counted in determining eligibility for Medicaid is the gross amount due the client. The exception to this rule is that the gross amount of unearned income may be reduced by certain expenses incurred to obtain that income. The most common expenses of this type are attorney fees; however, there are others. Fees for medical examinations, legal papers, proofs of relationship, birth and death, filing fees, etc., can be involved in securing income and diminish the amount which is countable. Proof of having incurred the expense (bills, canceled checks, money orders, etc.) is required.

Deduct excludable expenses from the first and subsequent payments until completely offset. Excludable expenses may occur in periods prior to the receipt of income. All excludable expenses can be offset against the income when it is actually or constructively received.

INCOME
UNEARNED INCOME

1. Deductions Other Than Expenses

Any income deducted from the gross amount of unearned income which are not incurred expenses in obtaining the the income as outlined above, must be counted as income in in determining eligibility, such as:

a. Overpayment Recovery

Amounts withheld by Title II and other programs to recover overpayments are counted as unearned income.

This policy applies to income received by an applicant/recipient as well as to persons whose income is subject to deeming.

b. Taxes Withheld

Taxes withheld from unearned income are counted as unearned income in determining eligibility.

c. Other Deductions

Amounts withheld for pension fund contributions, garnishments, child support or optional deductions, such as life or medical insurance premiums, savings bonds or accounts, are counted as unearned income in determining eligibility.

2. Return of Money Previously Deducted

If any of these deductions listed above are later returned to an individual by the original source or the agency or organization to which the deducted amounts are transferred (e.g., governmental tax collection unit), the refunds cannot again be income but can be available resources when received and would be counted if retained into the following month.

3. Payments In Foreign Currency

Occasionally, an individual receives income tendered to him/her in a monetary unit other than U. S. dollars. This usually will be in the form of a check or a direct deposit to a bank. The U. S. dollar value of a payment made in foreign currency, less expenses, is income.

Foreign currency payments are counted as income when received unless the individual can establish that the payment was received too late in the month for conversion prior to the following month.

Use a check or documents in the individual's possession to verify receipt of a foreign payment and the amount in foreign currency. If the payment is made directly to a bank, the bank may provide a statement of the amount received.

Verify the exchange rate for conversion of the foreign currency into U. S. dollars using a receipt for the individual's last exchange or a telephone call to a local bank or currency exchange. Use the established exchange rate until the next redetermination or until a change is reported/verified.

C. BROAD CATEGORIES OF UNEARNED INCOME

The following is a discussion of broad categories of unearned income and the treatment of that income.

1. Annuities, Pensions, Retirement or Disability

An annuity is a sum paid yearly or at other specific times in return for the payment of a fixed sum. Annuities may be purchased by an individual or by an employer.

Pensions and retirement benefits are payments to a worker following his retirement from employment. These payments may be paid directly by a former employer, by a trust fund, an insurance company, or other entity.

Disability benefits are payments made because of injury or other disability.

Annuities, pensions, retirement benefits and disability benefits are unearned income. Exception: Certain accident disability benefits paid within the first 6 months after the month an employee last worked are earned income. Refer to the Earned Income subsection.

Verify the source, type, amount and frequency of the payment by award letters or other documents in the individuals' possession or contact the organization making the payment.

2. Deemed Income

Deemed income is unearned income attributed to an applicant/recipient from an ineligible spouse or parent. Deeming only applies in household situations. For a complete discussion of deemed income, refer to "Income Computations."

INCOME
UNEARNED INCOME

3. Income Based On Need (IBON)

Income based on need is assistance:

- provided under a program which uses income as a factor of eligibility; and,

- funded wholly or partially by the Federal government or a nongovernmental agency (e.g., Catholic Charities or the Salvation Army) for the purpose of meeting basic needs.

Income based on need received by an applicant or recipient is unearned income that is not subject to the $50 general exclusion. If received by the client, the income based on need is counted in its entirety. However, income based on need received by an ineligible spouse, parent, or child, is never deemed to the client. Refer to the discussion on "Deemed Income."

4. Assistance Based On Need (ABON)

Assistance based on need is assistance:

- provided under a program which uses income as a factor of eligibility; and

- funded wholly by a State (including the District of Columbia, Indian tribes and the Northern Mariana Islands), a political subdivision of a State, or a combination of such jurisdictions.

Assistance based on need is excluded from income.

5. **Work Relief (Workfare) Programs**

Many governmental assistance programs require the certain recipients work in exchange for the assistance provided. provided. Most often the amount of the assistance payment is divided by the minimum wage and the recipient required to perform some service for the resulting number of hours. Usually a participant in such a work program is given money to cover any expenses incurred (e.g., carfare, special clothing, miscellaneous, etc.) Programs connected with general assistance have various locally established names. Programs connected with AFDC include the Community Work Experience Program (CWEP), and the Work Incentive Program (WIN). Programs are often run as demonstrations or pilot projects.

The fact that an individual is required to work in exchange for an income based on need or assistance based on need payment does not change the nature of the payment. For SSI/Medicaid purposes, the payment in such situations is an assistance payment and is not earned income.

6. **Federal Emergency Management Agency (FEMA) Programs**

Through a national board chaired by the Federal Emergency Management Agency (FEMA) and local boards, funds are provided to private nonprofit organizations and State and local governmental entities for the purpose of providing emergency food and shelter to needy individuals. The entity receiving these funds decides how they will be best used (e.g., to buy beds and blankets, to stock a soup kitchen or to pay an individual's rent). The Federal funds are not provided to meet ongoing basic needs.

Assistance involving FEMA funds is subject to the general rules pertaining to income and income exclusions. It is neither IBON nor ABON.

7. Community Service Block Grants

The Department of Health and Human Services makes community service block grants to States to provide a broad range of services and activities to assist low-income individuals and alleviate the causes of poverty in a community. States may subsequently make grants or enter into contracts with private nonprofit organizations or political subdivisions.

Assistance involving community service block grants is subject to the general rules pertaining to income.

8. Refugee Cash Assistance

Refugee Cash Assistance and Cuban and Haitian Entrant Cash Assistance are federally funded programs which make on-going needs-based payments to refugees during their first 18 months in the United States. The payments are made by the State or local government basically according to AFDC standards and rules, although there need not be a child involved. The Federal government will also reimburse States and localities for any general assistance payments made to refugees during their second 19-31 months in the United States.

Refugee Cash Assistance, Cuban and Haitian Entrant Cash Assistance and federally reimbursed general assistance payments to refugees are federally funded income based on need and, unless excluded under a PASS, are counted dollar for dollar as income. The $50 general income exclusion does not apply to this income.

9. Refugee Reception & Placement Grants

Federal funds are provided to national voluntary refugee resettlement agencies such as Catholic Charities or the Hebrew Immigrant Aid Society, which provide services including food, clothing and shelter) related to initial resettlement of new refugees. Assistance involving these funds will usually be received during the first 30 days after the refugee arrives in this country.

Assistance involving a refugee reception and placement grant or a refugee matching grant is subject to the general rules pertaining to income and income exclusions.

10. Bureau of Indian Affairs General Assistance

Bureau of Indian Affairs General Assistance (BIA GA is a federally funded program administered by the Bureau of Indian Affairs (BIA) through its local agency (usually the tribe). The program makes periodic payments to needy Indians.

BIA determines need according to the standards used by State welfare agencies for Aid to Families with Dependent Children (AFDC).

BIA GA payments are federally funded income based on need and, therefore, count as income on a dollar-for-dollar basis regardless of whether they are paid in cash or in kind. The $20 per month general income exclusion does not apply.

D. BENEFITS PAID BY THE SOCIAL SECURITY ADMINISTRATION

The following benefits are paid by the Social Security Administration (SSA) and are counted as unearned income:

1. RSDI & Prouty Benefits

RSDI (Retirement, Survivors and Disability Insurance) benefits are paid under title II of the Social Security Act.

Prouty benefits are a special monthly benefit paid to certain persons who reached age 72 before 1968 who are not insured for regular monthly benefits.

The full amount of the monthly benefit to or on behalf of the designed beneficiary is unearned income.

The amount of premiums deducted for the optional Supplemental Medical Insurance (SMI) under Medicare from RSDI benefits is included in unearned income. Do not charge refunded SMI premiums as unearned income.

Overpayments recovered from SSA benefits are included as income in determining eligibility for Medicaid. Refer to "Determining Amount of Unearned Income" for further discussion of overpayments.

Lump-sum payments made by SSA, such as retroactive Social Security benefits or death benefits paid to a surviving spouse, are treated as unearned income in the month of receipt with the exception of the following:

Retroactive Social Security benefits paid to an individual who also received SSI for the same period will have the retroactive Social Security benefit reduced by an amount equal to the amount of SSI payments that would not have been paid if Social Security benefits had been paid when due. The balance due the beneficiary after the reduction of the retroactive payment is not income for SSI purposes. This is the only exception to the SSI rule of counting unearned income when received.

Any retroactive Social Security benefits paid for periods prior to SSI entitlement are not subject to the reduction and are considered income when received. The award letter issued to the recipient will specify the offset amount. Any payment over and above this amount is income in the month received. If the award letter is not available, contact SSA for assistance.

2. Resource Exclusion for Retroactive Payments

Retroactive SSI benefits are any SSI benefits issued in any month after the calendar month for which they are paid. Benefits for January that are issued in February are retroactive.

Retroactive RSDI benefits are those issued in any month that is more than a month after the calendar month for which they are paid. RSDI benefits for January that are issued in February are not retroactive, but RSDI benefits for January that are issued in March are retroactive.

The unspent portion of retroactive SSI and RSDI benefits is excluded from resources for the 6 calendar months following the month in which the individual receives the benefits.

3. SSA Benefits-Reductions, Deductions, Rounding & Verification

The title II benefit payable to a beneficiary is rounded at difference points in the computation process by SSA. Charge as income the amount of title II shown as the "Gross" benefit amount on the Third Party Query (TPQY) or the BENDEX which is the amount of the benefit after rounding but before the Medicare premium is deducted.

Exceptions:

a. Rounding does not apply to Prouty benefits. The gross benefit shown is the amount counted as income for all J1 or K1 beneficiaries.

b. For Medicaid applicants entitled to Medicare who are not already enrolled in State buy-in, the Gross Benefit Amount payable prior to State buy-in of the Part B premium is less than the benefit payable after State buy-in occurs. To account for this difference, the "Gross" amount shown on the TPQY must be rounded up to the nearest dollar to determine the amount of title II to count as income. For example: If the TPQY "Gross Benefit Amount" shows $487.90 at the time of application, the amount to charge as income is $488.

c. If a title II monthly benefit is reduced because of a worker's compensation offset, charge the net amount of the title II benefit received plus any SMI premium withheld as unearned income. A title II benefit is reduced dollar for dollar in the amount of any monthly worker's compensation paid.

Verify title II benefits and/or Medicare entitlement by on-line viewing of BENDEX or obtain a TPQY response. If available, examine evidence the client may possess, such as an award letter or adjustment letter and make copies for the record if appropriate.

4. Mandatory State Supplement

Aged, blind and disabled individuals converted from State Welfare roles are deemed to have filed for SSI beginning January 1, 1974. Converted recipients receive SSI and a Mandatory State Supplement (MSS) to maintain the 12/73 income levels of former assistance recipients. Certain recipients may receive MSS without an SSI payment.

The SSA administers MSS payments in Mississippi. MSS payments are included with SSI benefits each month or paid separately if the individual does not receive SSI. A MSS payment is shown on a TPQY as a "State Amount" and is treated the same as Income Based on Need for Income purposes.

5. **Black Lung Benefits**

Black Lung (BL) benefits are paid to miners and their survivors under the provisions of the Federal Mine Safety and Health Act (FMSHA).

Benefits under **Part B** of the FMSHA are paid by the **Social Security Administration** (SSA) and benefits under **Part C** of the FMSHA are paid by the **Department of Labor** (DOL).

In general, Part B benefits are paid on the third of the month while Part C benefits are paid on the fifteenth of the month.

Both Part B and Part C Bl benefits are subject to offsets (e.g., workers' compensation) and can be reduced due to the recovery of an overpayment. In addition, Part C benefits may be reduced because of liens imposed by other Federal agencies (such as the Internal Revenue Service).

The amount deducted from a Part C BL benefit because of garnishment (e.g., liens imposed by other Federal agencies) is unearned income. The amount of the BL benefit to charge as income is the amount paid after application of an offset (i.e. workers compensation offset) but before the collection of any obligations of the recipient.

Verify the receipt of Part B Black Lung benefits via on-line viewing of BENDEX or TPQY response. Verify the receipt of Part C with the individual's own records, such as an award notice and check, if available. Contact the Department of Labor if information from the client is unavailable.

E. DEPARTMENT OF VETERANS AFFAIRS PAYMENTS (VA BENEFITS)

The Department of Veterans Affairs (VA) has numerous programs which make payments to SSI/Medicaid recipients and their families. For SSI/Medicaid purposes, treatment of VA payments depends on the nature of the payments. The most common types are pensions, compensation, educational assistance, aid and attendance allowance, housebound allowance, clothing allowance, and payment adjustments for unusual medical expenses. Each type of payment is discussed in this subsection.

Explore the possibility of receipt of, or potential eligibility for, a VA payment, whenever it becomes known that an applicant or recipient is:

a. a veteran;

b. the child or spouse of a disabled or deceased service person or veteran;

c. an unmarried widow or widower of a deceased service person or veteran (be alert to previous spouses who were veterans);

d. the parent of a service person or veteran who died before January 1, 1957 from a service-connected cause.

NOTE: The Utilization of Other Benefits Provision specifies that an applicant or recipient who is potentially eligible for certain VA benefits must apply for those benefits as a condition of eligibility.

1. VA Pensions

VA pension payments are made on the basis of a combination of service and an age of 65 or over, a nonservice-connected disability or death. With a few rare exceptions noted below, VA pension payments are also based on need.

The VA may take dependents' needs into account in determining a pension. However, normally the VA will not make a pension payment directly to a dependent during the lifetime of the veteran. Instead, the amount of the veteran's basic pension is increased if the veteran has dependents. A VA pension payment that has been increased for dependents is called an augmented VA payment. A VA pension payment made directly to the dependent of a living veteran is called an apportioned payment. These types of payments are discussed later in this subsection.

VA pension payments are usually made on a monthly basis; however, when the payment due is small, the VA will pay quarterly, biannually or annually. The VA may also make an extra payment if an underpayment is due. VA payments made less frequently than monthly are income in the month received for eligibility purposes.

All VA pension payments except those listed below are federally funded income based on need. As such, the $50 general income exclusion does not apply. Pensions paid to veterans or their dependents on the basis of:

- a Medal of Honor; or

- a Special Act of Congress

are unearned income but are not needs based. Therefore, the $20 general exclusion applies to these payments.

The Veterans and Survivors Pension Improvement Act (referred to as VA Improved Pension) was signed into law October, 1978 with an effective date of January, 1979. The major change was in the method of determining the pension payable. The new rates of payment are not automatic: therefore, the veteran or survivor must file an application with

VA to establish entitlement. In the majority of cases, entitlement under the improved pension results in increased payments; therefore, recipients who receive benefits under old VA law must file for the improved pension as a factor of eligibility under the utilization of other benefits provision. If approved for the improved pension, the client must accept the improved pension if it results in increased payments. If accepting the improved pensions results in less money, the client is not required to accept.

2. VA Compensation Payments

Compensation payments are made by the VA to a veteran because of a service-connected disability or to a widow, widower, child or parent of a veteran because of the service-connected death of a veteran. VA compensation payments are not based on need except in two instances:

a. Death compensation to parents, and

b. Dependency and indemnity compensation (DIC) paid to parents.

Eligibility for death compensation and DIC is determined by the parents' income; therefore, these types of payments are based on need and the $50 general exclusion does not apply.

A living veteran's compensation payment may be increased (augmented) for dependents. In unusual circumstances, a VA compensation payment may be made directly to the dependent of a living veteran (apportioned). Refer to the discussion later in this subsection on augmented VA payments.

3. VA Educational Benefits

The VA provides educational assistance under a number of different programs including vocational rehabilitation. Depending on the nature of the VA program, different SSI income and resource policies apply.

Generally, veterans have 10 years after leaving the service to complete their education and 12 years to complete a program of vocational rehabilitation. Payments are usually made on a monthly basis only for months in which the veteran is in school. However, if school attendance is less than half time, the payments may be made less frequently. Dependents and survivors of veterans may also be eligible for educational benefits.

Some programs are "contributory." That is, the money is contributed to an educational fund and the government matches the money when it is withdrawn while the veteran is pursuing an education. The veteran has the right to withdraw as a lump sum the funds he has contributed.

The following policy principles apply when educational benefits are involved:

- Payments made as part of a VA program of vocational rehabilitation are not income. Subsistence allowances received during vocational rehabilitation may be augmented but the augmentation is not income.

- Any VA educational benefit payment or portion of such a payment which is funded by the government and is not part of a program of vocational rehabilitation is unearned income.

- Any portion of a VA educational benefit payment which is a withdrawal of the veteran's own contributions is a conversion of a resource and is not income.

- If payments are made under a contributory program or the nature of the program is in question, obtain evidence of the following:

  a. The amount of the veteran's contributions remaining in the fund that can be withdrawn as a lump sum.

  b. The portion of any VA educational benefit payment that is a withdrawal of the veteran's contributions to the fund.

4. VA Aid and Attendance and Housebound Allowances

The VA pays an allowance to veterans, spouses of disabled veterans and surviving spouses who are in regular need of the aid and attendance of another person or are housebound. This allowance will be combined with the individual's pension or compensation payment. VA Aid and Attendance (A&A) and household allowances are not income for eligibility purposes and must be excluded from the total VA payment when determining eligibility; however, A&A is a third party medical payment to be added to an institutionalized client's Medicaid Income through June 30, 1994. Effective July 1, 1994, VA A&A is no longer considered a third party medical payment.

Anyone in a nursing home who receives a VA benefit is potentially eligible for Aid and Attendance except:

- Individuals drawing a "child's" benefit. If an individual becomes disabled prior to age 18, he/she draws a child's benefit which continues into the adult years. A recipient of a VA child's benefit is not eligible for A & A.

- Individuals drawing only VA Insurance benefits. Usually someone who draws a VA Insurance benefit will also receive a DIC benefit; however, it is possible for someone to receive only the VA Insurance benefit. If an individual draws only VA Insurance benefits, that person is not eligible for A&A.

A nursing home applicant potentially eligible for VA Aid and Attendance must be advised in writing to apply for the payment. However, as specified in the "Utilization of Other Benefits" policy provision, the penalty for failure to apply for the benefit is not applicable when the only benefit involved is VA A & A.

5. **VA Clothing Allowance**

A lump sum clothing allowance is payable in August of each year to a veteran with a service-connected disability for which a prosthetic or orthopedic appliance (including a wheelchair) is used. The allowance is intended to help defray the increased cost of clothing due to wear and tear caused by the use of such appliances.

A VA clothing allowance related to use of a prosthetic or orthopedic appliance is not income for eligibility or Medicaid Income purposes.

6. **VA Payment Adjustment for UME (Unusual Medical Expenses**

VA considers unusual medical expenses (UME) when determining some needs-based pension and compensation payments. (Unusual medical expenses are expenses that exceed 5 percent of the maximum annual VA payment rate.) VA does this by deducting UME from any countable income. UME may result in a higher monthly VA payment, an extra payment, or an increase in an extra payment.

a. Policy in effect through June 30, 1994

An increase in a needs-based VA pension or compensation payment which is the result of UME is income whether included with the regular VA payment or paid as a separate payment. The increase related UME is a pension or compensation payment.

Claiming UME is part of the VA Improved Pension application process. If claiming UME will result in a higher benefit, then an applicant or recipient must claim these expenses whether the client lives at-home or in a nursing facility, as part of the Utilization of Other Benefits provision.

Note: There are instances where VA will not increase payments resulting from UME when a veteran enters a nursing home. One instance is due to Spousal Impoverishment rules that allow a Medicaid eligible Institutionalized Spouse (IS) to allocate his/her income to a Community Spouse (CS). The VA will not increase payments when a veteran will be allocating income to a CS. Form DOM-318 is used to notify the VA of any nursing home case involving a veteran IS allocating monthly income to a CS.

b. Policy effective July 1, 1994

Effective 07-01-94, SSI/Medicaid policy will no longer consider VA payments resulting from UME as income for eligibility and Medicaid Income purposes. SSI/Medicaid will consider such payments as reimbursements for medical expenses or services that are excluded from the definition of income.

Note: This change will affect the deeming process for certain individuals. The income of an ineligible spouse or parent who receives income based on need is not deemed to an eligible spouse or child in at-home cases. Needs-based pension and needs-based compensation payments are currently non-deemable income along with any other income of the ineligible. However, if an ineligible spouse or parent receives a VA payment that is only attributed to UME or A & A, then receipt of such payment will result in deeming the remaining income of the ineligible to the eligible. For example, if an ineligible spouse receives Social Security and VA and the VA is attributed solely to UME, then the ineligible's Social Security would be deemable to the eligible spouse effective 07-01-94. If the ineligible receives a VA needs-based pension or needs-based compensation payment in addition to payment for UME, then all income of the ineligible will continue to be non-deemable.

c. Income Trust Cases With Basic VA Benefits

Effective 07/01/94, count only basic VA benefits (as verified by VA) as an Income Trust client's total income available to fund the Income Trust. Any UME/A & A that is not counted as income can be retained by the client and/or spouse. The Income Trust Detail Sheet would need to specify the amount of VA that is not income.

d. IS/CS Cases With Basic VA Benefits

For IS/CS cases whereby the IS receives UME/A & A that is not countable as income, effective 0/01/94 the CS will be allowed to receive the IS payment attributable to UME and A & A along with the CS allocation amount computed in the Medicaid Income Computation. If the CS is not entitled to Medicaid, the extra income will have no impact. However, if the CS is Medicaid eligible at-home, the income that represents UME and A & A payable to the IS is income to the CS. UME and A & A is disregarded as income only to the one entitled to the payment. When it becomes income available to a CS, it is income to the CS. If the income is given to anyone else, the possibility of a transfer of resources exists.

If the CS does not receive the income attributed to UME/A & A, then the possibility of excess resources building up for the IS exists and resources must be monitored closely.

7. VA Benefit Allocated to a Spouse Receiving IBON

In cases where the spouse of an applicant or recipient receives IBON (Income Based On Need as defined in Unearned Income), the source of the IBON may count a portion of the VA benefit as income to the spouse receiving the IBON. When this is the case, a deduction will be made from the VA benefit of the Medicaid client equal to the amount counted as income by the source of the IBON.

Verify from the source of the IBON (not VA) the amount of the VA benefit counted as income to the spouse. This amount will be deducted from the countable VA benefit verified by VA.

For example, an applicant receives a VA pension and his spouse receives SSI. If SSI counts a portion of the VA pension as income in the spouse's SSI computation, then deduct the amount of the VA benefit verified by SSI as the SSI recipient's income.

8. VA Contract Patients in Nursing Facilities

Certain veterans qualify for VA contract payments which cover nursing home care for one to six months. The contract period begins with the date of nursing home placement and covers the date of admission but not the date the contract expires. For example, if a veteran is placed in a nursing facility under VA contract effective January 15, the contract will expire July 15 and VA will not reimburse the facility for the day of July 15.

It is possible for a service-connected veteran to be under VA contract in a nursing facility for an indefinite length of time. These individuals are not subject to the six-month limit for a VA contract as are nonservice-connected veterans.

Eligibility for Medicaid benefits other than nursing home reimbursement can begin prior to the date a VA contract expires, depending on the date application is filed and provided the applicant is eligible on all other factors. Reimbursement cannot begin until the date the VA contract expires. Do not count VA contract money paid to the nursing home as income to a MAO applicant. Although VA contract payments are a third party medical payment, it is not a payment subject to recovery by Medicaid.

It is possible for a veteran's ongoing VA benefits to be reduced during the VA contract period and returned to the full amount the month following the expiration of the VA contract. When verifying VA income for eligibility purposes during a VA contract period, it is important to determine if reduced benefits are involved and to determine when full benefits will resume. Benefits are usually raised in the month following the month the VA contract ends.

9. Reduction in VA Pension for Veterans & Surviving Spouses in Nursing Homes

Public Law 101-508 (OBRA-90) amended 38 USC 3203 to limit paying improved pension to $90 per month for veterans having neither spouse nor child who are in a Medicaid approved nursing facility and who are covered by Medicaid. Effective October 1, 1992, the Veterans Benefit Act of 1992 (P.L. 102.568) extends the reduced pension payment to surviving spouses (widows or widowers of veterans in the same manner as the provision applies to a veteran. The $90 is a maximum payment; the payment can be less than $90. A reduced pension of $90 or less is not income for eligibility purposes. Since federal law prohibits counting the reduced pension toward the veteran's or surviving spouse's cost of care (Medicaid Income), the Personal Needs Allowance (PNA) for all client's receiving a reduced pension is equal to the pension payment. Refer to the "Personal Needs Allowance" budgeting policy for further discussion.

Single veterans and surviving spouses of veterans in nursing homes (with no dependents) who become Medicaid eligible must be referred to the VA to determine if their pension is subject to the $90 limit. The worker must set appropriate ticklers to check with VA to determine appropriate case action.

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10. Income Trust Cases & $90 VA Reduced Pension

When a client who is eligible for LTC Nursing Home coverage under an Income Trust becomes entitled to the $90 Reduced Pension and the client continues to need the Income Trust to remain eligible, do not count the $90 as income to the Income Trust client. The $90 pension is entered in MEDS as VA Reduced Pension and the remaining income of the client (which should continue to be $1 less than the Institutional Income limit) is shown as Trust Income. By doing this, the client will correctly receive the $90 PNA in the Medicaid Income computation. A new Income Trust Detail Sheet is required to show the $90 PNA.

When an Income Trust client's pension is reduced to $90 and this results in total countable income that no longer exceeds the Income limit, the Income Trust must be dissolved.

11. Payments to Vietnam Veterans' Children With Spina Bifida

Public Law 104-204 authorizes VA to provide benefits, including a monthly monetary allowance, to certain Vietnam veterans' children who suffer from spina bifida. Beginning after 10/01/97, VA will make monthly payments to or on behalf of certain Vietnam veterans' natural children, regardless of their age or marital status, for any disability resulting from spina bifida. These VA payments are excluded from income and resources for SSI Medicaid purposes. Interest earned on unspent payments is not excluded.

12. Determine Amount of VA Payment

Whether or not an entire VA payment is counted as income depends on the type of VA payment being made and the policy in effect in the month of the payment.

Overpayments recovered from VA benefits are included as income in determining eligibility and Medicaid Income. Refer to the discussion of "Amount of Unearned Income" for policy governing overpayments withheld from unearned income.

Note: In cases where VA "suspends" VA Improved Pension benefits for failure to verify medical expenses, it is not correct to adjust the VA benefit to zero. VA benefits are only temporarily suspended and will be restored back to the date suspended when verification is received. The benefit in effect prior to the suspension date continues to count as income until VA benefits are restored because the recipient remains entitled to the VA benefit. Any lump sum retroactive VA payment to restore suspended benefits is not counted as income since the income has already been counted.

13. Augmented VA Payments

In some instances, the VA considers the number of dependents a veteran has in determining the amount of the veteran's or widow(er)'s benefit. Benefits which are increased because of dependents are termed "augmented" benefits. However, the presence of dependents in VA or SSA records does not necessarily mean a payment will be augmented. VA benefits which may be augmented are pensions, compensation and educational assistance. When a benefit is augmented, the augmentation (i.e., increase for dependent) may be included in the payment to the veteran or widow(er); or a payment may be made by apportionment (i.e., separate check to the dependent).

Augmented VA payments are income to the veteran. Apportioned VA payments are income to the dependent receiving the separate payment.

14. Verification of VA Payments

Verification of benefits paid by the VA is obtained by writing the appropriate VA Center. Written verification is obtained by use of the attached unnumbered VA form. These forms are mailed to:

Veterans' Service Division
VA Regional Office
1600 E. Woodrow Wilson Drive
Jackson, MS 39216

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This form is used to verify veterans' benefits for several veterans or surviving spouses on one form. VA will verify the "Total" benefit amount and the "Basic" amount if the total benefit includes UME and/or A & A. If there is a difference in the "Total" and the "Basic", use the amount entered by VA as the Basic payment as income. The difference in the two payments is attributable to UME or A & A, or both. VA will not provide a breakdown of A & A and UME since both are excluded from income.

If the "Type of Benefit" is pension and the "Total Benefit Amount" equals $90 and "$0" is entered as "Basic", then this indicates the client receives a $90 Reduced Pension.

Any amounts that VA enters as "Back Pay" will be basic amounts only.

To obtain written verification of VA Insurance benefits, write to:

VA Center
P. O. Box 8079
Philadelphia, MS 19101

Note: VA Insurance benefits do not change once the benefit amount has been determined. Therefore, once the benefit amount has been verified, it is not necessary to re-verify the benefit amount.

F. OTHER MAJOR BENEFITS

The following is a discussion of other types of unearned income, in addition to Social Security and VA, considered a payment of a major benefit.

1. Railroad Retirement Benefits

There are 3 basic categories of payments made by the Railroad Retirement Board (RRB):

- Life and survivor annuities.

  Life annuities for retirement and disability are paid under the Railroad Retirement (RR) Act to the railroad employee and his/her spouse. Children of a living annuitant are not entitled to benefits.

  Survivor annuities are payable to widows, widowers, children, and dependent parents of railroad employees. A small number of widows receive two annuities, a regular widow's check and a check payable to them as designated survivors of retired railroad employees who elected to receive reduced benefits during their lifetimes.

  RR annuity payments are **similar to title II** benefits in that a check for one month is paid the next month. Also, cost of living adjustment (COLA) for RR annuities are effective the same month as title II COLA'S. However, since RRB benefits are computed on separate amounts, the COLA increase on the total may not be as high as for a title II benefit.

- Social Security benefits certified by RRB.

  SSA may authorize the payment of Social Security benefits for RR employees to RRB instead of directly to Treasury. Although RRB in these situations has responsibility for certifying title II benefits to Treasury, they remain title II benefits.

Individuals entitled to this type of benefit receive two award notices. The first notice, from SSA, informs the beneficiary that RRB has responsibility for making Social Security payments. The final notice, from RRB, specifies the amount of the first check.

RR annuity payments and Social Security benefits certified by RRB may be paid as a single check. In these cases, RRB may issue an interim notice before the final notice which specifies the amount of the first check.

- Unemployment, sickness and strike benefits.

  Unemployment, sickness, and strike benefits are computed on a daily basis with each check covering a period of up to 2 weeks. These claims are usually filed through the railroad employer or directly with RRB in Chicago.

Payments made by the RRB are unearned income. A Medicare premium deducted from a RRB check is added to the check payment amount to determine total income.

Overpayments recovered from RRB benefits are included as income in determining eligibility for Medicaid. Refer to the discussion of "Amount of Unearned Income" for policy governing overpayments withheld from unearned income.

Contact the Railroad Retirement Board for verification of benefits. Offices and addresses are listed in the Appendix.

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2. Government Pensions and Retirement Payments

Payments made to former employees, their dependent(s) or survivor(s) by Federal, State or local governments, including foreign governments, are unearned income. Examples include Civil Service Retirement, State Retirement and Municipal Retirement.

Verify the amount of the retirement benefit by award letters or other documents in the individual's possession or contact the agency which is the source of the payment. It is not permissible to verify payment amounts by viewing the actual check because optional deductions are usually available to the recipient which are not allowable deductions for SSI/Medicaid purposes. The full amount of the benefits which the recipient is entitled to receive is counted as income as outlined in "Amount of Unearned Income."

Civil Service Retirement

Civil Service Retirement adjustment notices may show an amount under "Monthly Health Benefits" which is an addition to the gross amount of the benefit rather than a deduction. This occurs whenever the beneficiary of the benefit refuses the Federal health insurance offered. Civil Service adds an amount which is a health insurance "allowable." The recipient may use the extra amount toward the purchase of private health insurance. However, this addition to the gross amount is counted as income. This is one instance where net proceeds count rather than the gross amount, since the net is more.

To verify Federal Civil Service Retirement Benefits, a long distance Washington, D. C. number (not toll free) is available. The number is (412) 794-8442. direct written inquiries to:

Office of Personnel management
Employee Service and Records Center
Claims Correspondence Section
Boers, PA 16017

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State Retirement

Certain State retirees (including those drawing benefits from a deceased spouse's record) are eligible to receive a 13th check each year in addition to their regular monthly check which is referred to as a bonus check. The bonus check, which is usually issued each December 15, is computed on a percentage basis multiplied by the number of years retired and the annual income received.

The 13th check is counted as income each December to determine eligibility for the month of December. If a client is eligible based on receipt of the bonus check, the bonus payment may be averaged in the Medicaid Income computation as per budgeting instructions.

To ensure that each affected recipient has the bonus check counted as income in the month of December, a tickler must be set for each November 1 for each recipient of a State retirement check. The purpose of the tickler is to anticipate the bonus check based on the amount of the previous year's bonus check amount, as verified by the Public Employees' Retirement System Office.

Note: Whenever eligibility is approved for a State retirement recipient after the month of December of each year, the worker must verify the most recent bonus check amount. This is necessary so that the amount of the previous year's bonus check can be anticipated as income the following December, as outlined above.

3. **Unemployment Insurance Benefits**

Unemployment insurance benefits, also known as unemployment compensation, means payments received under a State or Federal unemployment law and additional amounts paid by unions or employers as unemployment benefits. Unemployment insurance benefits are unearned income.

Workers should routinely check for unemployment benefits for applicants or recipients with recent work history.

Form DOM-334 will be used to verify Unemployment Compensation benefits. Refer to the Appendix for a listing of the addresses of local Employment Offices. The DOM-334 should be mailed to the local Employment Office which serves the county in which the applicant or recipient resides.

4. **Workers' Compensation**

Workers' compensation (WC) payments are awarded to an injured employee or his/her survivor(s) under Federal and State WC laws, such as the Longshoremen and Harbor Workers' Compensation Act. The payments may be made by a Federal or State agency, an insurance company, or an employer.

The WC payment less any expenses incurred in getting the payment is unearned income.

Any portion of a WC award or payment that the authorizing or paying agency designates for medical expenses or legal or other expenses attributable to obtaining the WC award is not income. The expenses may be past, current, or future. The WC payments designated for such expenses may be received in a lump sum or as a continuing payment.

Regional office staff needing information concerning an individual's WC benefits should send DOM-333 and a signed DOM-301 to the State Office giving all pertinent facts and identifying information. All inquiries must come through the State Office as the Workers' Compensation agency will not fill individual written requests.

5. Military Pensions

The Air Force, Army, Marine Corps, and Navy pay military pensions to military retirees and survivors normally on the first day of the month.

There are three categories of beneficiaries who may be entitled to military payments:

- **RETIREE** - A person with 20 years of service who meets the requirements for entitlement;

- **ANNUITANT** - A survivor who is designated by the retiree to receive benefits upon the death of the retiree under the Retired Serviceman's Family Protection Plan (RSFPP), Survivor's Benefit Plan (SBP), or both;

- **ALLOTTEE** - Anyone other than an annuitant of the RSFPP or SBP who is designated to receive money out of the service member's or retiree's check. Entitlement as an allottee terminates upon the death of the retiree. However, an allottee can become an annuitant when the retiree dies.

The RSFPP and SBP annuitant programs pay money to surviving spouse(s) and children.

The SBP program also pays:

- "Insurable interest" persons: i.e., someone other than a surviving spouse or child that a service member designated to receive survivor benefits based on monies withheld from his or her retirement payment under the provisions of the SBP program; and,

- Minimum income level widows (MIW) who are certified by the VA as having low income and are referred by the Department of Defense (DOD).

Military pensions are unearned income. Payments to MIW's are income based on need not subject to the $20 general income exclusion.

The following addresses and phone numbers will verify military retirement and annuity payments for all branches of service except the Coast Guard:

Defense Finance and Accounting Service
Directorate for Retired Pay (CodeRO)
P. O. Box 99191
Cleveland, Ohio 44199-1126
Phone: 1-800-321-1080
Fax: 1-800-469-6559

For verification of Military Retiree Annuity Payments, mail the DOM-301 to the following address:

De-fas-DE/FRB
6760 E Irvington Place
Denver, CO 80279-6000
Phone: 1-800-435-3396

For verification of Coast Guard Retirement call the following number:

1-800-424-7950 or 913-295-2657

When calling, state the retiree's name and Social Security Number to obtain benefit information.

G. PAYMENTS FOR CHILDREN & SPOUSES

The following types of unearned income are made for or on behalf of children and/or spouses.

1. TANF Payments

TANF (Temporary Assistance for Needy Families), formerly AFDC (Aid to Families With Dependent Children), makes a payment to a family unit rather than an individual. The payment is frequently referred to as a "grant." An individual who meets the eligibility requirements for both TANF and SSI may choose the program under which he/she prefers to receive benefits. However, if the individual receives SSI, he/she may no longer be included in the TANF grant.

TANF payments are federally funded income based on need and are counted dollar for dollar as income. The $20 general income exclusion does not apply to this income.

2. Foster Care

An individual is considered to be in foster care when:

a. a public or private nonprofit agency (i.e., one which is tax exempt under section 501(a) of the Internal Revenue Code) places the individual under a specific placement program; and

b. the placement is in a home or facility which is licensed or otherwise approved by the State to provide care; and

c. the placing agency retains responsibility for continuing supervision of the need for such placement and the care provided.

A foster care payment is a payment made to the provider for the purpose of meeting the needs of the individual in foster care. Foster care payments made to a provider of foster care are <u>not</u> income to the provider.

Foster care payments made under title IV-E are federally funded income based on need to the child in care. This income is not subject to the $50 general exclusion.

Foster care payments involving funds provided under title IV-B or title XX of the Social Security Act are Social Services and are not income.

3. Adoption Assistance

Adoption assistance programs provide payments and/or services for children for whom unassisted adoption is unlikely because of age, ethnic background, physical, mental or emotional disability, etc. The income of either the adopting parent, the adopted child, or both may have been considered in determining the payment. Usually, adoption assistance will be formalized in a written agreement between the adopting parents and the agency involved. Adoption assistance may be provided by public or private agencies and may be based on financial need.

Adoption assistance provided by States under title IV-E of the Social Security Act involved Federal Funds and is needs-based. Under IV-E, there is no income test for the adopting parents but the children must be those who are, or could be, eligible for AFDC or SSI prior to adoption. Therefore, there is an income test for children who receive IV-E adoption assistance. Concurrent receipt of IV-E adoption assistance and SSI is permissible.

Adoption assistance cash payments made to adoptive parents under title IV-E are federally funded income based on need to the adopted child. This income is not subject to the $50 general exclusion. Therefore, the total payment is considered cash income to the individual and is counted dollar for dollar.

NOTE: In addition to a cash payment to the adoptive parents, social services may be provide under title IV-E. Social services are not income.

4. Support Payments (Child Support Alimony

Alimony and support payments are cash or in-kind to meet some or all of a person's needs for food, clothing, or shelter. Support payments may be made voluntarily or because of a court order. Alimony (sometimes called "maintenance" is an allowance made by a court from the funds of one spouse to the other spouse in connection with a suit for separation or divorce.

Alimony, spousal, and other adult support payments are unearned income.

Child support payments are unearned income; however, exclude one-third of the amount of a payment made to or for an eligible child by an absent parent.

A parent is considered absent if the parent and the child do not reside in the same household.

a. If the periods of living together are brief and the child remains independent or under the care and control of another person, agency, institution, or is living in the home of another, the parent is usually considered absent unless he/she retains **parental responsibility and control.**

b. A parent is not considered absent if he is away due to **employment**, intends to resume living with the child, and retains parental control and responsibility.

c. A child (or parent) who is a **boarding student** in an educational facility is not considered absent.

Verify the amount and frequency of support payments by using:

- court records;
- records of an agency through which the payments are made;
- documents in the individual's possession or contact with the source of the payment.

In the case of one payment for two or more individuals:

a. To determine one individual's share of a support payment made for more than one person, **look first to the legal document** setting the payments.

b. **If the legal document** addresses each person's share, divide the payment according to the terms of the document. If the payment does not equal the established support amount, contact the source of the payment to establish intent and divide the payment according to that intent. If this is unsuccessful, divide the payment proportionately.

H. RENTAL INCOME

Rent is a payment which an individual receives for the use of real or personal property, such as land, housing or machinery.

Net rental income is gross rent less the ordinary and necessary expenses paid in the same taxable year.

Ordinary and necessary expenses are those necessary for the production or collection of rental income. In general, these expenses include:

- interest on debts;
- State and local taxes on real and personal property and on motor fuel;
- general sales taxes; and
- expenses of managing or maintaining property.

See below for a more specific list.

To determine if rental property can be excluded as a resource, refer to the Resources section for a discussion of Income-Producing Property.

1. Policy Principles

The following policy principles apply to rental income:

- Depreciation or depletion of property is not a deductible expense.
- Deduct expenses when paid, not when incurred.
- Net rental income is unearned income unless it is earned income from self-employment (e.g., someone who is the business of renting properties).
- Rental deposits are not income to the landlord while subject to return to the tenant. Rental deposits used to pay rental expenses become income to the landlord at the point of use.

- In determining net rental income, do not consider rents received or expenses paid in months prior to Medicaid eligibility.

- In determining net rental income, consider rents received or expenses paid in a month in which the case is ineligible as if the case had been eligible (interim months of ineligibility).

2. Deductible Expenses

Examples of deductible expenses:

- interest and escrow portions of a mortgage payment (at the point the payment is made to the mortgage holder);

- real estate insurance;

- repairs (i.e., minor correction to an existing structure);

- property taxes;

- lawn care;

- snow removal; and

- advertising for tenants.

3. Nondeductible Expenses

Examples of nondeductible expenses:

- principal portion of a mortgage payment; and

- capital expenditures (i.e., an expense for an addition or increase in the value of property which is subject to depreciation for income tax purposes).

If uncertain whether an expense is allowable (e.g., whether it is an incidental repair or a capital expenditure), contact the local Internal Revenue Service (IRS) or refer to IRS Publication 527. Document the file with the information obtained from IRS.

4. Multiple Family Residence

In multiple family residences:

- If the units in the building are of approximately **equal size**, prorate allowable expenses based on the number of units designated for rent compared to the total number of units.

- If the units are **not** of approximately **equal size**, prorate allowable expenses based on the number of rooms in the rental units compared to the total number of rooms in the building. (The rooms do not have to be occupied.)

5. Rooms in Single Residence

For rooms in a single residence:

a. Prorate allowable expenses based on the **number of rooms** designated for rent compared to the number of rooms in the house.

b. Do not count **bathrooms** as rooms in the house.

c. Count **basements** and **attics** only if they have been converted to living spaces (e.g., recreation rooms).

6. Land

We prorate expenses based on the percentage of total acres that is for rent.

7. Determining Net Rental Income

a. **Determine** gross rent received and deductible expenses month-by-month.

b. **Subtract** deductible expenses paid in a month from gross rent received in the same month.

c. If deductible expenses exceed gross rent in a month, subtract the **excess expenses** from the next month's gross rent and continue doing this as necessary until the end of the tax year in which the expenses is paid.

d. If there are **still excess expenses** after applying b. above, subtract them from the gross rent received in the month prior to the month the expenses were paid and continue doing this as necessary to the beginning of the tax year involved.

NOTE: Do not carry excess expenses over to other tax years nor use them to offset other income.

Example:

An individual receives $100 gross rental income monthly. He pays allowable expenses of $200 in July and $400 in November. His taxable year is January 1 through December 31. The allocation is as follows:

The $200 allowable expenses paid in July reduce the net rental income to zero in July (the month the expenses were paid) and August (the subsequent month). The $400 allowable expenses paid in November reduce the net rental income to zero in November (the month paid); December (the subsequent month); October (the month preceding the month the expenses were paid); and September (the next preceding month).

Note: Allowable expenses must be timely submitted in order for the expense to be considered as a deduction from rental income. This is true since policy specifies to begin the deduction in the month in which the expense is paid. For each month the expense is not submitted after payment of the expense, the deduction for that month is lost (although any excess may be allowed in a subsequent month or a month prior to payment if an excess exists at the end of the tax year).

8. Verification of Rental Income

To verify rental income, request the individual's Federal income tax return (including Schedule E) for the most recent closed tax year, and retain a copy for the file. This will be helpful in identifying the most usual expenses deducted from rental income in the past, and as an aid in estimating rental income for the future. Regardless of whether the most recent tax return is available, also request other records (bills, receipts, etc.) to establish actual gross rental income and allowable expenses for the period involved.

Verification of the amount of rental income and dates received, and of the amount of allowable expenses and dates paid, must be documented in the file. Therefore, place in the file copies of all records (bills, receipts, etc.) use in computing the amount of net rental income. If the individual has no tax return or other records, obtain the individual's signed statement explaining why no records are available and providing his/her allegation of the amount of gross rental income and allowable expenses for the period involved.

Use an individuals' **amortization schedule** to determine interest expense. If a **schedule** is **not available**, divide the yearly interest by twelve to determine monthly interest.

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UNEARNED INCOME

9. Joint Ownership Rental Income

If an eligible individual and eligible spouse (couple) jointly own rental property, it is not necessary to compute each person's share of the rental income in cases where income must be combined for the couple. In all other joint ownership cases, including those where a third person owns rental property with an eligible couple, it is necessary to determine what share of the rental income (after deduction of allowable expenses, if any) is charged to the eligible. Absent evidence to the contrary, apportion the net rental income equally among the owners. However, if the joint ownership agreement or other evidence (e.g., tax return, statements of joint owners) shows some other distribution, consider that evidence in determining the eligible's share of net rental income. In situations where there is evidence of other than equal apportioning, document the file with a copy of any evidence obtained, the decision reached, and the reason for the decision as to how income is apportioned.

10. Estimating Future Rental Income

When projecting future rental income, use the documentation obtained from the prior tax year, as outlined in "Verification of Rental Income," to estimate anticipated income and expenses for the current tax year. For future periods, deduct only those expenses which are predictable; i.e, those which recur regularly and the amount of which can be estimated with a reasonable degree of accuracy. Examples of such predictable expenses include interest payments, property taxes, insurance premiums and utilities. Do not project variable (unpredictable) expenses. Consider variable expenses after they have been paid, when the payment can be documented. Examples of variable expenses include repairs and advertising costs.

I. MISCELLANEOUS UNEARNED INCOME

The following lists various different types of unearned income categorized as "miscellaneous."

1. Tuition, Fees & Other Expenses of Grants, Scholarships & Fellowships

Grants, scholarships, and fellowships are amounts paid by private nonprofit agencies, the U.S. Government, instrumentalities or agencies of the U.S., State and local governments, foreign governments, and private concerns to enable qualified individuals to further their education and training by scholastic or research work, etc.

a. Any amount provided by an individual to aid a relative, friend, or other individual in pursuing his studies where the grantor is motivated by family or philanthropic considerations is a **gift** and is not a grant, scholarship, or fellowship for purposes of this section.

b. Any amount which is **earned income** is not a grant, scholarship, or fellowship.

c. Any portion of a grant, scholarship, or fellowship used for paying tuition, fees, or other necessary educational expenses is excluded from income. This exclusion does not apply to any portion set aside or actually used for food, clothing or shelter.

d. It is expected that **expenses will include** carfare, stationery supplies, and impairment-related expenses necessary to attend school or perform schoolwork (e.g., special transportation to and from classes, special prosthetic devices necessary to operate school machines or equipment, etc).

Verify the nature of the assistance by using documents in the individual's possession or contact with the institution or provider.

Use receipts, bills with canceled checks, contact with the provided, etc., to verify expenses paid. If an expense is verified as incurred but not paid, assume the individual will pay the expense unless you have reason to question the situation. No follow up is required if the assumption is applied.

2. Dividends & Interest

Dividends and interest are returns on capital investments such as stocks, bonds, or savings accounts. Dividends and interest are unearned income at the earlier of the following:

- the month they are credited to an individual's account and are available for use;

- the month they are set aside for the individual's use; or

- the month they are received by the individual.

NOTE: Account service fees or penalties for early withdrawal do not reduce the amount of interest or dividend income.

The following describes when dividends or interest are considered unearned income.

Financial Institution

- interest is income when credited to the customer's ccount

Series E/EE U.S. Savings Bonds

- if the bonds were purchased by the owner or was a gift to the owner prior to the expiration of the minimum retention period, the interest is not income. It is an increase in the value of a resource.

- if the bonds were a gift to the owner after expiration of the minimum retention period, the purchase price of the bond plus accrued interest is income in the month received.

Series H/HH U.S. Savings Bonds

- if the bonds make semi-annual interest payments, the interest is income when available to the individual.

- if the bonds were a gift to the owner after the expiration of the minimum retention period, the purchase price of the bond plus accrued interest is income in the month received.

Life Insurance Policy

- if the policy pays dividends, the dividends are not income. If the policy pays interest on dividends, the interest is income. This is true even when the policy is not a countable resource.

Promissory Note or Loan Agreement

- SSI Policy - if the note or loan pays interest, or pays principal and interest in same payment, the interest only is income.

- Liberalized Policy - interest and principal count as income in order to determine if the 6% rule applies so that the note or loan can be excludable as a resource. Although interest is income, the note or loan can be excluded if the 6% rule (and life expectancy rule, if appropriate) is met. This is more liberal than SSI since SSI would count the note or loan as a resource that could be sold.

Verify and document the amount and frequency of interest or dividend payments by using a check or notice issued by the source. If dividends are received in a form other than cash, to determine the amount of the dividend, establish the value of the item, e.g., share of stock, stock options, etc.

3. Royalties

Royalties are payments to the holder of a patent or copyright, owner of a mine, etc., for the duplication of a writing, use of an invention, extraction of a product, etc. Royalties are unearned income unless they represent self-employment earnings from a royalty-related trade or business.

Verify these payments by examining any receipts or royalty agreements the individual may have which reflect the amount of the royalty payment and the frequency of payment. If the individual has no such evidence in his possession, contact the company or source of the royalty.

Some documents that indicate royalty payments will provide a gross figure and a net figure. When the difference between the gross and the net figure is due to income taxes withheld, the gross figure is to be used when determining income. However, when the difference between the gross and net figures represents a production of severance tax (e.g., most oil royalties will be reduced by this tax), the next figure should be used when determining income. The production or severance tax is a cost of producing the income and, therefore, is deducted from the gross income.

Effective 10-01-91, royalties earned by an individual in connection with any publication of his/her work and any honoraria received for services rendered is earned income.

4. Awards

An award is usually something received as the result of a decision by a court, board of arbitration, or the like.

An award is unearned income subject to the general rules pertaining to income and income exclusions.

Use documents in the individual's possession or contact with the court, board, source, etc; to verify:

- the amount of the award;

- the payment date; and,

- if needed, the purpose(s) of the payment (e.g., part of the payment is reimbursement for medical expenses).

Determine the nature of the award and apply the appropriate rules pertaining to income and income exclusions.

5. Gifts

A gift is something a person receives which is **not repayment** for goods or services the person provided and is **not** given because of a **legal obligation** on the givers' part.

To be a gift, something must be given **irrevocably** (i.e., the donor relinquishes all control).

"Donation" and "contributions" may meet the definition of a gift.

NOTE: A gift received as the result of a death is a **death benefit.**

A gift is unearned income subject to the general rules pertaining to income and income exclusions.

A gift of a house which is used as a shelter is valued under the presumed maximum value (PMV) rule. A gift of a house which is not shelter is valued at its current market value (CMV).

Accept an individual's signed estimate of the value of the gift (or actual value if cash) unless you have reason to doubt the estimate. If you doubt the estimate, determine the item's current market value with an independent source.

Determine the nature of the gift and apply the appropriate operating instructions pertaining to income and income exclusions.

6. Prizes

A **prize** is generally something won in a contest, lottery or game of chance.

A prize is unearned income subject to the general rules pertaining to income and income exclusions.

NOTE: Do not subtract gambling losses from gambling winnings in determining an individual's countable income.

If an individual is offered a choice between an in-kind prize and cash, the cash offered is counted as unearned income. This is true even if the individual chooses the in-kind item and regardless of the value, if any, of the in-kind item.

When an individual reports receipt of a prize, obtain the individual's signed statement of the following:

- date the prize was received;
- type of prize received;
- individual's estimate of the value of the prize if not cash;
- amount of income tax withheld, if any and
- source of prize.

Accept an individual's signed estimate of the value of the prize (or actual value if cash or cash offer) unless you have reason to doubt the estimate. If you doubt the estimate, determine the item's current market value with an independent source.

7. Death Benefits

A death benefit is something received as a result of another's death. Benefits Examples of death benefits include:

- proceeds of life insurance policies received due to the death of the insured;

- lump sum death benefits from SSA;
- Railroad Retirement burial benefits;
- VA Burial benefits;
- inheritance in cash or in-kind;
- cash or in-kind gifts given by relatives, friends, or a community group to "help-out" with expenses related to the death.

NOTE: Recurring survivor benefits such as those received under Title II, private pension programs, etc., are not death benefits.

Effective April 1, 1988, death benefits provided to an individual are income to that individual to the extent that the total amount exceeds the expenses of the deceased person's last illness and burial paid by the individual. Last illness and burial expenses include:

- related hospital and medical expenses;
- funeral, burial plot and interment expenses;
- other related expenses such as clothing to wear to the funeral, food for visiting relatives, taxi fare to and from the hospital and funeral home, etc.

Verify all last illness and burial expenses. If verification (bills, receipts, etc.) cannot be obtained, accept the individual's signed allegation. If an expense has been incurred but not paid, assume that the individual will pay the expense unless there is reason to question the situation. No follow-up is required if the assumption is applied.

To determine the income derived from death benefits, subtract the total expenses from the total death benefits. Charge the income in the month the death benefit(s) is received. If death benefits are received in more than one month, assume that the funds first received are the first spent. For example, if the death benefits are $1000 received in January and $1500 in February and allowable expenses are $2000, charge the remaining $500 as income in February.

Death benefits that are not income are also not a resource for one calendar month following the month of receipt. This allows time for the death benefit to be used for illness/burial expenses. If death benefits are retained into the second calendar month following receipt, they are resources.

8. Inheritances

Inheritance means cash, other liquid assets and non-cash items, or any right in real or personal property of the deceased to which one succeeds in ownership as a result of the death of another. Inheritance is not counted until actually received, i.e., available for support. An inheritance is a death benefit.

If an individual has been charged with a resource as a result of deeming and later inherits the same resource, there is no income to the individual due to the inheritance. Note: The proceeds of a life insurance policy were not a resource before the death.

9. Work-Related Unearned Income

The following work-related payments are unearned income.

Certain in-kind items provided as remuneration for employment (food/shelter).

Money paid to a resident of a public institution when no employer employee relationship exists.

Tips under $20 per month.

Jury fees (i.e., fees paid for services, not expense money).

Food, clothing, and shelter provided to members of the Uniformed Services and their families; cash allowances for these items; and all types of special and incentive pay.

10. Military Allowances

Military personnel rarely apply for Medicaid; however, spouses and children may make application and the military pay would be subject to deeming. For Medicaid purposes only, the base pay is earned income; cost allowances for quarters, rations, and clothing are unearned income.

INCOME
EARNED INCOME

A. GENERAL

Earned income may be received in cash or in kind and consists of:

- Wages
- Net earnings from self-employment (NESE)
- Payments for services performed in a sheltered workshop or work activities center
- Earned income tax credit (EITC) payments; excluded effective January 1, 1991
- Royalties earned by an individual in connection with any publication of his/her work and any honoraria received for services rendered, effective December 1, 1991.

B. SICK PAY

Sick pay is a payment made to or on behalf of an employee by an employer or a private third party for sickness or accident disability.

Sick pay is either wages or unearned income. (Payments to an employee under a workers' compensation law are neither wages nor sick pay.)

The following chart shows how to treat sick pay received since January 1, 1982.

INCOME

EARNED INCOME

WHEN RECEIVED	ATTRIBUTABLE TO EMPLOYEE'S OWN CONTRIBUTION ?	TYPE OF INCOME
More than 6 months after stopping work	N/A	Unearned Income
	No	Wages
Within 6 months after stopping work	Yes	Unearned Income

To determine the 6-month period after stopping work:

- Begin with the first day of nonwork.
- Include the remainder of the calendar month in which work stops.
- Include the next 6 full calendar months.

For example, if an individual stops work on May 5, the 6-month period begins on May 6 and runs through November 30.

Verify sick pay which is wages by using the wage verification procedure.

Verify the last day (or month) worked with the employer or knowledgeable third party.

Document the file with the employer/third party's statement or report of contact showing the last day (or month) worked.

INCOME
EARNED INCOME

C. WAGES

Wages are what an individual receives (before deductions) for working as someone else's employee.
NOTE: Under certain conditions, services performed as an employee are deemed to be self-employment rather than wages (e.g., ministers, real estate agents, share farmers, insurance salesman, etc.).

1. Types of Wages

Wages may take the form of:

a. **Salaries** - These are payments (fixed or hourly rate) received for work performed for an employer.

b. **Commissions** - These are fees paid to an employee for performing a service (e.g., a percentage of sales).

c. **Bonuses** - These are amounts paid by employers as extra pay for past employment (e.g., for outstanding work, length of service, holidays, etc.)

d. **Severance pay** - This is payment made by an employer to an employee whose employment is terminated independently of his wishes.

e. **Military basic pay** - This is the service member's wage, which is based solely on the member's pay grade and length of service.

Absent evidence to the contrary, if FICA taxes have been deducted from an item, assume it meets the definition of wages.

2. When To Count Wages

Wages for each month count at the earliest of the following points:

- when they are received, or
- when they are credited to the individual's account, or
- when they are set aside for the individual's use.

INCOME
EARNED INCOME

3. Wage Advances

Advances are payments by an employer to an individual for work to be done in the future.

An advance is wages in the month received.

4. Deferred Wages

Wages are considered "deferred" if they are received later than their normal payment date. Types of wage payments which may be deferred include vacation pay, dismissal and severance pay, back pay, bonuses, etc.

Wages that are deferred **due to circumstances beyond the control of the employee** are considered earned income when actually received.

Wages that are deferred **at the employee's request or by mutual agreement with the employer** are considered earned income when they would have been received had they not been deferred.

5. Verification of Wages & Termination Wages

Earned income must be verified. The burden of proof is on the client, however, assistance will be provided by the worker if the client is unable to secure evidence of wages.

Acceptable evidence of wages include:

1. Pay Slips - for pay slips to be acceptable, it is necessary that they contain the wage earner's name or Social Security Number, gross wages and the period of time covered by the earnings. Pay slips which do not contain all the required information may be used in conjunction with other evidence; however, any discrepancies must be resolved.

2. A written statement of wages from the employer, such as DOM-335, Request for Verification of Wages.

3. W-2 forms may be used to estimate income when pay slips are not available and the individual alleges that earnings will be about the same. Use of W-2's should be restricted to situations where employment is sporadic or there are multiple or a long succession of employers.

4. Verbal statement of wages from the employer. Record the statement on a Record of Contact.

6. Determining Amount of Earned Income

Gross wages are used to determine the amount of wages rather than the net amount received by the wage earner. Do not allow for deductions from gross wages such as taxes, garnishments, insurance premiums, savings deductions, etc. Wages are counted as earned income when paid rather than when earned.

7. Converting Week/Biweekly Wages

When wages are paid on a weekly or biweekly basis, convert wages to monthly amounts:

1. Establish the day of the week wages are received.

2. Compute the number of paydays in each month.

3. If the gross wage amount is the same each payday, multiply it by the number of paydays in each month. If the gross wage amount is different each payday, add the individual amounts for each payday in each month.

8. Estimating Future Wages

In estimating future wages, consider any recent past work history, unless inappropriate to the current situation (e.g.,individual has stopped working because of retirement or disability). Carefully question the applicant, recipient or representative to obtain accurate monthly estimates of future wages. Try to establish a logical wage pattern by reviewing with the individual the rate of pay, hours worked per week, number of pay periods each month, etc. Be alert to individuals who perform seasonal work (e.g., school bus drivers), in deriving an estimate.

If an estimate cannot be established, contact the employer for information. Use this information along with worker judgment to arrive at an estimate. Do not average. Document the case record to support the estimate.

D. SELF-EMPLOYMENT

Net Earnings from Self-employment (NESE) is the gross income from any trade or business less allowable deductions for that trade or business. NESE also includes any profit or loss in a partnership.

1. Determining Monthly NESE

Divide the entire taxable year's NESE equally among the number of months in the taxable year, even if the business:

- is seasonal;
- starts during the year;
- ceases operation before the end of the taxable year; or
- ceases operation prior to initial application for SSI.

2. Offsetting Net Loss

Divide any **verified** net loss for a taxable year evenly over the months in the taxable year. Subtract each resulting monthly amount from the individual's or couple's other earnings in the same month. Apply this procedure whether a couple filed a joint income tax return or separate returns, and regardless of which member of the couples listed below incurred the loss:

- an eligible couple;
- an eligible individual with an ineligible spouse;
- two parents;
- a sponsor and his/her spouse

3. Work Expenses

If an individual is self-employed (whether or not he/she is also a wage earner), reduce his/her earned income by any allowable work expenses which have not already been used to compute NESE.

INCOME

EARNED INCOME

4. **Deduction for Taxable Years After 1989**

For taxable years beginning after 1989, a 7.65 percent deduction is applied to net profit in determining NESE. Therefore, net profit is multiplied by .9235 to determine NESE. Refer to "How to Verify NESE" to find the correct NESE amount on the Federal income tax forms.

NOTE: This deduction recognizes, as a business expense, part of the Social Security taxes paid. If Social Security tax is not paid (e.g., in situations involving less than $400 per year in NESE, net losses, and when no tax return is filed), the deduction does not apply.

5. **Withdrawals for Personal Use**

When an individual alleges (or the worker discovers) cash or in-kind items are withdrawn from a business for personal use, proceed as follows:

Ask the individual whether the withdrawals were **properly accounted for** in determining NESE. That is, were they either deducted on the individual's Federal income tax return in determining the cost of goods sold or the cost of expenses incurred, or deducted on his business record.

IF THE WITHDRAWALS ARE...	**THEN...**
Properly accounted for	Do not charge them again as income.

IF THE WITHDRAWALS ARE...	THEN...
Not properly accounted for	- Ask the individual to estimate the value of the cash or in-kind withdrawals. Deduct that amount from the cost of goods sold or the cost of expenses incurred on the profit and loss statement to arrive at the proper NESE.
Not properly accounted for	If the individual cannot or will not provide the profit and loss statement, but alleges an amount of NESE, add the value of the withdrawals to the individuals allegation of NESE.

6. How to Verify NESE

Verify NESE whenever an individual is self-employed or has been self-employed during the current taxable year. Verify NESE by obtaining the most recent federal income tax return filed with IRS. If the business is new, use the individual's business records or the best estimate available.

The Federal income tax return contains evidence of NESE in the following schedules:

a. Schedule SE

- Net earnings - Section A, line 4 or Section B, line 4.C. **NOTE:** If line 4 or 4C shows a positive amount of less than $400, then line 3 is used, even if the amount on line 3 is greater than $400. For example, line 3 shows $410 and line 4/4C shows $378. Line 3 should be

used because no tax was due.

- Net loss - Section A, line 3 or Section B, line 4.C.

b. Schedule C - Line entitled "Net Profit or Loss."

c. Schedule F - Line entitled "Net Profit or Loss."

7. **How To Estimate NESE for Current Taxable Year**

Use the first of the following procedures which is applicable. Document the file so that it supports the estimate made by the worker.

WHEN TO USE	METHOD
When an individual:	Current Year's Estimate Based on Prior Year's Profit
- has been conducting the same trade or business for several years;	Use the NESE from the prior year as an estimate for the current taxable year.
- has had NESE which has been fairly constant from year-to-year; and	
- anticipates no change or gives no satisfactory explanation of why current NESE would be substantially lower than past NESE	

INCOME
EARNED INCOME

When an individual:	Gross-Net Ratio
- is engaged in the same business that he/she had **only** in the preceding taxable year; and	- Calculate from the individual's tax return or business records the ratio between net profit and gross receipts for the last year. **EXAMPLE:** Net profit of $1,200 for $6,000 gross income or 20 percent.

When an individual:	Gross-Net Ratio
- anticipates no change or gives no satisfactory explanation of why current NESE would be substantially different from what it has been in the past	- Calculate from his/her records the actual gross receipts for the current taxable year and project it for the remainder of the year. **EXAMPLE: $4,000** in current year's receipts for the first 6 months gives an assumed gross of $8,000 for the entire year. - Apply the previously calculated gross-net ratio to the current year's assumed gross to arrive at the estimated NESE. **EXAMPLE:** 20 percent of $8,000 is $1,600.

EXCEPTION: Do not use this method for businesses which are seasonal or have unusual income peaks at certain times of the year; go to next applicable procedure.

When an individual is engaged in a new business

Projecting Partial Year's Profit for Whole Year

- Obtain the individual's profit and loss statement or other business records for his/her taxable year to date.

When an individual is engaged in a new business

Projecting Partial Year's Profit for Whole Year

- Ascertain his/her net profit to date.

- Project that net profit for the entire taxable year.

EXCEPTION: Do not use this method for businesses which are seasonal, or have unusual income peaks at certain times of the year; go to next applicable procedure.

INCOME
EARNED INCOME

When:	Individual's Estimate
- an individual is engaged in a new business and records are not yet available; or - the business has been going on for some time but no records were kept	Use a signed allegation of the individual's best estimate.
When an individual:	**Current Year's Estimate Varies from Past Records**
- alleges his/her NESE for the current year will vary from for past years; and	- Obtain a written statement from the individual explaining the basis for the NESE variation.
- gives a satisfactory explanation for the variation	- If the individual's estimate of NESE for the current year is higher than that of the prior years, and the individual satisfactorily explains why, accept the individual's estimate of NESE. **EXAMPLE:** Individual recently added new products to his mail order sales catalog and sales have picked up dramatically.

- If the individual's estimate of NESE for the current year is lower than that of prior years, and the individual satisfactorily explains why, request any relevant documentation for the file and accept the lower estimate.

EXAMPLES:

- Satisfactory Explanation - the business has suffered a heavy loss or damage due to fire, flood, burglary, serious illness or disability of the owner, or other catastrophic event.

- Relevant Documentation - copies of newspaper accounts of the event, police reports, etc.

NOTE: In some cases (e.g., downturns in the economy) there may not be any documentation of the event. In such cases, the individual's written statement explaining the basis for the variation is sufficient documentation.

E. EARNED INCOME TAX CREDITS

The earned income tax credit (EITC) is a special tax credit which reduces the Federal tax liability of certain low income working taxpayers. This tax credit may or may not result in a payment to the taxpayer. EITC payments can be received as an advance from an employer or as a refund from IRS.

Exclude from income any EITC payments received January 1, 1991 or later, either as an advance or as a refund, regardless of the tax year involved.

F. ROYALTIES/ HONORARIUM

Royalties are payments to the holder of a copyright or patent. Royalties may also be paid to the owner of a mine, oil well, timber tract, or other resource, for extraction of a product, including proceeds from the direct sale of the product.

An honorarium is an honorary payment, reward, or donation usually received in consideration of services rendered (e.g., guest speaker), for which no payment can be enforced by law. However, the amount also may include payment for items other than services rendered (e.g., travel expenses and lodging).

Effective December 1991 or later, royalties earned by an individual in connection with any publication of his/her work are earned income (e.g., publication of a manuscript, magazine article, artwork, etc.).

Effective December 1991 or later, the portion of any honorarium **which is received in consideration of services rendered** is earned income. An honorarium which is **not** in consideration of services rendered (e.g., for travel expenses) is unearned income to the extent that it exceeds expenses.

a. Verify these payments by examining documents in the individual's possession which reflect:

- the amount of the payment,
- the date(s) received, and
- the frequency of payment, if appropriate.

b. If the individual has no such evidence in his possession, contact the source of the payment.

Assume that any honoraria received is **in consideration of services rendered,** absent evidence to the contrary. Evidence to the contrary would include a statement or document indicating that part or all of the honoraria is for something other than services rendered (e.g., travel expenses or lodging).

INCOME
INCOME COMPUTATIONS

A. COUNTABLE INCOME

Countable income is the amount of income subtracted from from the appropriate need standard to determine if an individual or couple is eligible for Medicaid.

Countable income is what remains after:

- eliminating all amounts that are not income; and
- applying all appropriate exclusions.

Countable income is the sum of a month's countable earned and unearned income.

1. Need Standards

The appropriate need standard used to test income for eligibility depends on the coverage group for which the client is applying. Medicaid need standards are based on the following:

a. SSI Federal Benefit Rates (FBR) set by SSI policy and subject to increase in January of each year. SSI FBR's are used for SSI-related cases, i.e., SSI retro determinations and former SSI recipient cases. Countable income cannot be equal to or exceed the appropriate FBR in order to be eligible for Medicaid.

b. Federal Poverty Levels (FPL) set by the federal government and subject to change each year, usually in February for March implementation.

FPL's are used at varying rates (100% FPL, 110% FPL, 200% FPL) depending on the coverage group, i.e., PLAD, QMB, QWDI, SLMB. Countable income can be equal to but cannot exceed the appropriate FPL in order to be eligible for Medicaid.

c. 300% of the SSI FBR is the formula required by federal regulation (42 CFR 435.1005) to set the institutional need standard used for all long term care coverage groups. This limit is subject to increase in January of each year when SSI FBR's increase. Countable income cannot be equal to or exceed the institutional limit in order to be eligible for Medicaid.

2. Income Break-Even Points

An income break-even point is the earned or unearned income amount an individual can have so that countable income equals the appropriate FBR or FPL.

a. For SSI FBR cases:

- 2 x FBR + $85 = monthly earned income break-even point
- FBR + $20 = monthly unearned income break-even point.

b. For FPL cases:

- 2 x FPL + $85 = monthly earned income break-even point prior to 07-01-99
- Effective 07-01-99, 2 x FPL + $115 = monthly earned income break-even point.
- FPL + $20 = monthly unearned income break-even point prior to 07-01-99
- Effective 07-01-99, FPL + $50 = monthly unearned income break-even point.

c. For institutional cases, total income, whether earned or unearned, cannot exceed the institutional limit.

INCOME

INCOME COMPUTATIONS

B. DEEMED INCOME

The term deeming identifies the process of considering another person's income and resources to be available for meeting a Medicaid client's basic needs. Deemed income and resources are attributed to an eligible individual whether or not they are actually available to him/her with the following restrictions:

- deeming only applies in household situations
- income is only deemed from an ineligible spouse to an eligible spouse or from ineligible parent(s) to an eligible child.

Deeming is based on the concept that a husband and wife (including "holding-out" couples) and/or parents and children who live together have a responsibility for each other and share income and resources. Both SSI and Medicaid regulations require deeming in household situations.

A portion of an ineligible parent's or spouse's income is used to provide for the ineligible's own living expenses and those of any ineligible children living in the household. Based on this consideration, allocations are applied for:

- ineligible parent(s); and
- ineligible children in the household.

Application of these allocations reduces the amount of income available for deeming.

1. Definition of Eligible/ Ineligible Child for Deeming Purposes

A child is someone who is neither married nor the head of a household, and:

- under age 18; or
- under age 22 and a student

An eligible child, for deeming purposes, is a natural or adopted child under age 18 who lives in a household with one or both parents, and is eligible for or applying for Medicaid. A child is eligible if the child receives Medicaid from any source (SSI, AFDC, etc.).

Deeming to such an eligible child no longer applies beginning the month following the month the child attains age 18.

An individual attains a particular age on the day preceding the anniversary of his/her birth. Deeming applies in the month of attainment of age 18 regardless of whether an application filed that month is filed before or after the day of attainment.

An ineligible child, for deeming purposes, is a natural or adopted child of an eligible individual, or the natural or adopted child of a parent, who lives in the same household with the eligible individual, and is:

- under age 18; or
- under age 21 and a student

2. **Definition of Parent for Deeming Purposes**

A parent whose income and resources are subject to deeming is one who lives in the same household with an eligible child and is:

- a natural parent of the child
- an adoptive parent

Deem a parent's income and resources to an eligible child beginning the month:

- after the month the child comes home to live with the parent(s) (e.g., the month following the month the child comes home from the hospital); or

- of birth when a child is born in the parent's home; or

- after the month of adoption (the month of adoption is the month the adoption becomes final); or

Deeming applies from a parent to a child when they live together in the same household. However, if a natural or adoptive parent is deceased or is divorced from the stepparent, and the child is living with the stepparent, the stepparent is not considered a parent or spouse of a parent of the eligible child for deeming purposes. Also, a relative or other adult who has legal custody of a child but is not also the natural or adoptive parent of the child is not a parent for deeming purposes. Also, a relative or other adult who has legal custody of a child but is not also the natural or adoptive parent of the child is not a parent for deeming purposes.

3. Waiver of Parental Deeming Rules

Effective July 1, 1989, a child who is eligible under the coverage group "Disabled Child Living At-Home" is exempt from deeming of parental income and resources. The eligible child's own income and resources affect Medicaid eligibility in the usual manner.

INCOME
INCOME COMPUTATIONS

4. Income Excluded From Deeming

Any item which is not income to an eligible individual is also not income to an ineligible spouse or parent.

In addition, the following types of income are excluded:

- Exclude income used by an ineligible spouse, ineligible parent (or ineligible child) to make court-ordered support payments. Exception: If an ineligible child receives child support payments, do not disregard one-third of the payment as is done for an eligible child.

- A stepparent's income is excluded from deeming. Work the case as a one-parent household, deeming the legal parent's income to the eligible child.

- In-Home Supportive Services Payments provided under title XX or other Federal, State or local governmental programs to an eligible individual and paid by the individual to his/her ineligible spouse, parent or child living in the same household in return for in-home supportive services (chore, attendant, homemaker), are excluded from income for deeming purposes. Such payments made directly to the ineligible spouse, parent or child to provide the services to the eligible are also excluded for deeming purposes.

  Retroactive IHSS payments are not a resource for one calendar month following the month of receipt. Any unspent portion becomes a resource if retained into the second calendar month following receipt.

5. Public Income Maintenance Payments Received By a Deemor (Income Based on Need)

Any Public Income Maintenance (PIM) payments received by an ineligible spouse or parent and any income counted in determining the payment is excluded from income in the deeming computation. RESOURCES CONTINUE TO BE DEEMED (OR COMBINED) FROM THE SPOUSE OR PARENT RECEIVING INCOME BASED ON NEED.

Note: If the spouse or parent who receives the PIM payments wishes to apply for Medicaid, the PIM payment is counted according to the income rules regarding the specific payment.

PIM payments are payments made under:

- TANF
- SSI
- The Refugee Act of 1980
- The Disaster Relief Act of 1974
- General Assistance programs of the Bureau of Indian Affairs
- State or local government assistance programs based on need, and
- VA benefits based on need.

No allocation is given for a parent or child in a household who receives a PIM payment.

As a result of the exclusions from the deeming process, there may be situations advantageous to a couple if the potentially eligible spouse who has nondeemable income does not file. For example, if one spouse has a VA pension of $500, the pension is not deemable and the other spouse who has no income would be treated as an individual with $0 income. If the spouse who has the pension also files, the $500 would result in a dollar-for-dollar reduction in the couple FBR or FPL since income based on need is considered income to an eligible individual.

6. Events Affecting Deeming-Couples

There are several events which can change deeming status:

Ineligible Spouse Becomes Eligible

The individual and spouse are treated as an eligible couple effective with the month the spouse becomes eligible (and applies).

Spouses Separate or Divorce

The ineligible spouse's income is no longer deemed to the eligible the month after the month of separation or divorce.

Eligible Begins Living with Ineligible Spouse

Deeming of the ineligible's income begins with the month after the month they begin living together.

Ineligible Spouse Dies

Deeming stops the month after the month of death.

Eligible Becomes Institutionalized

Deeming stops in the month of entry into the facility.

7. Events Affecting Deeming-Parents/ Children

Ineligible Parent Becomes Eligible

Deeming from the parent stops beginning with the month the parent becomes eligible.

Eligible Parent Becomes Ineligible

Deeming of the parent's income begins with the first month of the parent's ineligibility to determine if the child is eligible.

Ineligible Parent Dies

Deeming stops the month after the month of death.

Ineligible Parent and Eligible Child No Longer Live in Same Household

Deeming of the parent's income stops effective the month after the month the parent (or child) leaves the household.

Ineligible Parent & Eligible Child Begin Living in Same Household

The parent's income is deemed to the child beginning the month after the month they begin living together.

An example is that of a newborn child. No income of the parent(s) is deemed until the month after the month the child is home.

Eligible Child Becomes Institutionalized

Deeming stops in the month of entry into the facility.

Eligible Child Attains Age 18

Deeming stops the month following the month an individual attains age 18.

INCOME
INCOME COMPUTATIONS

C. IN-KIND INCOME

In-kind income is any income other than cash income. To To meet the definition of income, the in-kind item received by an individual must be:

1. Food, clothing, or shelter

2. Something the individual can sell or convert to obtain food, clothing, or shelter.

If the in-kind item is neither food, clothing, nor shelter and it cannot be sold or converted to cash, it is not income.

In-kind Support and Maintenance (ISM) is an SSI policy principal that applies only to SSI-related cases such as SSI retro cases and former SSI recipient cases. Cases that use the Federal Poverty Level or Institutional income limit as the need standard for eligibility purposes do not require placing a value on any ISM received by an eligible individual or couple.

1. Value of ISM

For purposes of treating in-kind support and maintenance as income, three types of values are used:

- Current Market Value (CMV) - This is the amount for which something can be purchased locally on the open market. Depending on the type of support and maintenance received, the determination of the CMV may be based on various factors such as the assessed value from a knowledgeable source, property owner's statement, and the individual's payment.

- Actual Value (AV) is the CMV divided by the number of people receiving support and maintenance minus any payment made out of an individual's own funds. If he makes no payment, AV and CMV may be the same amount.

- Presumed Maximum Value (PMV) is an amount equivalent to one-third of the applicable FBR plus $20. The PMV rules apply to in-kind support and maintenance which is countable as unearned income. The PMV never applies to earned income. Use of the PMV in determining an individual's countable income is rebuttable by the individual's showing that the AV of the in-kind support and maintenance he receives is less than the PMV. The lower of the two figures is always used, but never an amount in excess of the PMV, regardless of the number of sources of such income or the variety of living arrangements during any given period.

2. Value of ISM

If an eligible individual or couple:

- lives in the household of another,
- receives rent free shelter,
- has someone else (a third party) pay for goods and services provided to the eligible, or
- receives rental subsides

then the value of such ISM must be developed. The value of the ISM is counted as income using the lesser of the CMV, AV or PMV.

3. State Office Clearance

ISM is rarely included in Medicaid budgeting since Medicaid does not make a money payment for food, shelter and clothing as does the SSI Program. If there are cases where it is questionable whether ISM is countable as income in an SSI-related case, the case should be referred to the State Office for clearance.

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RESOURCES
GENERAL

A. **ROLE OF RESOURCES**

Medicaid uses the value of a person's resources as a factor in determining eligibility. The general expectation is that individuals or couples whose resources exceed the applicable limit will use the excess to meet their needs before becoming eligible for Medicaid.

Not everything a person owns is a resource and not all resources count against the statutory limit. The Social Security Act and other federal statutes require the exclusion of certain types and amounts of resources. Any assets that are resources but not specifically excluded are "countable.

If countable resources do not exceed the applicable limit, they have no effect on Medicaid eligibility. If countable resources do exceed the limit, an individual or couple is not eligible.

In certain situations, federal statutes requires other people to share financial responsibility for an individual or couple. In those situations, Medicaid considers resources of the other person(s) along with resources actually belonging to the individual or couple.

RESOURCES
GENERAL

B. RESOURCE LIMITS

Federal law establishes a limit on the value of the resources an individual or couple can own and still be eligible for full Medicaid benefits. Countable resources must not exceed the limits specified below for the applicable time period.

	INDIVIDUAL LIMIT	COUPLE LIMIT
Prior to 01-01-85	$1500	$2250
Effective 01-01-85	$1600	$2400
Effective 01-01-86	$1700	$2550
Effective 01-01-87	$1800	$2700
Effective 01-01-88	$1900	$2850
Effective 01-01-89	$2000	$3000
Effective 07-01-99	$3000	$4000
Effective 07-01-00	$4000	$6000

and continuing

These increased limits apply to coverage groups subject to liberalized resource policies. Groups subject to SSI resource limits remain $2000/$3000.

There are Medicaid coverage groups for noninstitutional individuals (living at home) with a resource limit that is twice as high as the SSI-related resource limit cited above:

- Effective 07-01-89, the resource limit for Qualified Medicare Beneficiaries (QMB) is $4000 for an individual and $6000 for a couple; however, Medicaid pays only Medicare cost-sharing expenses for QMB eligibles.

- Effective 07-01-90, the resource limit for Qualified Working Disabled Individuals (QWDI) is $4000 for an individual and $6000 for a couple; however, Medicaid pays only Medicare Part A premiums QWDI eligibles.

RESOURCES
GENERAL

C. SSI RESOURCE POLICY VS LIBERALIZED RESOURCE POLICY

As a 1634 State, Mississippi is required to use SSI resource rules for all eligibility determinations. However, Section 303 (e) of the Medicare Catastrophic Coverage Act (P.L. 100-360) added 1902(r)(2) to the Medicaid statute that allows a State to employ income and resource methods that are more liberal than those of the most closely related cash assistance program (SSI) to certain MAO coverage groups. Exempted from this provision are coverage groups considered "deemed" cash assistance groups. The Division of Medicaid requested and received approval from HCFA to liberalize certain resource policies effective October 1, 1989, for the following coverage groups:

B. - Long Term Care Coverage Groups
C. - Long Term Care "At-Home" Coverage Groups
D. - Poverty Level Aged & Disabled (PLAD's)
E. - Qualified Medicare Beneficiaries (QMB's)
F. - Specified Low Income Medicare Beneficiaries (SLMB's)
G. - Working Disabled (WD's)

Liberalized resource policies do not apply to:

H. - SSI Retro Determinations (unless the client is placed in another coverage group for the retro period)
I. - Former SSI Recipient Coverage Groups
J. - Disabled Children Living At-Home
K. - Qualified Working Disabled Individuals (QWDI)

1. Liberalized Resource Policies

The following briefly describes the liberalized resource policies currently in effect. The liberalizations are described in greater detail in later subsections which discuss each type of resource.

L. - Spenddown of resources within a month to become eligible in that month;

RESOURCES
GENERAL

M. - Excess resources earmarked for payment of private pay in a nursing facility in month(s) prior to Medicaid eligibility are not considered countable resources.

N. - Income that accumulates pending Medicaid approval that results in excess resources can be excluded if this income is obligated for Medicaid Income purposes

O. - Certain property and types of ownership are totally excluded, regardless of value, for home property, life estate and remainder interests in any property, 16th Section land leaseholds, mineral rights or timber rights that are not under production and housing on government owned land

P. - Income Producing Property if it produces at least 6% of the equity value of the property

Q. - Promissory Notes, Loans and Property agreements are excluded if the note produces a net annual return of 6% of the principal balance

R. - Up to two automobiles can be excluded

S. - Household goods are totally excluded and personal property up to $5000 in equity value is excluded

T. - Life insurance is excluded if the face value of all life insurance policies on any one individual is $10,000 or less

U. - Burial spaces for family members are excluded as resources, and

V. - Burial funds set aside in a revocable arrangement are subject to a $3,000 limit. Effective 04/01/01, the limit is $6,000.

2. SSI Resource Policy

SSI policy, as it relates to the topics outlined above, specifies different exclusion limits or different ways to determine countable resources. The differences in the way each policy applies is outlined in the discussion of each resource type. If the resource policy has not been liberalized, then SSI policy is applicable, unless a subsequently issued federal statute or Medicaid regulation supersedes the SSI policy.

D. VALUATION OF RESOURCES

For SSI purposes, the value of a resource is the amount of an individual's or couple's equity in it. Equity value is determined as follows:

1. Current Market Value

The current market value (CMV) of a resource is the going price for which it can reasonably be expected to sell on the open market in the particular geographic area involved.

If a resource sells for more than the CMV assigned to it, the CMV is equal to the sale price.

2. Equity Value

Equity value (EV) is the CMV of a resource minus any encumbrance on it.

An encumbrance is a legally binding debt against a specific property. Such a debt reduces the value of the encumbered property but does not have to prevent the property owner from transferring ownership (selling) to a third party. However, if the owner of encumbered property does sell it, the creditor will nearly always require debt satisfaction from the proceeds of sale.

E. OWNERSHIP INTERESTS

Ownership interests in property, whether real or personal, can occur in various types and forms. Since the type and form of ownership may affect the value of property and even its status as a resource, they are significant in determining resources eligibility.

1. Types of Ownership

a. Sole Ownership of (real or personal property means means that only one person may sell, transfer or otherwise dispose of the property. However, sole ownership may be subject to conditions imposed by others as, for example, sole ownership of a remainder interest in property.

b. Shared Ownership of (real or personal) property means that two or more people own it concurrently.

c. Fee Simple Ownership, which relates only to real property, is completely free of conditions imposed by others.

Fee simple ownership means absolute and unqualified legal title to real property. The owner(s) has unconditional power of disposition of the property during his or her lifetime. Upon his or her death, property held in fee simple can always pass to the owner's heirs. Fee simple ownership may exist with respect to property owned jointly or solely.

d. Less Than Fee Simple Ownership

- Life Estate - A life estate confers upon one or more persons (grantees) certain rights in a property for his/her/their lifetimes or the life of some other person. A life estate is a form of legal ownership and usually created through a deed or will or by operation of law. See B. below.

- Equitable Ownership - An equitable ownership interest is a form of ownership that exists without legal title to property. It can exist despite another party's having legal title (or no one's having it). Ownership in unprobated estates or trust property are examples of this type of ownership.

e. Property Rights Without Ownership

- A leasehold conveys a time-limited control of property but not ownership of it, such as 16th Section land leases.

- An incorporeal interest in property is a right to use the property but without any right to possess it or sell the property. These rights encompass mineral and timber rights and easements.

All of these types of ownership are discussed in greater detail in the "Types of Resources" policy subsection.

RESOURCES
GENERAL

2. General Rule

Absent evidence to the contrary, each owner of property owns only his/her share of the ownership interest vested in the individual. The total value of shared property is divided among all of the owners in direct proportion to the ownership share held by each. The exception to this general rule is for jointly owned bank accounts. For a joint checking or savings account or a jointly owned time deposit, all of the funds in the account belong to the Medicaid client.. Jointly owned bank accounts are held in equal shares if there is more than one client listed as a joint owner.

RESOURCES
IDENTIFYING RESOURCES

A. RESOURCES VS. INCOME

It is important to distinguish between resources and income to know which rules to use for any given month. An item is not subject to both income and resources counting rules in the same month.

1. Income-Counting Rules

Items received in case or in-kind during a month are evaluated under the income-counting rules.

2. Resource-Counting Rules

Items retained as of the first moment of the month following receipt are subject to evaluation under resource counting rules.

3. Distinguishing Resources From Income

In order to distinguish resources from income, a distinction must be made as to what has occurred, determine what was the monetary gain. The monetary gain would be considered a resource if it:

- was an increase in value of an existing resource,
- was for the receipt or replacement of a resource,
- was from the conversion or sale of a resource,
- was cash or in-kind item for the replacement or repair of an excluded resource which is lost, damaged, or stolen . Additional policy on this subject is discussed in detail later in this subsection.

RESOURCES
IDENTIFYING RESOURCES

B. FACTORS THAT MAKE PROPERTY A RESOURCE

Property of any kind, including cash, cannot be a resource in a month unless it meets all 3 criteria outlined below. The criteria outlined below is subject to change so a "nonresource" can become a resource and vice versa; i.e., a key factor can materialize or go out of existence.

1. Ownership Interest

An individual must have some form of ownership interest in property in order for the property to be considered a resource. The fact that an individual has access to property, or has a legal right to use it, does not make it a resource if there is no ownership interest (such as homestead rights).

2. Legal Right to Access (Spend or Convert) Property

An individual must have a legal right to access property. Despite having an ownership interest, property cannot be a resource if the owner lacks the legal ability to access funds for spending or to convert noncash property into cash.

The fact that an owner does not have physical possession of property does not mean it is not his/her resource, provided the owner still has the legal ability to spend it or convert it to cash.

An individual has free access to, and unrestricted use of, property even when he/she can take those actions only through an agent; e.g., a representative payee, conservator, etc.

3. Legal Ability to Use For Personal Support and Maintenance

Even with ownership interest and legal ability to access property, a legal restriction against the property's use for the owner's own support and maintenance means the property is not his/her resource.

C. CASH & IN-KIND ITEMS RECEIVED FOR THE REPAIR/ REPLACEMENT OF LOST, DAMAGED OR STOLEN EXCLUDED RESOURCES

Cash and in-kind receipts from any source for the replacement or repair of lost, damaged, or stolen excluded resources are themselves not treated as resources for 9 months from the date of their receipt.

For cash receipts, the initial 9-month period can be extended for a reasonable period up to an additional 9 months if the individual shows good cause why repair or replacement was not possible during the first 9 months.

Good cause is present if circumstances beyond the individual's control:

- prevent repair or replacement of the lost, damaged, or stolen property; or
- keep the individual from contracting for such repair or replacement.

An individual cannot qualify for an extension of the initial 9 month period unless he/she intends to use the funds for their designated purpose, i.e., repair or replacement of excluded resources. The good cause extension will terminate as of the date of any change of intent. The funds then become a resource the following month.

Effective February 15, 1996, for individuals who incurred damage to or loss of excluded resources as a result of a Presidentially-Declared major disaster, the 18-month period described above can be extended for up to an additional 12 months if evidence of good cause is presented.

1. Source of Funds

There are no restrictions on where cash and/or in-kind items come from for purposes of this policy (e.g., it may come from an insurance company, a Federal or State agency, a public or private organization, or an individual).

However, funds received from the following sources are to be excluded in accordance with income/resource policy regarding these payments.

- the Disaster Relief and Emergency Assistance Act;
- some other Federal statute because of a presidentially-declared major disaster;
- comparable assistance received from a State or local government; or
- a disaster assistance organization.

2. **Interest on Funds Not Treated as Resources**

Interest earned by funds not treated as resources under this provision is not treated as income and resources for the period during which the funds themselves are not considered resources.

3. **Funds for Temporary Housing**

This policy applies to funds received for the purchase of temporary housing.

4. **Personal Injury Payments**

This policy does not apply to funds received on account of personal injury.

5. **Evidence**

Make sure the evidence shows the source, value, date(s), and intended purpose of the items received, including whether any cash received is for a purpose other than the replacement or repair of the lost, damaged, or stolen (and excluded) resource.

Obtain a copy of any evidence the individual has.

Of the individual cannot provide evidence that suffices for a determination, obtain the necessary information from the source of the payment(s). Do so by telephone, if possible, recording the facts on a Record of Contact.

D. IDENTIFYING EXCLUDED FUNDS COMMINGLED WITH NON-EXCLUDED FUNDS

Otherwise excludable funds must be identifiable in order to be excluded.

Identifiability does not require that excluded funds be kept physically apart from other funds (e.g., in a separate bank account).

Always assume, when withdrawals are made from an account with commingled funds in it, that nonexcluded funds are withdrawn first, leaving as much of the excluded funds in the account as possible.

If excluded funds are withdrawn, the excluded funds left in the account can be added to only by deposits of subsequently received funds that are excluded under the same provision.

1. One-Time Receipt And Deposit of Excluded Funds

An individual deposits a $800 retroactive RSDI check in a checking account. The account already contains$300 in nonexcluded funds.

- Of the new 1,100 balance, $800 is excluded as retroactive RSDI excluded.
- The individual withdraws $300. The remaining $800 balance is still excluded.
- The individual withdraws another $300, leaving a balance of $500. All $500 is excluded.
- The individual deposits $500, creating a new balance of $1,000. Only $500 of the new balance is excluded.

2. Periodic Receipt and Deposit of Excluded Funds

An individual deposits $200 in excluded funds in a non-interest bearing checking account that already contains $300 in non-excluded funds.

- The individual withdraws $400. The remaining $100 is excluded.

- The individual then deposits $100 in nonexcluded funds. Of the resulting $200 balance, $100 is excluded.

- The individual next deposits $100 in excludable funds. Of the new $300 balance, $200 is excluded.

RESOURCES
IDENTIFYING RESOURCES

E. UNIFORM GIFTS TO MINORS ACT

Most States have adopted the Uniform Gifts to Minors Act (UGMA) which permits making to minors gifts which are free of tax burdens. The UGMA is sometimes called the Uniform Transfers to the Minors Act.

Under UGMA legislation:

W. - an individual (donor) makes an irrevocable gift of money or other property to a minor (the donee)

X. - the gift, plus any earnings it generates, is under the control of a custodian until the donee reaches the age of majority established by State law

Y. - the custodian has discretion to provide to the minor or spend for the minor's support, maintenance, benefit, or education as much of the assets as he/she deems equitable

Z. - the donee automatically receives control of the assets upon attainment of majority (age 21 in Mississippi).

1. Creation and Transfer of "Custodial" Property

According to Mississippi State Law, gifts that are valid under the Mississippi Uniform Transfer to Minors Act must reflect that the gift is being made under this Act. This means the gift(s) (annuity, C.D., property, life insurance, etc.) must be assigned in writing and substantially worded to show the custodian's name, minor's name and the designation that the gift is authorized under the Uniform Transfer to Minors Act (in Mississippi, Mississippi Code Ann. Section 91-20-19).

2. Donor Access

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

Gifts made under the UGMA may involve a countable transfer of resources to the donor, if applicable.

3. **While Donee Remains A Minor**

UGMA property, including any additions or earnings are 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.

4. **When Donee Reaches Age 21**

All UGMA property becomes available to the donee and subject to evaluation as income in the month of retainment of age 21 and a resource thereafter.

RESOURCES
TYPES OF RESOURCES

A. CASH/ FINANCIAL ACCOUNTS

Cash consists of money which is on hand in the form of currency or coin. Foreign currency or coins are cash to the that they can be exchanged for U.S. currency. However, coin collections are not considered to be cash even though they are a resource. The value of coin collections is based on collector's value and is determined by a knowledgeable source. Refer to the discussion of Personal Property for the treatment of hobby collection.

While an individual's allegation of actual cash on hand is accepted without verification, he/she must be made aware that cash on hand includes amounts he has on his person, at home, or being held elsewhere.

1. Checking/ Savings Accounts

Funds maintained in checking and savings accounts are usually payable on demand. When an individual has unrestricted access to an account, all of the funds in the account are considered as a resource to the owner of the account regardless of who deposited the funds.

Savings accounts pay interest unless the financial institution has a minimum balance requirement and the account does not meet this requirement.

NOW (Negotiable Order of Withdrawal) accounts are interest-bearing checking accounts. Super NOW accounts are money market checking accounts. They have higher rates than NOW accounts.

Money Market Deposit Accounts allow banks to compete with mutual fund money markets. They are interest-bearing checking accounts.

a. Development/Verification of Bank Accounts

Because of the high potential for error, it is important to fully investigate all of a client's allegations about bank accounts. Unless eligibility is being denied for another reason, a worker must search for leads into the possible existence of bank accounts. Skillful interviewing may produce leads which the interviewer can use to detect undisclosed resources. The interviewing process should include the following explanations to the applicant or his/her representative.

(1) Information about all savings, checking or time deposits which show the client's name or the name of someone whose resources must be deemed to the client must be furnished regardless of the amount on deposit or in what capacity the name of the client or deemor appears on the account.

(2) The client or representative is responsible for providing the needed information regarding bank accounts and this information is required even if the client does not consider any of the funds in the account to be his/hers.

Request the client's own records as verification of activity on the account and to establish account balances. If the client's records are unavailable, complete DOM-330 (Bank Clearance Form) and obtain an authorizing signature so the bank can be contacted.

Do not consider as a resource any amounts counted as income for the same month.

b. Special Development - Applicants

In the event an applicant fails to claim ownership of any type of bank account, either currently or within the previous two years, or if only one type of account is claimed, a special development is necessary to obtain additional information concerning the applicant's banking activities and determine whether there are undisclosed accounts through direct contact with financial institutions.

The first step in the special development is to question the applicant and/or representative concerning the applicant's past and present business activities.

1. Where does the applicant cash his/her checks?

2. Where does the applicant buy money orders?

3. Where has the applicant borrowed money in the past 2 years?

4. Where does the applicant pay his/her home mortgage or rental payment?

5. Where are the applicant's checks deposited?

6. Where does the applicant have a special account, such as a Christmas Club?

7. Where has the applicant set aside money for a special purpose or for an emergency?

8. Does applicant's name appear on any account which he/she considers to be someone else's?

If a financial institution is identified through questioning, verify the account by the client's records or DOM-330.

c. Banking Activity Handled Through Accounts Not Owned By Client

In cases where a client's funds are deposited and/or held in an account that does not belong to the client, i.e., the client's name does not appear on the account, a determination must be made as to whether the client has access to the funds. In so doing, it is necessary to obtain a statement from the account holder(s) regarding ownership of the funds on deposit. If the funds on deposit, or a portion thereof, are acknowledged as belonging to the client, the account is treated as a countable resource to the extent the funds belong to the client.

If the funds are not acknowledged as belonging to the client yet evidence indicates that funds belonging to the client are deposited and retained in the account, the possibility of a transfer of resources exists.

Note: Entitlement income deposited into an account which is not owned by a client does not alter the fact that the income belongs to the client and is used to determine eligibility and Medicaid Income (if applicable). Funds belonging to the client (including non-entitlement income) that are deposited into another account and not accessible to the client are subject to the transfer penalty.

2. **Joint Checking/ Savings Accounts**

When only one holder of a joint account is a client who has unrestricted access to the funds in the account, all of the of the funds in the account are presumed to be the client's.

This presumption is made regardless of the source of the funds. If more than one account holder is a client, the joint account is divided equally among the eligible account holders.

If one or more account holders is a deemor (none of the account holders is a client), assume all of the funds in the account belong to the deemor(s) (equal shares if more than one deemor is on the account.

A joint account holder has the right to provide evidence rebutting the ownership assumption of a joint checking/savings account if he/she disagrees with it.

a. **Rebuttal Statement**

If an individual wishes to rebut the applicable ownership assumption, document the following:

- who owns the funds;
- why there is a joint account;
- who has made deposits to and withdrawals from the account; and
- how withdrawals have been spent.

b. **Required Evidence**

In addition, inform the individual that he or she must submit the following evidence:

- a corroborating statement from each other account holder (if the only other account holder is incompetent or a minor, have the individual submit a corroborating statement from anyone aware of the circumstances surrounding establishment of the account);
- account records showing deposits, withdrawals and interest in the months for which ownership is at issue;

- if the individual owns none of the funds, evidence showing that he or she can no longer withdraw funds from the account;

- if the individual owns only a portion of the funds, evidence showing removal from the account of such funds, or removal of the funds owned by other account holder(s), and redesignation of the account.

c. **Determination**

Any funds that the evidence establishes were owned by the other account holder(s), and that the individual can no longer withdraw from the account, were not and are not the individual's resources. However, such funds can be deemed available to the individual if the account holder to whom they belong is a deemor. Document the determination in file.

3. **Time Deposits**

A time deposit is a contract between an individual and a financial institution whereby the individual agrees to leave funds on deposit for a specified period (six months, two years, five years, etc.) and the financial institution agrees to pay interest at a specified rate for that period. Certificates of Deposit (C.D.s) and savings certificates are common forms of time deposits.

Withdrawal of a time deposit before the specified period expires incurs a penalty, which usually is imposed against the principal. This penalty does not prevent the time deposit from being a resource, but does reduce its value as a resource.

On rare occasions, the terms of a time deposit will prohibit early withdrawal altogether.

The assumptions regarding ownership of bank accounts apply to time deposits.

a. **Principal**

If the owner of a time deposit cannot under any circumstances withdraw it before it matures, it is not a resource. It becomes a resource (not income) on the date it matures, and may affect countable resources for the following month.

b. **Interest**

If the owner has no access to the interest before the deposit matures, accrued interest is not a resource and is income in the month the deposit matures (not before then).

c. **Resource Value**

The resource value of a time deposit at any given time is the amount the owner would receive upon withdrawing it at that time, excluding interest paid that month. Generally, this is:

- the amount originally deposited;
- plus accrued interest for all but the current month;
- minus any penalty specified on the certificate for early withdrawal.

4. Patient Accounts

When a patient enters a nursing facility, it is probable that the patient will establish an account with the facility similar to a checking and/or savings account whereby the facility "holds" funds belonging to the patient. These accounts are referred to as patient accounts, accounts receivable or credit accounts. These accounts are treated in the same manner as a checking and savings account when the patient is a Medicaid client.

5. Retirement Funds

Retirement funds include annuities or work related plans providing income when employment ends, such as a pension, disability or retirement plan administered by an employer or union. It also includes funds held in individual retirement accounts (IRA's) or plans for self-employed individuals, such as Keogh plans.

Note: The terms IRA and Keogh accounts refer only to retirement plans and do not identify the underlying investment vehicle, which can be a bank account, CD, mutual fund, etc. Develop IRA's and Keogh accounts in accordance with the policy that deals with the underlying investment vehicle.

If an applicant owns a retirement fund and is eligible for retirement benefits, the applicant **must** apply for those benefits under the utilization of other benefits provision. Retirement benefits are payments made to an individual at some regular interval (such as monthly) which result from entitlement to a retirement fund. The payments must be of uniform rate, principal and interest. These payments are counted as unearned income.

If an individual owns a retirement fund and is not eligible for periodic payments but has the option of withdrawing the funds, the retirement fund is counted as a resource the month the funds become available for withdrawal. The value of a retirement fund is the amount of money an individual can currently withdraw from the account. If there is a penalty assessed for early withdrawal, the value is the amount available after any penalties are deducted. If taxes are owed on the funds, any taxes are due are not deducted in determining the value of the retirement fund.

If an individual owns a retirement fund, as defined above, and is eligible for or is already receiving periodic payments from the funds, the value of the funds is not a resource.

If an individual must terminate employment in order to file for a retirement fund, the funds is not a resource.

If a claim for periodic payment is denied, and the client can withdraw the funds from his/her retirement fund, the value of the retirement fund is counted as a resource effective the month after the month of the denial notice for periodic payments.

6. **Contents of a Safe Deposit Box**

Although not a financial account, safe deposit boxes are located at financial institutions and contents of a safe deposit box must be verified if the contents belong to an applicant or recipient. The applicant or recipient is responsible for listing the contents and a bank official's witness in writing serves as sufficient documentation of the contents. The treatment of the contents is contingent upon the type of item stored in the safe deposit box.

If a client has possessions stored in a safe deposit box belonging to another person, the worker must determine whether the client has access to the safe deposit box. A statement from the owner of the safe deposit box is required to determine access of the client. The worker must request that the owner state whether or not the client would be allowed access to the client's belongings in the safe deposit box. If so, handle as outlined above.

B. REAL PROPERTY OWNERSHIP

Real property is land, including buildings or immovable objects attached permanently to the land.

Real property ownership can consist of an interest in the title or a right to the use of the property without title to the property. Since the types of real property ownership may influence the individual's interest and his right of disposition, it is necessary to determine and document the type of ownership. The various types of ownership are discussed below.

1. Sole vs. Shared Ownership

Sole ownership of real property means that only one person may sell, transfer or otherwise dispose of the property. However, sole ownership may be subject to conditions imposed by others as, for example, sole ownership of a remainder interest in property.

Shared ownership of real property means that two or more people own it concurrently. The different types of shared ownership are:

a. Tenancy-In-Common

In tenancy-in-common, two or more persons each has an undivided fractional interest in the whole property for the duration of the tenancy. These interests are not necessarily equal; e.g., two joint tenants do not necessarily each own half of the property. One owner may sell, transfer or otherwise dispose of his or her share of the property without permission of the other owner(s) but cannot take these actions with respect to the entire property.

When a tenant-in-common dies, the surviving tenant(s) has no automatic survivorship rights to the deceased's ownership interest in the property. Upon a tenant's death, the deceased's interest passes to his or her estate or heirs.

For example: Don, Charles, and Fred Evans own property as tenants-in-common. Charles and Fred each owns an undivided one-fourth interest in the property while Don owns the remaining one-half interest. If Don Evans were to sell his half interest to Stanley Long, Mr. Long would become a tenant-in-common with Charles and Fred Evans. If Mr. Long were then to die so that his property passed to his four children, each of them would own a one-eighth interest as tenants-in-common with Charles and Fred who would each continue to own a one-fourth interest.

b. Joint Tenancy

In joint tenancy, each of two or more persons has one and the same undivided ownership interest and possession of the whole property for the duration of the tenancy. In effect, each owner owns all of the property.

Upon the death of one of only two joint tenants, the survivor becomes sole owner. On the death of one of three or more joint tenants, the survivors become joint tenants of the entire interest.

c. Tenancy By the Entirety

A tenancy by the entirety can exist only between the members of a married couple. The wife and husband as a unit own the entire property which can be sold only with the consent of both parties. However, if a marriage has been legally dissolved, the former spouses become tenants-in-common and one can sell his or her share without the consent of the other.

Upon the death of one tenant by the entirely, the survivor takes the whole.

Absent evidence to the contrary, each owner of shared property owns only his/her fractional interest in the property. Divide the total value of the property among all the owners in direct proportion to the ownership share held by each.

2. Ownership in Fee Simple or Less Than Fee Simple

Fee simple ownership means absolute and unqualified legal title to real property. The owner(s) has unconditional power power of disposition of the property during his or her life-time. Upon his or her death, property held in fee simple can always pass to the owner's heirs. Fee simple ownership may exist with respect to property owned jointly or solely.

Less than fee simple ownership in property involves the following types of property ownership:

a. Life Estate

A life estate conveys upon an individual or individuals for his lifetime certain rights in property. A life estate can be created by deed, will, or division of property. Its duration is measured by the lifetime of the tenant or of another person or by the occurrence of some specific event, such as remarriage of the tenant. The owner of a life estate has the right of possession, the right to use the property, the right to obtain profits from the property and the right to sell his/her life estate interest unless the contract establishing the life estate restrains one or more of the life estate holder's rights. The owner of a life estate does not have title to the property or the right to sell the property.

b. Remainder Interest

A life estate instrument often conveys property to one person for life (life estate owner) and to one or more (remaindermen) upon the expiration of the life estate. A remainderman has an ownership interest in the physical property but without the right to possess and use the property until termination of the life estate.

Unless restricted by the instrument establishing the remainder interest, the remainderman is generally free to sell his/her interest in the physical property even before the life estate interest expires. In such cases, the market value of the remainder interest is likely to be reduced since such a sale is subject to the life estate interest.

c. Ownership By Will or Descent

An individual may have ownership interest in an unprobated estate acquired through a will or through the death of a relative who died intestate (without a will). The heir(s) may be sole owner or joint or common owners, etc.

(1) Heirs by will have ownership and control of the property or their joint or common share; however, if the will has not been filed with the proper court nor probated there is a question as to whether the will is legally binding. Legally, wills are required to be filed for probate; however, there is no time limit placed on filing. Absent evidence to the contrary, assume the client owns the property in proportion whereby one has the right to the will's directives.

(2) Heirs by descent (intestate estates) acquire ownership interest in property by virtue of the heirs' relationship to the deceased.

- Interstate property of a deceased person with a spouse and children is shared equally by the surviving spouse and children. Grandchildren become involved in ownership interest in intestate property only when their parent, who was a child of the original owner, is deceased. The grandchildren's interest is only in the share that their deceased parent held in interest.

- Intestate property of an individual who had no spouse or children at the time of death descends equally to his parents and brothers and sisters. If the deceased's parents are also deceased, the property descends to his brothers or sisters. Nieces and nephews become involved only if their parent, who was brother or sister to the deceased, is deceased. Their ownership interest is only in the share that their deceased parent held an interest.

Absent evidence to the contrary, assume an heir inherited property based on their laws of descent.

d. Other Rights to the Use of Real Property

(1) Homestead Rights

Under State law a surviving spouse (widow or widower) is entitled to the homestead on the real property used as the home at the time of the death of the spouse and to receive income from it for his lifetime. This is not a life estate interest in the property, but is quite similar. This situation occurs when spouses jointly or commonly own property without a right of survivorship clause in the property. The surviving spouse has homestead rights to the portion of the property which belonged to the deceased spouse. The surviving spouse would also own his/her own interest in the property. A homestead right does not have value and cannot be sold.

(2) Mineral Rights, Timber Rights, Easements, Leaseholds

- Mineral Rights - A mineral right is an ownership interest in certain natural resources such as coal, sulphur, petroleum, sand, natural gas, etc., which are usually obtained from the ground.

- Timber Rights - Timber rights permit an individual to cut and remove freestanding trees from property owned by another as designated by contract with the person holding title to the land on which the timber stands.

- Easements - An easement is a property right whereby one has the right to use of land of another person for a special purpose.

- Leasehold - A leasehold does not designate rights of ownership, but conveys to an individual the control of property for a definite period or duration, at the owner's will and usually for an agreed rent.

Note: Mineral rights, timber rights, easements, and leaseholds may all be countable resources if they have a cash value available to the individual upon disposition. In some cases, none of the above are saleable and therefore would not be a countable resource. For example, an individual may own an easement to pass through another's property to get to his own property. There would be little or no market for the sale of this property right. Also, a timber right to land that has been stripped of its trees would have little market value.

(3) 16th Section Land

16th section land or land acquired in lieu of 16th section land is land controlled by the State Board of Education under the general supervision of the State Land Commissioner. Generally each county Board of Supervisors has the authority to approve or re-new leases on the land.

An individual who leases such land does not own the property and has limited rights. The value of the lease decreases as the expiration date nears. Lease rights to 16th section or lieu lands are negotiable. These rights may be sold to another person provided the governing authority which approves such leases is agreeable to such a sale.

3. Evidence of Real Property Ownership

Property ownership must be verified for the case record. The following official records are utilized in establishing real property ownership:

- Current deed. If the client does not have a copy of the current deed, a copy must be obtained from records in the Chancery Clerk's Office in the county where the property is located.

  Note: Any discrepancies which exist between a deed and a tax receipt must be resolved in order to determine the true ownership situation. Deeds must be recorded in the appropriate county office to be considered a true deed documenting ownership.

- Tax Assessment notice or most recent tax receipt. Tax records and receipts describe the property. Phrases such as "Et al" or "Et ux" beside the name on a tax receipt indicates joint or common ownership of some form.

- Current mortgage statement. Mortgages are recorded in the Chancery Clerk's Office; however, the name of the mortgage holder must be known.

- Report of title search.

- Wills, court records, or relationship documents which show rights of an heir to the property after death of the former owner.

Obtain a copy of the official record used to verify ownership for the case record. When ownership or ownership interest is verified, proceed with determining the current market value of the client's ownership interest.

4. Determining Current Market Value (CMV) of Real Property

Real property which cannot be excluded must have its Current Market Value (CMV) determined. The CMV is the amount for which the property can be expected to sell on the open market in the geographic area involved and under existing economic conditions. The CMV is established based upon either the most recent property tax assessment, or if the tax assessment method is not applicable as outlined below, upon an estimate of probable market value obtained from a knowledgeable source.

A CMV is assigned to real property using one of the methods listed below in order to obtain a "base" CMV. If property is disposed of for less than the CMV assigned to it, a possible transfer of resources exists. If property is sold on the open market for more than the "base" CMV, the CMV equals the sale price and not the "base" CMV.

a. Tax Assessment Notice

Obtain from the individual a copy of the most recently issued tax assessment notice for the property. Base the CMV on this assessment notice unless:

- the notice is more than a year old based on its date of issue (unless it specifies that it covers more than one year and it is no older than the number of years it covers);

- the notice pertains to a special purpose assessment (unless it also provides a fair market value assessment, which can be used);

- the assessment is under appeal;

- the assessment uses a fixed rate per acre method based on land usage, such as agricultural or industrial. (This does not refer to assessments where conditions dictate similar taxes for similar types of land, such as desert, swamp, landfills, etc.); or

- the notice provides either no assessment ratio or only a range, e.g., between 25 and 50 percent (unless the individual would be ineligible using even the top of the range).

A tax assessed value divided by the county tax assessment ratio is the CMV based on the assessment. For example, if the tax assessed value is $500 and the assessment ratio is 15%, the CMV is $3333 based on the assessment.

Note: Property in Mississippi is assessed at 10% for home property and 15% for non-home property. Class 1 property, as reflected on the tax receipt, is home property assessed at 10%. Class 2 property is non-home property assessed at 15%. (Note: Class 2 property may adjoin home property and therefore be included in the definition of home property.)

b. Knowledgeable Source Estimate

If the tax assessment method cannot be used, have the client obtain an estimate of the property's CMV from a knowledgeable source. Knowledgeable sources include, but are not limited to:

- real estate brokers;
- the local office of the Farmer's Home Administration (for rural land);
- the local office of the Agricultural Stabilization and Conservation Service (for rural land);
- banks, savings and loan associations, mortgage companies, and similar lending institutions;
- an official of the local property tax jurisdiction (be sure to obtain the individual's estimate rather than the office's assessment);
- the County Agricultural Extension Service; and
- the Bureau of Land Management, the U. S. Geological Survey or any mining company that holds leases (such as for mineral rights CMV).

The estimate must show, in addition to the estimate itself:

- the name of the person providing the estimate;

- the name, address and telephone number of the business or agency for whom the person providing the estimate works;

- the basis for the estimate, to include such things as a description of the property and its condition and, where appropriate, the value of similar property in the same area; and

- the period to which the estimate applies (which should correspond to the period for which it is being requested).

If the client is incapable of obtaining an estimate, lend assistance. If obtaining an estimate by phone, be sure to record all pertinent facts in file.

If the validity of an estimate furnished by the individual is in doubt, obtain an estimate from an additional knowledgeable source.

c. CMV Rebuttals

If the individual disagrees with CMV evidence that he or she submits or that the worker obtains, and the difference is material to eligibility, prepare a rebuttal determination. The determination must take into account:

- **all the evidence previously in file** (the individual;'s original allegation, any tax assessment notices, and any estimates from knowledgeable sources);

- any **additional** evidence the individual wishes to submit, including evidence that the individual's ownership interest in the property is worth less than the total value of the property divided by the number of owners; and

- any other facts the Regional Office has about the property or about market conditions where it is located.

The rebuttal determination must be supported by a preponderance of the evidence (which may require one or more additional estimates from knowledgeable sources).

5. Determining CMV of Life Estates & Remainder Interests

Determine the value of life estate interests as follows:

Determine Current Market Value as described in Determining Current Market Value of Real Property" for the property as a whole.

Note: It is possible to own a life estate in a structure (house) only and not the surrounding land. If this is the case, determine CMV for only the structure or for whatever the life estate tenant has the right to use as established in a deed or will.

- Determine the individual's age as of his/her last birthday and find the age on the Life Estate and Remainder Interest Table located in the Appendix.

- Multiply the figure in the Life Estate column for the individual's age by the CMV of the property to determine the value of the life estate.

If there is a joint ownership of a life estate, first determine the CMV in the entire property. Divide the CMV of the entire piece of property by the number of joint owners to determine the individual's share. Determine the individual's life estate value as outlined above.

When one joint owner of a life estate dies, the surviving owners increase their interest. Life estates do not descend. For example, if a couple owns a life estate and one spouse dies, the remaining spouse is the sole owner of the life estate.

Determine the value of a remainder interest in the same manner used to compute a life estate interest except refer to the "Remainder" column of the Life Estate and Remainder Interest Table located in the Appendix to obtain the figure to use for multiplying by the CMV. Use the life estate tenants age when referring to the "Remainder" column.

6. **Determining CMV of Other Types of Ownership**

For other types of property ownership, such as mineral rights or timber rights, determine the CMV through a knowledgeable source. If the property right is under production, it is necessary to obtain a copy of the land lease to determine if the lease is transferable in order to determine if the property right is a countable resource.

7. **Treatment of Real Property As A Resource**

Absent evidence to the contrary, real property is presumed to be disposable at the CMV established. The portion of the resource that is "countable" as a resource is determined by:

- Establishing client's ownership interest, then
- Obtaining CMV, then
- Determine the client's Equity Value (EV).

The client's EV in real property is the amount "countable" as a resource unless:

- The property is excluded under Real Property Exclusion; and/or
- The property is excluded under "liberalized" resource policy.

8. Liberalized Real Property Exclusions

Under "liberalized" resource policy applicable to:

- LTC coverage groups,
- LTC "At-Home" coverage groups (Hospice & HCBS Handicapped Groups),
- PLAD, SLMB and QMB coverage groups, the following types of real property ownerships are excluded regardless of value:
- Life Estate and Remainder interests in any property or properties.
- Undivided Heir interests in any property
- 16th Section Land Leases
- Mineral Rights, Timber Rights or Leaseholds that are not under production. If these types of ownerships are income-producing, test the net annual return against the 6% income-producing property rule.

RESOURCES
TYPES OF RESOURCES

C. REAL PROPERTY-HOME/NON-HOME

Real property is generally classified as either home property or non-home property. There are exclusions that apply only to property classified as "home" property and other real property exclusions that can apply to either home and/or non-home property.

1. Home Property

An individual's home, regardless of value, is an excluded resource.

An individual's home is property in which he or she has an ownership interest and that serves as his her principal place of residence. It can include:

- the shelter in which he or she lives;
- the land on which the shelter is located; and
- related buildings on such land, or the shelter in which he or she lives; or the land on which the shelter is located; and/or related buildings on such land.

An individual's principal place of residence is the dwelling the individual considers his or her established or principal home and to which, if absent, he or she intends to return. It can be real or personal property, fixed or mobile, and located on land or water.

For purposes of excluding "the land on which the shelter is located" it is not necessary that the individual own the shelter itself.

EXAMPLE: If an individual lives on his or her own land in someone else's trailer, the land meets the definition of home and is excluded.

a. Land

The home exclusion applies not only to the plot of land on which the home is located, but to any land that adjoins it.

Land adjoins the home plot if not completely separated from it by land in which neither the individual nor his or her spouse has an ownership interest.

Easements and public rights of way (utility lines, roads, etc.) do not separate other land from the home plot.

b. Buildings

The home exclusion applies to all buildings on land excluded per a. above.

c. Home Ceases to be Home

Property ceases to be the principal place of residence - and, therefore, to be excludable as the home - as of the date that the individual, having left it, does not intend to return to it.

Such property, if not excluded under another provision, will be included in determining countable resources as of the first of the following month.

d. Exceptions to Home Ceasing to be Home

Even if the individual leaves the home without the intent to return, the property remains an excluded resource for as long as:

(1) A spouse or dependent relative of the individual continues to live there while the individual is institutionalized. Dependency may be of any kind (financial, medical, etc.) Relative means:

- child, stepchild, or grandchild;
- parent, stepparent, or grandparent;
- aunt, uncle, niece, or nephew;
- brother or sister, stepbrother or step-sister, half brother or half sister;
- cousin; or
- in-law

(2) Sale of the home would cause undue hardship, due to loss of housing, to a co-owner of the property (Repeated in Real Property Exclusions).

Obtain a signed statement from the dependent relative or co-owner to apply either exclusion.

Only one residence can be excluded as home property. If there are multiple residences, obtain the client's statement concerning such points as:

- how much time is spent at each residence;
- where he or she is registered to vote; and
- which address he/she uses as a mailing address or for tax purposes.

Determine the principal place of residence accordingly and document the case record.

Note: If an applicant's home property is located out of state, policy governing residency requires that a determination be made regarding the intent of the applicant to reside in Mississippi. It is not permissible for an individual to intend to return home to a principal place of residence located out of state for the purpose of the home exclusion and at the same time intend to reside permanently in Mississippi for the purpose of a residence determination. If an applicant intends to return home to property in another state, the he/she cannot be considered a Mississippi resident. If an applicant intends to reside in Mississippi, he/she cannot intend to return home to property located out of state.

2. "Liberalized" Home Property Exclusion

Under "liberalized" resource policy, home property can be excluded regardless of intent to return home or whether a dependent relative lives on the property. Each client en-titled to liberalized policy is allowed one home that can be excluded regardless of its use. If more than one residence is owned, exclude the property that would be to the client's advantage.

The liberalized home property exclusion applies to clients in the following coverage groups:

- LTC
- LTC "At-Home" (Hospice, HCBS Handicapped)
- PLAD, QMB, SLMB

3. Evidence of Home Property Ownership

Verify ownership of home property by obtaining copies of one or more items of evidence.

- tax assessment notice;
- recent tax bill;
- current mortgage statement;
- deed; and

- 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). and

- title and current registration for mobile homes

4. Home Replacement Exclusion

of

When an individual sells an excluded home, the proceeds the sale are excluded resources if the individual:

- plans to use them to buy another excluded home, and

- does so within 3 full calendar months of receiving them. This is 3 full months following the month the proceeds are received.

If the individual receives the proceeds under an installment contract, the contract is an excluded resource for as long as the individual:

- plans to use the entire downpayment and the entire principal portion of a given installment payment to buy another excluded home; and

- does so within 3 full calendar months of receiving such downpayment or installment payment.

The proceeds of the sale are the net amount the seller receives at settlement. If paid in installments, the proceeds consist of any downpayment and that portion of any subsequent payment that is not interest.

Use of proceeds to buy another excluded home includes payment of any costs that stem from the purchase. These include, but are not necessarily limited to:

- downpayment;
- settlement costs;
- loan processing fees and points;
- moving expenses;
- necessary repairs to or replacements of the new home's structure or fixtures (e.g., roof, furnace, plumbing, built-in appliances) that are identified and documented prior to occupancy; and
- mortgage payments

Use of proceeds to pay other costs will warrant their exclusion if such costs are identified and documented prior to occupancy and stem directly from the purchase or occupancy of the new home.

Document the file with a copy of the settlement sheet, contract for sale and/or other evidence that shows the new proceeds and how paid or payable.

If the home is not replaced within the allowable 3 month period, the proceeds are a countable resource retroactive to the month following the month of receipt.

The exclusion does not apply to that portion of the proceeds of the sale of the original home that is in excess of the costs of the purchase and occupancy of the substitute home.

5. Non-Home Real Property

Non-home real property consists of land and buildings or immovable objects (including some mobile homes) that are attached permanently to the land and that do not meet the definition of a home.

Document ownership of all non-home property using the same evidence used for home property.

Non-home property is a countable resource unless excludable under "Real Property Exclusions" outlined in the following subsection or as "Income Producing Property," also discussed later in this section.

RESOURCES
TYPES OF RESOURCES

D. REAL PROPERTY EXCLUSIONS

The types of exclusions described below can apply to home/non-home property as appropriate. Each exclusion can apply to any type of ownership interest.

1. Jointly Owned Real Property Whose Sale Would Cause Undue Hardship

Effective April 1, 1988, the value of an individual's owner-interest in jointly owned real property is an excluded resource for as long as sale of the property would cause undue hardship, due to loss of housing, to a co-owner.

Undue hardship would result if such co-owner:

- uses the property as his/her principal place of residence;
- would have to move if the property were sold; and
- has no other readily available housing.

Verify joint ownership and obtain a signed statement from the client and joint owner which documents undue hardship.

The exclusion ends when any one of the above conditions no longer applies.

2. Exclusion of Real Property Due to Reasonable Efforts to Sell

Effective April 1, 1988, real property can be excluded from resources provided the owner makes reasonable efforts to sell it and those efforts have been unsuccessful. The specific requirements listed below must be met in order this exclusion to apply.

a. Reasonable Efforts to Sell

Reasonable efforts to sell real property consist of taking all necessary steps to sell it through media serving the geographic area in which the property is located. For purposes of this provision, reasonable efforts specifically mean that:

(1) Within 30 days of signing Form DOM-320A, Agreement to Sell Property, the owner(s) must:

a. List the property with an agent; or

b. Begin to advertise in at least one of the appropriate local media, place a "For Sale" sign on the property (if permitted), begin to conduct open houses or otherwise show the property to interested parties on a continuing basis, and attempt any other appropriate methods of sale; and

(2) Except for gaps of no more than 1 week, the owner must maintain efforts of the type listed in 1. above; and

(3) The owner does not reject any reasonable offer to buy the property and accepts the burden of demonstrating to Medicaid's satisfaction that an offer was rejected because it was not reasonable.

b. Reasonable Offer to Buy

Assume that an offer to buy property at a particular price is reasonable if it is at least two-thirds of the estimated current market value (CMV) unless the owner proves otherwise (e.g., provides convincing evidence of a different CMV).

c. Good Cause

Good cause exists when circumstances beyond an individual's control prevent his or her taking the required action to accomplish reasonable efforts to sell. If good cause exists for the failure to meet any of the criteria specified in "Reasonable Efforts to Sell", the exclusion can continue, provided action is taken to resume efforts to sell.

d. Failure to Make Reasonable Efforts

Unless there is good cause, failure to meet any of the criteria specified in "Reasonable Efforts to Sell" means that:

1. An individual is not making reasonable efforts to sell the property;

2. The individual's countable resources include the value of the property beginning with the month following the month in which reasonable efforts to sell stop; and

3. The individual will be charged with an improper payment, if applicable.

e. Initial Verification of Efforts to Sell

The effort to sell must be documented in the case record within the 30 day time period for applying the exclusion by requiring all appropriate proof such as:

1. Copy of the listing agreement with the real estate agency in current use;

2. Dated advertisement(s) indicating the property is for sale;

3. Contracts with local media to advertise the property;

4. A photograph of the "For Sale" sign on the property;

5. Any other relevant items.

f. Effective Date of Exclusion

If the appropriate proof is submitted, the exclusion is applied back to the first of the month in which the effort to sell was initiated.

If the effort to sell was in existence prior to the date of application, the exclusion can be applied retroactively provided the effort is documented and DOM-320A is signed.

If the effort to sell is just beginning, the exclusion applies effective with the first of the month DOM-320A is signed (provided it is signed within 30 days). If not signed within 30 days, the exclusion applies as of the first of the month the effort to sell is initiated.

g. Follow-Up Contacts

Contacts must be scheduled at 90-day intervals until the property is sold or the exclusion ends. Follow-up contacts may be by telephone to determine the efforts being made to accomplish the sale and to document whether there has been any offer to buy since the prior contact. If an offer to buy has been refused, a statement must be submitted explaining the refusal. Note: the refusal of an offer to buy must be evaluated under the "Reasonable Offer to Buy" guidelines. If the refusal is unacceptable, the exclusion ends beginning with or retroactive to the month after the month of the refusal to sell.

If the reasonable efforts to sell are not continuing at each follow-up contact, determine if good cause exists. If good cause does not exist, the exclusion ends beginning with or retroactive to the month after the month the reasonable efforts stopped.

3. **Interests of Individual Indians in Trust or Restricted Lands**

In determining the resources of an individual (and spouse, if any) who is of Indian descent from a federally recognized Indian tribe, any interests of the individual (or spouse) in trust or restricted lands are excluded from resources.

If an individual Indian alleges an interest in trust or restricted land:

- obtain for the file a copy of any document or documents that might identify it as such; and/or
- verify the allegation with the appropriate Indian agency.

If verification is by phone, document the file.

RESOURCES
TYPES OF RESOURCES

E. REAL OR PERSONAL to INCOME-PRODUCING PROPERTY

The Social Security Act provides for the exclusion from resources of certain real and personal property if essential an individual's means of self-support.

The income generated by income-producing property is not excluded under this provision. Income is either earned or unearned, depending on the type of income producing property that is involved.

The different types of income-producing property include:

- Property Essential to Self-Support,
- Property Used to Produce Goods or Services,
- Nonbusiness Income Producing Property, and
- Liberalized Income Producing Property

Each of these types of property and its use and applicable exclusions are discussed below.

1. Current Use Requirement

Property must be in current use in the type of activity that qualifies it as income-producing in order to be excluded. Current use is evaluated on a monthly basis. Property <u>not</u> in current use can be excluded only if:

- it has been in use; and
- there is expectation that the use will resume.

Resumption of use must be expected within 12 months of last use. This 12 month period can be extended for an additional 12 months if nonuse is due to a disabling condition:

a. If property is not in current use, obtain the client or spouse's statement as to:

- the date of last use;
- the reason(s) the property is not in use; and
- when the individual expects to resume the self-support activity, if at all.

Explain that property can be excluded for up to 12 months if resumption of the self-support activity can reasonably be expected to occur within that time.

If the individual does not intend to resume the self-support activity, the property is a countable resource for the month after the month of last use.

If, after property has been excluded because an individual intends to resume self-support activity, the individual decides not to resume such activity, the exclusion ceases to apply as of the date of the change of intent. Thus, unless excluded under another provision, the property is a resource for the following month:

b. If an individual alleges that self-support property is not in current use because of a disabling condition, obtain the individual's signed statement as to:

- the nature of the condition;
- the date he or she ceased the self-support activity; and
- when he or she intends to resume the activity, if at all.

Prepare a special determination as to whether up to an additional 12 months will be allowed for resuming use of the property.

RESOURCES
TYPES OF RESOURCES

2. **Property Essential to Self-Support Exclusion Applies to All MAO Coverage Groups**

The properties described in a., b., and c., below are excluded as essential to self-support regardless of value or rate of return. However, they must be in current use or, if not in use for reasons beyond the individual's control, there must be a reasonable expectation that the required use will reume.

a. Trade or Business Property

This includes the necessary capital and operating assets of a business, e.g., real property, buildings, inventory, equipment, machinery, livestock, motor vehicles. Effective May 1, 1990, any and all property that is used in a trade or business is excluded as a resource, regardless of value. Prior to 05/01/90, the $6000/6% rule, as outlined in "Limits on Income Producing Property," must be met for trade or business property.

When a client or spouse owns a trade or business, document the following information:

- a description of the trade or business;
- a description of the assets of the trade or business;
- the number of years it has been operating;
- the identity of any co-owners;
- the estimated gross and net earnings of the trade or business for the current tax year.

Obtain a copy of the business tax return (i.e., Form 1040 and the appropriate schedules) for the tax year prior to the application or redetermination. Use the return to determine the net earnings from self-employment and validity of the trade or business. The following can be particularly helpful:

- Schedule C, Profit or Loss from Business or Profession;
- Schedule SE, Computation of Social Security Self-Employment;
- Schedule F, Farm Income and Expenses;
- Form 4562, Depreciation and Amortization; and
- Form 1065, U. S. Partnership Return of Income.

If the current tax return is not available, obtain a copy of the latest tax return available.

b. Government Permits

Government permits represent authority granted by a government agency to engage in income producing activity. Examples are commercial fishing permits granted by a State Commerce Commission and tobacco crop allotments issued by the U. S. Department of Agriculture.

If a client or spouse owns government license, permit, or other property that represents government authority to engage in an income producing activity, and that has value as a resource, document the following information:

- the type of license, permit or other property;
- the name of the issuing agency, if appropriate;
- whether the law requires such license, permit, or property for engaging in the income producing activity at issue; and
- how the license, permit, or other property is being used; or
- if it is not being used, why not.

c. Personal Property Used By An Employee

Personal property used by an employee for work is excluded from resources beginning May 1, 1990. For periods before that date such items were excluded if they were required by the individual's employer. Excluded items include tools, safety equipment, uniforms, etc.

If a client or spouse owning items that are used in his or work as an employee; or, for months of eligibility before May 1, 1990, that his or her employer required he or she provide as a condition or employment, obtain his or her statement to include:

- the name, address, and telephone number of the employer;
- a general description of the items;
- a general description of his or her duties; and
- whether the items are currently being used.

3. **Property Used To Produce Goods/ Services (SSI Policy)**

For MAO Coverage Groups subject to SSI policy, up to $6,000 of the equity value of nonbusiness property used to produce goods or services essential to daily activities is excluded from resources.

There is no requirement that the property produce a certain rate of return. The property must be in current use or, if it is not in use for reasons beyond the individual's control, there must be a reasonable expectation that the required use will resume.

Any portion of the property's equity value in excess of $6,000 is not excluded under this provision.

Nonbusiness property essential to self-support can be real or personal property but not cash or bank accounts. It produces goods or services essential to daily activities if, for example, it is used to:

- grow produce or livestock solely for personal consumption in the individual's household; or

- perform activities essential to the production of food solely for home consumption.

NOTE: While this category of property may encompass a vehicle used solely in a nonbusiness self-support activity (e.g., a garden tractor, or a boat used for subsistence fishing), it does not include any vehicle that qualifies as an automobile.

When a client or spouse owns property that he or she uses to produce goods or services necessary for daily activities, document the following:

- a description of the property;

- how it is used; and

- an estimate of its CMV and any encumbrances on it.

4. Nonbusiness Income-Producing Property (SSI Policy)

Up to $6,000 of the equity value of nonbusiness income producing property (and business income producing property for months of eligibility before May 1, 1990) can be excluded from resources if the property produces annual return equal to at least 6% of the excluded a net equity.

Any portion of the property's equity value in excess of $6,000 is not excluded under this provision.

If the property produces less than a 6% return, the exclusion can apply only if:

- the lower return is for reasons beyond the individual's control (e.g., crop failure or illness); and

- there is a reasonable expectation that the property will again produce a 6% return.

Otherwise, none of the EV is excluded under this provision.

If an individual owns more than one piece of income producing property:

- the 6% return requirement applies individually to each; and

- the $6,000 EV limit applies to the total EV exceeds $6,000 that portion of the total EV in excess of $6,000 is not excluded under this provision.

a. Nonbusiness Income-Property Defined

Property includes land which produces rents or other land-use fees (e.g., nonliquid notes or mortgages, ownership or timber rights, mineral or oil exploration) or other nonliquid property which provides rental or other income, but is not used as part of a trade or business.

b. Verification Required

When a client or spouse owns nonbusiness property which produces income, document the following:

- The number of years the individual has owned the property;
- The owner and/or co-owners of the property;
- A description of the property and how it is used;
- The estimated CMV of the property and any encumbrances on the property; and
- The estimated net and gross income for the current tax year.

Nonbusiness property is generally reported on Schedule E (Supplemental Income Schedule) of Form 1040. Obtain a copy of the tax return for the year prior to filing the application or redetermination. The Schedule E provides income information, a description of the property, use of the property, and the value of the property.

When no tax returns are available, obtain other evidence from the individual which establishes that the property is producing income. For example, if an individual is leasing land for mineral or oil exploration, he/she should have a copy of the lease agreement for the period in question.

c. Development When Rate of Return is Less Than 6%

When income from income producing property has declined below 6%, document the file with the following:

- Obtain an explanation for the decline in earnings for the year in question;

- Obtain evidence of prior years' earnings (e.g., tax returns for at least 2 years prior to the current taxable year) to establish whether the activity has produced a 6 percent rate of return before;

- If evidence establishes that the earnings decline is for reasons beyond the individual's control, allow up to 24 months from the end of the tax year in which the earnings went below 6% to meet the 6% requirement;

- Set up a 12-month tickler to check on the individual's progress with the business. The individual can have the additional 12 months to achieve the 6% rate of return if he/she is actively pursuing the activity. If, at the 12-month interval, the individual has ceased to actively pursue the activity the value of the property counts as a resource the month following the month of review; and

- If the property is still not producing at least a 6 percent return at the end of the 24-month period, discontinue the exclusion. The value of property counts as a resource the month following the month the 24-month period expires.

5. Liberalized For MAO Coverage Groups subject to liberalized resource

Income-Producing Property Policy

policy, effective 10-01-89, the $6000 resource cap for income producing property is lifted. Property can be considered income-producing if it produces a net annual return of at least 6% of the Equity Value (EV) of the property.

- Property essential to Self-Support, as defined in policy, is excluded regardless of value or rate of return so the 6% of EV rule does not apply,

- Property used to produce goods or services as defined in policy, is not required to have a rate of return so the 6% of EV rule does not apply. Property that qualifies as used to produce goods or services can therefore be excluded regardless of value or rate of return, and

- Nonbusiness income-producing property must produce a net annual return of 6% of the EV for each property. If multiple properties are involved, each must be evaluated under the 6% of EV rule.

Refer to the discussion of each type of property exclusion for the verification requirements that apply to SSI and liberalized policies.

NOTE: Property that a client sells via a property agreement must meet the 6% net annual return criteria and the agreement must be actuarially sound in order to avoid a possible transfer of resources penalty. Refer to the discussion of "Promissory Notes, Loans & Property Agreements" later in this subsection.

RESOURCES

TYPES OF RESOURCES

F. PERSONAL PROPERTY

Personal property is any property that is not real property. The term encompasses such things as household goods, jewelry, automobiles, life insurance, burial funds.

1. Household Goods & Personal Effects

Household goods are items of personal property customarily found in the home and used in connection with the maintenance, use and occupancy of the premises (such furniture, appliances, carpets, etc).

Personal effects are those items of personal property worn or carried by an individual (clothing, jewelry, hobby items, etc.)

An item of unusual value is one whose CMV exceeds $500.

a. SSI Policy

A general exclusion of up to $2,000 applies to the total equity value of household goods and personal effects other than those excluded regardless of value. Any portion of the total equity in excess of $2,000 is not excluded under this provision.

Exception: Some items of personal property are excluded regardless of value. They are:

- One wedding ring and one engagement ring per individual are excluded regardless of value.

- Prosthetic devices, wheelchairs, hospital beds, dialysis machines and other items required by a person's physical condition are excluded regardless of value if they are not used extensively and primarily by other members of the household.

Items of unusual value that may not be excludable are: expensive china/silver/glassware, antiques, art works, hobby collections, jewelry, etc.

If the client or other evidence indicates ownership of items of unusual value worth more than $500, establish CMV by a knowledgeable source. Use CMV and not replacement value in determining the value.

Where it is determined that the verified CMV of all items of unusual value is more than $500, the total CMV of all other durable household goods and personal effects must be considered in arriving at the countable equity value.

As a interim step in the developmental process, conclude, absent evidence to the contrary, that the CMV of all other durable household goods and personal effects is $1,000. Add this amount to the CMV of those items that are of "unusual value." Deduct $2,000 from this figure and add the remainder to the total value of all other includable resources. If the estimated CMV of countable household goods and personal effects does not exceed the applicable resource limit for an individual or couple, no further development is necessary. If the estimate exceeds the applicable resource limit, further development is necessary to establish the actual CMV and equity value of the countable household goods and personal effects. As with items of unusual value, any reasonable or practical method should be used to establish CMV. In regard to equity development, the claimant's records may be used; but if there is any doubt about the documentation, third party verification of any alleged legal debts against the property should be made. Combine the established equity value of the items of unusual interest and durable household goods and personal effects. The excess over $2,000, if any, is added to other includable resources in determining whether the applicable individual or couple resource limit is exceeded.

b. Liberalized Policy

For MAO Coverage Groups subject to liberalized resource policy, effective 10-01-89, household goods are totally excluded regardless of value and personal property up to $5000 in EV is excluded. For example, a Recreational Vehicle (RV) is personal property rather than an automobile. The RV can be excluded if the EV is $5000 or less. Follow SSI policy for items totally excluded and the steps to take in documenting value.

2. Automobiles

For SSI purposes, "automobile" means any vehicle used for transportation. It thus can include, in addition to cars and trucks: boats, snowmobiles, animal-drawn vehicles, and even animals, whether registered or not. A vehicle not used for transportation is not an automobile but may be a countable resource. A vehicle temporarily out of service may still be an automobile.

The CMV of an automobile is the average price an automobile of that particular year, make, model and condition will sell for on the open market (to a private individual) in the particular geographic area involved. Use the N.A.D.A. Official Used Car Guide or Older Car Guide. Use as the automobiles CMV the average trade-in value shown for it in the most recently published guide. If the client wishes to rebut the N.A.D.A. value, he/she can obtain a knowledgeable source statement.

a. SSI Policy

One automobile is excluded regardless of value if, for the individual or a member of the individual's household, it is:

- necessary for employment;

- necessary for the treatment of a specific or regular medical problem;

- modified for operation by, or the transportation of, a handicapped person; or

- necessary, because of climate, terrain, distance or similar factors, for the performance of essential daily activities.

If no automobile is totally excluded up to $4,500 of the CMV of one automobile is excluded. If the CMV exceeds $4,500, the excess counts as a resource unless the automobile can be excluded under some other provision. Equity value is not a consideration for purposes of this exclusion.

Any automobile an individual owns in addition to the one wholly or partly excluded (up to $4,500 CMV) and which cannot be excluded under the income-producing property provision is a resource in the amount of its equity value.

The exclusion applies in the manner most advantageous to the individual.

If one of two cars can be excluded as necessary for medical treatment, and the other will be a countable resource, the exclusion applies to the car with the greater equity value regardless of which car is used to obtain medical treatment.

For example, a client owns two cars. One has a CMV of $8,000 and an equity value of $500. The other, which has been paid off, has a CMV and equity value of $2,500. Neither can be excluded based on use.

Applying the $4,500 exclusion to the car with the $8,000 CMV would leave $3,500 of the CMV of that car as a countable resource. It also would leave the $2,500 equity value of the other car as a countable resource.

Applying the $4,500 exclusion to the car with the $2,500 CMV excludes that car entirely, leaving only the $500 equity value of the other car to be included among countable resources. Therefore, the exclusion applies to the car with the $2,500 CMV.

b. Liberalized Policy

For MAO Coverage Groups subject to liberalized resource policy, effective 10-01-89, up to two automobiles can be excluded totally or up to $4,500 CMV. Any vehicle that is not used for transportation due to the inoperable condition of the car (junk car) can be totally excluded as a resource.

AUTOMOBILE CHART

SSI Policy	Liberalized Policy
Exclude 1 car due to use, or	Exclude up to 2 cars due to use, or
Exclude 1 car up to $4500 CMV,	Exclude up to 2 cars up to $4500 CMV,
or	or
Count EV as a resource if this is more advantageous to 1 car.	Exclude 1 for use and 1 up to $4500 CMV, or,
Additional cars, count EV	Count EV as a resource if this is more advantageous for up to 2 cars.
	Additional cars, count EV

Note: If counting EV is chosen, the full EV is shown as a countable resource. EV is not an

3. Life Insurance

A life insurance policy is a contract. Its purchaser (the owner pays premiums to the company that provides the insurance (the insurer). In return, the insurer agrees to pay a specified sum to a designated beneficiary upon the death of the insured (the person on whom, or on whose life, the policy exists).

Face value (FV) is the amount of basic death benefit contracted for at the time the policy is purchased. The face page of the policy may show it as such or as the "amount of insurance," "the amount of this policy," "the sum insured," etc. A policy's FV does not include:

- the FV of any dividend addition, which is added after the policy is issued (see 5. below);
- additional sums payable in the event of accidental death or because of other special provisions; or
- the amount(s) of term insurance, when a policy provides whole life coverage for one family member and term coverage for the other(s).

A policy's cash surrender value (CSV) is a form of equity value that it acquires over time. The owner of a policy can obtain its CSV only by turning the policy in for cancellation before it matures or the insured dies. A loan against a policy reduces its CSV.

Dividends (shares of any surplus insurance company earnings) can be applied to premiums due or paid by check or by an addition or accumulation to an existing policy. Dividend additions are amounts of insurance purchased with dividends and added to the policy, increasing its death benefit and CSV. The table of CSV's that comes with a policy does not reflect the added CSV of any dividend additions.

Dividend accumulations are dividends that the policy owner has constructively received but left in the custody of the insurer to accumulate at interest. They are not a value of the policy; the policy owner can obtain them without affecting FV or CSV. Dividend accumulations cannot be excluded from resources under the life insurance exclusion, even if the policy that pays the accumulations is excluded from resources. Unless they can be excluded under another provision (e.g., as set aside from burial), they are a countable resource.

a. SSI Policy

A life insurance policy is a resource if it generates a CSV. Its value as a resource is the amount of the CSV.

A life insurance policy is an excluded resource if its FV and the FV of any other life insurance policies the individual owns on the same insured total $1,500 or less. However, the FV of some policies does not count toward this $1,500 total (see below).

Do not include the FV of dividend additions in determining whether a policy is a countable or excludable resource. If the policy is a countable resource, we include the CSV of dividend additions in determining the resource value of the policy.

In determining whether the total FV of the life insurance policies an individual owns on a given insured is $1,500 or less, the FV of the following are not taken into account.

- burial insurance policies; and
- term insurance policies that do not generate a CSV.

The maximum of $1,500 that can be excluded as set aside for the burial expenses of an individual must be reduced by the FV of:

- any insurance policy on the life of the individual that is excluded under this provision; and

- any burial insurance policy for the burial expenses of the individual.

This includes the FV of a life insurance policy for which a funeral provider has been made the irrevocable beneficiary, if the policy owner has irrevocably waived his or her right to, and cannot obtain, any CSV the policy may generate.

Ask the individual to submit all the life insurance policies owned by the client and/or spouse/parent(s) and the most recent annual dividend statement issued for each policy. Use these records to verify:

- the owner;

- the insured;

- the FV;

- whether the policy pays dividends and, if it does, what option the individual selected for their disposition (i.e., accumulations, additions, applied to premiums, paid by check); and

- if dividend accumulations, their current amount.

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TYPES OF RESOURCES

- whether the policy generates a CSV and, if it does,

- the current CSV (including the CSV of any dividend additions and any loans on the policy which reduce the CSV).

If examination of a policy does not reveal needed information, contact the insurance company via DOM-331, Request for Information Concerning Insurance, after obtain an authorizing signature.

NOTE: Several insurance companies have begun offering a new provision that allows a terminally ill person (or in some cases, individuals permanently confined to a medical institution) an option to receive the proceeds (or a portion thereof) of their life insurance policy while still living. This type of provision has been called a "living needs benefit program."

If an individual has a life insurance policy that allows them to receive their death benefit while living and the individual meets the insurance company's requirements for receiving such proceeds, they will not be required to file for such proceeds. If, however, the individual does file and receive the benefits, the payment will be considered income in the month it is received and available as a resource to the extent remaining into following months.

b. Liberalized Policy

For MAO Coverage Groups subject to liberalized resource policy, effective 07-01-99, replace the SSI exclusion limit of $1500 with a $10,000 exclusion limit. All other SSI policy applies except that limit is increased to $10,000. From 10-01-89 to 06-30-99, the exclusion limit was $5,000.

4. Burial Spaces

A burial space or agreement which represents the purchase of a burial space held for the burial of the individual, his or her spouse, or any other member of his or her immediate family is an excluded resource, regardless of value.

The burial space exclusion is in addition to, and has no effect on, the burial funds exclusion.

For purposes of this exclusion, burial spaces include burial plots, gravesites, crypts, mausoleums, urns, niches, and other customary and traditional repositories for the remains of the deceased person.

The exclusion also includes necessary and reasonable improvements or additions to such spaces including, but not limited to, vaults, headstones, markers, plaques, or burial containers and arrangements for opening and closing or the gravesite.

SSI policy defines an individual's immediate family (for this exclusion) as parents (including adoptive parents and stepparents), minor or adult children (including adoptive and stepchildren), and siblings (brothers and sisters including adoptive and stepsiblings). Immediate family also includes the spouses of the above named relatives provided the marriage is still in effect (not divorced).

For Medicaid cases eligible for the liberalized policy provisions, effective 10-01-89, an individual's immediate family includes all of the relatives included in SSI's definition and extends to family members with any degree of relationship.

For both policies, if a burial space is being held by a funeral provider in accordance with a burial agreement, whether revocable or irrevocable, then the value of the burial space or burial space item is excluded under the burial space exclusion.

5. **Burial Funds**

Burial funds are:

- revocable burial contracts;
- revocable burial trusts;
- other revocable burial arrangements (including the value of certain installment sales contracts for burial spaces);
- cash;
- financial accounts (e.g., savings or checking accounts); or
- other financial instruments with a definite cash value (e.g., stocks, bonds, certificate of deposit, etc.).

These funds must be clearly designated for the client's or spouse's burial, cremation or other burial-related expenses. Property other than that listed in this definition will not be considered burial funds and may not be excluded under the burial funds provision. For example, a car, real property, livestock, etc. are not burial funds.

Burial funds <u>cannot</u> be commingled with other resources not intended for burial. The burial fund exclusion applies only if funds set aside for burial expenses are kept separate from all other resources not intended for burial. If excluded burial funds are mixed with resources not intended for burial, the exclusion will not apply to any portion of the funds. It is possible to have excluded and nonexcluded funds commingled provided all funds are intended for burial, but it is not permissible to have burial/nonburial funds commingled.

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a. SSI Policy

SSI policy allows up to $1500 in funds set aside for the burial of the individual, and up to an additional $1500 in funds set aside for burial of the individual's spouse (eligible or ineligible).

b. Liberalized Policy

For Medicaid cases eligible for the liberalized policy provisions, effective 10-01-89, there is a $3000 maximum that can be excluded for burial of the individual, and up to $3000 allowed for burial of the individual's spouse (eligible or ineligible).

Effective 04-01-01, the maximum that can be excluded for burial of the individual is $6,000 and up to $6,000 is allowed for burial of the spouse (eligible or ineligible).

c. Reductions in Maximum Exclusions

The maximum $1,500 or $6,000 that can be excluded is reduced by:

- the face value of any life insurance policy on the individual (or spouse, if applicable), if such policy is excluded under the life insurance exclusion; and

- any amount held in an irrevocable trust, burial contract, or other irrevocable arrangement for the individual's (or spouse's) burial expenses except to the extent that it represents excludable burial spaces.

d. Irrevocable Burial Arrangements

Irrevocable burial arrangements are not resources and are not subject to the $1,500 or $6,000 maximums; however, irrevocable burial arrangements reduce the amount of the burial fund exclusion allowed. Burial insurance is considered an irrevocable arrangement.

The value of the burial arrangements purchased must be equal to the value of the vehicle that funds it, such as the value of the prepayment, life insurance or annuity that is irrevocably assigned to the funeral home.

If the value of the burial arrangement is not equal to the value of the prepayment, a penalty may be assessed under the transfer of assets provision for institutionalized clients.

e. Designation of Burial Funds & Effective Date

Burial funds may be designated as such by:

AA. - An indication on the burial funds document such as a revocable burial contract or the title on a bank account. Whenever burial funds are already clearly set aside as burial funds, no separate signed statement or further designation is required.

BB. - Completion of DOM-321B, Designation of Burial Funds form. This form provides documentation of the value and owner of the resource, the person for whom the funds are intended, the form in which the funds are held, and the date the funds were set aside for burial.

Once the date that burial funds were considered set aside for burial has been established, the exclusion can be effective as of:

CC. - The first of the month of application or the first month or retroactive eligibility if the intent to designate was after 11/01/82; or,

DD. - October 1, 1989, is the first possible month to exclude up to $3,00 under the liberalized resource policy provision.

EE. - April 1, 2001, is the first possible month to exclude up to $6,000 for burial.

f. Changes in Burial Exclusion Amounts

Interest earned on excluded burial funds and appreciation in the value of excluded burial arrangements are excluded as income and resources if left to accumulate and become part of the separate burial fund. However, once a burial fund is excluded, it may not always remain excluded. Changes in the individual's circumstances may raise or lower the amount that can be excluded for burial, such as:

- The purchase of additional life insurance with cash surrender value may change the allowable exclusion. Similarly, cashing in life insurance may raise or lower the allowable exclusion.

- The face amount of life insurance may change, thereby changing the allowable exclusion.

- An irrevocable burial contract may be purchased, thereby reducing the allowable burial exclusion.

- Deposits made to bank accounts designated for burial will change the allowable exclusion.

- If the amount designated is less than the maximum exclusion amount, the individual may add additional funds to the burial fund to bring up the original amount to the maximum exclusion amount.

g. Documentation Requirements

Document the case record by use of DOM-321A, Burial Assets Exclusion Worksheet, for each case involving application of the burial fund exclusion. A separate worksheet is required for each person eligible to receive an exclusion, which includes:

FF. - an eligible
GG. - a spouse (eligible or ineligible)
HH. - an eligible child
II. - parent(s) (eligible or ineligible)

Burial funds in excess of the exclusion limit are countable resources.

The burial fund exclusion, once applied, must be reevaluated whenever a change becomes known that would affect the exclusion amount or at each redetermination. It is not necessary for the client/representative to sign a new statement, Form DOM-321B, unless there is a new or revised designation of fund(s). It is necessary to verify the value of the fund(s) designated for burial to determine if the exclusion amount has changed. If there is a change in the amount of the exclusion, a new Form DOM-321A must be prepared. If there is no change from the previous excluded amount, the previous DOM-321A should be updated.

Note: A decrease in the value of any excluded funds will be subject to a penalty for misuse, which is outlined below.

h. Misuse of Burial Funds

If a client or spouse uses funds (including interest) which were excluded under the burial fund exclusion for any purpose other than expenses connected with the burial, cremation, etc., of the individual or the individual's spouse for whom the funds were set aside, any future benefits payable to the eligible individual (and spouse, if any) must be offset by an amount equal to the amount of funds used for some other purpose.

The penalty for misuse applies only if the client would have excess resources without the exclusion.

For Medicaid purposes, count misused burial funds as income the next possible month after the month in which the misuse is discovered. The misused funds will be included as income in the eligibility computations; however, for institutionalized recipients, misused burial funds are not counted as income in the Medicaid Income computation unless the funds are "available to the recipient."

Upon discovery of the misuse of excluded burial funds, the worker will obtain verification (which may be in the form of a statement from the client and/or representative) that all or a portion of the funds have been used for another purpose other than burial. The worker will then determine the effect the misuse will have on eligibility based on income. If ineligibility results, the case will be closed in accordance with ongoing policy, i.e., advance notice issued, etc. If the misuse of burial funds does not result in excess income and the funds are not available to the client to include in the Medicaid Income computation (if applicable), no action is required other than documenting the case record.

RESOURCES

TYPES OF RESOURCES

5. **Burial Funds**

Burial funds are:

- revocable burial contracts;
- revocable burial trusts;
- other revocable burial arrangements (including the value of certain installment sales contracts for burial spaces);
- cash;
- financial accounts (e.g., savings or checking accounts); or
- other financial instruments with a definite cash value (e.g., stocks, bonds, certificate of deposit, etc.).

These funds must be clearly designated for the client's or spouse's burial, cremation or other burial-related expenses. Property other than that listed in this definition will not be considered burial funds and may not be excluded under the burial funds provision. For example, a car, real property, livestock, etc. are not burial funds.

Burial funds <u>cannot</u> be commingled with other resources not intended for burial. The burial fund exclusion applies only if funds set aside for burial expenses are kept separate from all other resources not intended for burial. If excluded burial funds are mixed with resources not intended for burial, the exclusion will not apply to any portion of the funds. It is possible to have excluded and nonexcluded funds commingled provided all funds are intended for burial, but it is not permissible to have burial/nonburial funds commingled.

RESOURCES
TYPES OF RESOURCES

a. SSI Policy

SSI policy allows up to $1500 in funds set aside for the burial of the individual, and up to an additional $1500 in funds set aside for burial of the individual's spouse (eligible or ineligible).

b. Liberalized Policy

For Medicaid cases eligible for the liberalized policy provisions, effective 10-01-89, there is a $3000 maximum that can be excluded for burial of the individual, and up to $3000 allowed for burial of the individual's spouse (eligible or ineligible).

Effective 04-01-01, the maximum that can be excluded for burial of the individual is $6,000 and up to $6,000 is allowed for burial of the spouse (eligible or ineligible).

c. Reductions in Maximum Exclusions

The maximum $1,500 or $6,000 that can be excluded is reduced by:

- the face value of any life insurance policy on the individual (or spouse, if applicable), if such policy is excluded under the life insurance exclusion; and

- any amount held in an irrevocable trust, burial contract, or other irrevocable arrangement for the individual's (or spouse's) burial expenses except to the extent that it represents excludable burial spaces.

d. Irrevocable Burial Arrangements

Irrevocable burial arrangements are not resources and are not subject to the $1,500 or $6,000 maximums; however, irrevocable burial arrangements reduce the amount of the burial fund exclusion allowed. Burial insurance is considered an irrevocable arrangement.

The value of the burial arrangements purchased must be equal to the value of the vehicle that funds it, such as the value of the prepayment, life insurance or annuity that is irrevocably assigned to the funeral home.

If the value of the burial arrangement is not equal to the value of the prepayment, a penalty may be assessed under the transfer of assets provision for institutionalized clients.

e. Designation of Burial Funds & Effective Date

Burial funds may be designated as such by:

JJ. - An indication on the burial funds document such as a revocable burial contract or the title on a bank account. Whenever burial funds are already clearly set aside as burial funds, no separate signed statement or further designation is required.

KK. - Completion of DOM-321B, Designation of Burial Funds form. This form provides documentation of the value and owner of the resource, the person for whom the funds are intended, the form in which the funds are held, and the date the funds were set aside for burial.

Once the date that burial funds were considered set aside for burial has been established, the exclusion can be effective as of:

LL. - The first of the month of application or the first month or retroactive eligibility if the intent to designate was after 11/01/82; or,

MM. - October 1, 1989, is the first possible month to exclude up to $3,00 under the liberalized resource policy provision.

NN. - April 1, 2001, is the first possible month to exclude up to $6,000 for burial.

f. Changes in Burial Exclusion Amounts

Interest earned on excluded burial funds and appreciation in the value of excluded burial arrangements are excluded as income and resources if left to accumulate and become part of the separate burial fund. However, once a burial fund is excluded, it may not always remain excluded. Changes in the individual's circumstances may raise or lower the amount that can be excluded for burial, such as:

- The purchase of additional life insurance with cash surrender value may change the allowable exclusion. Similarly, cashing in life insurance may raise or lower the allowable exclusion.

- The face amount of life insurance may change, thereby changing the allowable exclusion.

- An irrevocable burial contract may be purchased, thereby reducing the allowable burial exclusion.

- Deposits made to bank accounts designated for burial will change the allowable exclusion.

- If the amount designated is less than the maximum exclusion amount, the individual may add additional funds to the burial fund to bring up the original amount to the maximum exclusion amount.

g. Documentation Requirements

Document the case record by use of DOM-321A, Burial Assets Exclusion Worksheet, for each case involving application of the burial fund exclusion. A separate worksheet is required for each person eligible to receive an exclusion, which includes:

OO. - an eligible
PP. - a spouse (eligible or ineligible)
QQ. - an eligible child
RR. - parent(s) (eligible or ineligible)

Burial funds in excess of the exclusion limit are countable resources.

The burial fund exclusion, once applied, must be reevaluated whenever a change becomes known that would affect the exclusion amount or at each redetermination. It is not necessary for the client/representative to sign a new statement, Form DOM-321B, unless there is a new or revised designation of fund(s). It is necessary to verify the value of the fund(s) designated for burial to determine if the exclusion amount has changed. If there is a change in the amount of the exclusion, a new Form DOM-321A must be prepared. If there is no change from the previous excluded amount, the previous DOM-321A should be updated.

Note: A decrease in the value of any excluded funds will be subject to a penalty for misuse, which is outlined below.

h. Misuse of Burial Funds

If a client or spouse uses funds (including interest) which were excluded under the burial fund exclusion for any purpose other than expenses connected with the burial, cremation, etc., of the individual or the individual's spouse for whom the funds were set aside, any future benefits payable to the eligible individual (and spouse, if any) must be offset by an amount equal to the amount of funds used for some other purpose.

The penalty for misuse applies only if the client would have excess resources without the exclusion.

For Medicaid purposes, count misused burial funds as income the next possible month after the month in which the misuse is discovered. The misused funds will be included as income in the eligibility computations; however, for institutionalized recipients, misused burial funds are not counted as income in the Medicaid Income computation unless the funds are "available to the recipient."

Upon discovery of the misuse of excluded burial funds, the worker will obtain verification (which may be in the form of a statement from the client and/or representative) that all or a portion of the funds have been used for another purpose other than burial. The worker will then determine the effect the misuse will have on eligibility based on income. If ineligibility results, the case will be closed in accordance with ongoing policy, i.e., advance notice issued, etc. If the misuse of burial funds does not result in excess income and the funds are not available to the client to include in the Medicaid Income computation (if applicable), no action is required other than documenting the case record.

G. INVESTMENTS CONTRACTS

Other common investment vehicles include stocks and bonds and contracts refer to promissory notes, loans and property agreements.

1. Stocks

Shares of stock represent ownership in a business corporation. Their value shifts with demand and may fluctuate widely. The following guidelines apply to all stocks, including preferred stocks, warrants and rights, and options to purchase stocks.

- Absent evidence to the contrary, assume that each owner owns an equal share of the value of the stock.

- Absent evidence to the contrary, assume that the owner of shares of stock can sell them at will at current value.

- Broker fees do not reduce the value that stocks have as resources.

Verify ownership by viewing the stock certificate or most recent statement of account (including dividend account) from the firm that issued or is holding the stock. Document the file with a photocopy. If the individual does not have this documentation, have him/her obtain a statement from the firm. Provide assistance as needed.

a. Publicly Traded Stock

The CMV of a stock is its closing price on the last business day of the preceding month.

The values of over-the-counter stocks are shown on a "bid" and "asked" basis. For example, "18 bid, 19 asked." Use the bid price as the CMV.

The "par value" or "stated value" shown on some stock certificates is not the market value of the stock.

The closing price of a stock on a given day can usually be found in the next day's regular or financial newspaper.

As a last resort, contact a local securities firm. Record the appropriate closing price and the source of the information on a Record of Contact.

b. Stock That Is Not Publicly Traded

The stock of some corporations is held within close groups and traded very infrequently. The sale of such stock is often handled privately and subject to restrictions. As a rule, it cannot be converted to cash within 20 working days.

The burden of proof for establishing the value of this kind of stock is on the individual. The preferred evidence is a letter or other written statement from the firm's accountants giving their best estimate of the stock's value and the basis for the estimate, e.g.:

- most recent sale,
- most recent offer from outsiders,
- CMV of assets less debts on them,
- cessation of activity and sale of assets,
- bankruptcy, etc.

Keep the statement or a photocopy of it in the file.

c. Common Stock

Common stock usually is held in the form of a certificate registered in the owner's name. Dividends usually are paid quarterly and may vary with company earnings.

- "Listed" stocks are those listed on the NYSE, AMEX, or on one of the regional exchanges such as Boston, Philadelphia, or Chicago.

- Over-the-counter (OTC) stocks, which include "penny" stocks, are not listed on the major exchanges. They usually are reported in the National Association of Security Dealers Automated Quotations (NASDAQ) system.

d. Preferred Stock

Preferred stock receives preference with respect to dividends and, in case of bankruptcy, the distribution of assets. Preferred stock dividends:

- are paid at a fixed rate;

- must be paid before common stock dividends can be paid; and

- must be made up later, when not paid timely, whereas common stock dividends may be skipped.

e. Reading Stock Quotations

Stock tables vary little from publication to publication. The following quote is typical, showing from left to right:

- the standard abbreviation of the name of the company (Philadelphia Electric in this case), followed by "pf" for preferred stock on the second line;
- the dividend amount;
- the price-to-earnings ratio;
- sales volume, in thousands;
- the day's high, low, and closing prices (22 3/4 = $22.75); and
- the change in price from the previous day.

NAME	DIV	PE	SALES	HIGH	LOW	LAST	CHG
Phil El	2.20	9	4323	22 7/8	22 5/8	22 3/4	- 1/8
Phil E pf	4.30	-	50	42 3/4	42 3/4	42 3/4	-

2. Options

An option is the right to sell or buy something at a specified price by a specified date. The "something" is usually stock, but there are options on interest rates, stock market indexes, commodity futures, and other items as well. An option to sell is call a "put." An option to buy is a "call." The value of an option depends on:

- the length of the contract (3, 6, or 9 months);

- the difference between the CMV of the item and the price at which the put permits it to be sold or the call permits it to be bought; and

- the volatility of the item (how much its CMV is expected to fluctuate).

a. Buying & Selling Options

Options can be sold through a broker. If the CMV of an item goes up in relation to a call price, the value of the option increases. If it goes down, the value of the option decreases. The reverse is true for a put.

b. Reading Option Quotations

There are several exchanges across the country that list option prices for about 300 stocks; the Chicago Board of Options Exchanges (CBOE), AMEX, the Philadelphia Stock Exchange, and the Pacific Stock Exchange. Transactions on these exchanges are listed in financial publications and many newspapers.

Although a stock option contract controls 100 shares of stock, options are quoted on the price per share. If a contract sells for $300, the cost per share is $3. Options come due and are quoted for each January, April, July and October.

The following example is a typical options quotation and shows, from left to right:

- the name of the stock (Tandy), the expiration month (April) and per-share price of the option ($30) for a put option on line 2);

- the number of contracts sold (996 on line 2);

- the high, low, and closing prices for a contract ($56.25, $25, and $37.50, respectively, on line 2); and

- the net change in the value of the contract ($6.25).

Name, Expiration Date, and Price	Sales	High	Week's Low	Last	Net Change
Tandy Apr. 30	1317	4 3/4	2 3/4	3 1/8	-1/8
Apr. 30p	996	9/16	1/4	3/8	-1/16

3. Mutual Fund Shares

A mutual fund is a company whose primary business is buying and selling securities and other investments. Shares in a mutual fund represent ownership in the investments held by the fund.

The term "mutual fund" encompasses a wide range of investments. Basically, it is a pool of assets (stocks, bonds, etc.) managed by the investment company. A mutual fund represents ownership interest in this pool as opposed to a particular stock or bond.

The development guidelines for stocks also apply to mutual fund shares. Many newspapers contain a separate table showing the values of funds not traded on an exchange.

a. Growth Funds

The primary objective of these funds, also known as performance funds and hedge funds, is aggressive long term growth of investment rather than current income. Dividends typically are low.

b. Income Funds

The objective is current income through high dividends and interest, as opposed to capital gains.

c. Balanced Funds

The objective is a balance of growth and income.

d. Municipal Bond Fund

The fund invests in tax-exempt bonds and the interest is passed along to holders on a tax-exempt basis.

e. Money Market Funds

The fund invests in conservative vehicles such as T-Bills and bank certificates. The minimum investment usually is $1,000, but may be less. Income may fluctuate daily based on interest rates. Money market funds often have a check-writing feature.

f. Buying & Selling Mutual Funds

"Load" funds are sold through a broker who collects a commission. "No-load" funds usually are purchased directly from the fund (no commission) and often are advertised in newspapers and magazines.

g. Reading Mutual Fund Quotations

The format of the following table is typical of those shown in newspapers and financial publications, showing from left to right:

- the names of the funds available for each management group (in this case, four funds managed by the Fund Founders Group);

- the high and low values for the preceding 52-week period;

- the most recent closing price;
- the change over the previous week; and
- the fund's income and capital gains totals for the previous 12 months.

Fund Founders Group	52 Weeks H	L	Close	Change	Week's Income*	Gains	Capitol
Growth n.		8.77	6.28	6.37	-0.08	0.157	2.505
Income n.		15.18	13.72	13.87	+0.01	1.273	0.232
Mutual		11.56	9.74	9.98	-0.07	0.426	0.706
Special n.		37.11	22.88	23.54	-0.13	1.900	1.395

n = no-load
* = last 12 months

4. Municipal, Corporate & Government Bonds

A bond is a written obligation to pay a sum of money at a specified future date. Bonds are negotiable and transferable.

Municipal, corporate, and government bonds are negotiable and transferable. Therefore, their value as a resource is their CMV. Their redemption value, available only at maturity, is immaterial.

Development and documentation instructions for stocks also apply to bonds.

a. Corporate Bonds

Corporate bonds are the obligation of a private corporation. Corporations sell corporate bonds to raise capital. There are two (2) types:

- **debentures**, which are backed by the issuer's full faith and credit; and
- **mortgage backed** bonds, which are backed by a lien on the company's assets.

Corporate bonds are issued in 2 forms:

- **registered**, which pay interest to their registered owner; and

- **bearer** or **coupon** bonds, which pay it to whomever holds the bond.

Convertible bonds are debentures that can be exchanged for a specified number of shares of a company's stock. Junk bonds are high risk bonds.

A UIT is a package of bonds in a portfolio. One can buy shares of the package for $1 to $1,000 per share with a minimum investment of $750 to $5,000, depending on the trust. The interest rate usually is fixed at purchase and does not change. Units usually are sold or redeemed through the trust sponsor.

Zero coupon bonds usually are issued by corporations. They do not pay current interest; accrued interest is paid at maturity. The U. S. Government does not issue zero coupon bonds directly. However, see TIGER and CATS (U. S. Securities).

Corporate bonds usually pay a fixed rate of interest for a fixed period of time (annually, semi-annually or quarterly).

b. Municipal Bonds

Municipal bonds are to city, county and State governments and authorities what corporate bonds are to corporations. They are exempt from Federal taxes and often are exempt from State and local taxes as well. Most municipal bonds are one of two general types:

- general obligation bonds, which are backed by the full faith and credit of the issuing municipality and supported by the taxing power; and

- revenue bonds, which are backed by the project being financed and the revenue or user fees it generates.

Other types of municipals are; limited-tax bonds, anticipation notes, industrial development bonds, and life-care bonds.

c. Government Bonds/U. S. Securities

Government bonds, as distinct from a U. S. Savings Bond, is a transferable obligation issued or backed by the Federal Government.

T-Bills are short-term obligations that require a minimum investment of $10,000. Certificates are not issued for T-Bills; they are registered in book form at the Treasury Department and receipts are provided as proof of purchase. T-Bills can be sold before maturity.

Treasury notes and bonds are similar to T-Bills but have longer maturities and a lower minimum investment requirement. They have been registered in book entry form since July 1986 but were sometimes issued as bearer bonds before then.

Tiger and Cats are Government securities issued with a zero coupon concept. The broker removes the interest coupons from the security and sells it at a big discount with a long maturity. Accrued interest is then paid at maturity. These bonds can be sold before maturity.

Some of the Federal agencies with charters to issue securities are:

- the Federal Home Loan Bank Board;
- the Federal Home Loan Mortgage Corporation (FREDDIE MAC);
- The Export-Import Bank; and
- the Government National Mortgage Association (GINNIE MAE).

Minimum investment requirements range from $1,000 to $25,000.

d. Buying & Selling Bonds

Bonds usually are bought and sold through brokers, securities dealers, or other investors. They may sell for more or less than their face value or purchase price, depending on a variety of factors.

e. Reading Bond Quotations

The following is a typical bond quotation, showing from left to right:

- the name of the issuer (AT & T);
- the bond's nominal or coupon rate (3 7/8 percent);

- the last two digits of the year in which the bond matures (1990);
- the current yield (5.6 percent);
- the number of bonds traded during the year (54,000);
- the highest, lowest, and last price of the bond for the period covered by the quotation (bond prices are quoted on a par of 100, so the last price of 69 1/4 equals $692.50).
- the net change in the bond price:

ISSUE	YIELD	CURRENT 1000'S	SALES HIGH	LOW	CLOSE	CHG
AT&T 3 7/8, 90	5.6	54	69 3/4	69 1/4	69 1/4	- 3/8

5. U. S. Savings Bonds

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 cannot be redeemed for six months after the issue date specified on the face of the bond.

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

The co-owners of a U. S. Savings Bond own equal shares of the redemption value of the bond.

U. S. Savings Bonds are not resources during the 6-month mandatory retention period. They are resources (not income) as of the first moment of the seventh month.

Verify ownership by viewing and photocopying any bonds in which a client or spouse has an ownership interest. Use the name(s) shown on the bond to determine ownership.

Use the Table of Redemption Values for U. S. Savings Bonds to determine value or obtain the value by telephone from a local bank and record it on a Record of Contract. The bank will need the series, denomination, date of purchase and/or issue date.

Exception: After the 6-month retention period, the redemption value of a series H or HH bond is its face value.

Physical possession of a U. S. Savings Bond is a requirement for redeeming it. If a person other than the client/spouse will not relinquish possession of a bond, it is not an available resource. A transfer of assets may exist unless a successful rebuttal of ownership is offered.

6. Promissory Notes, Loans, & Property Agreements

or property) loan, or

The context of the instructions in this section is the client spouse as the creditor (lender of money, seller of and, therefore, as the owner of the promissory note, property agreement.

A promissory note is a written unconditional agreement whereby one party promises to pay a specified sum of money at a specified time (or on demand) to another party. It may be given in return for goods, money loaned, or services rendered.

A loan is a transaction whereby one party advances money to or on behalf of another party, who promises to repay the lender in full, with or without interest. The loan agreement must be enforceable under State law and be in writing. A written loan agreement is a form of promissory note.

A property agreement is a pledge or security of particular property for the payment of a debt or the performance of some other obligation within a specified period. Property agreements on real estate generally are referred to as mortgages but also may be called land contracts, contracts for deed, deeds of trust, and so on. Personal property agreements-e.g., pledges of crops, fixtures, inventory, etc.-are commonly known as chattel mortgages.

When an individual enters into a contract for the sale of real estate, he or she owns two items until the settlement of the sale is completed; the real estate and the contract. The real estate is not a resource because the individual cannot sell it. The contract is a property agreement whose status and value as a resource must be determined in accordance with this section.

a. SSI Policy

Assume that the value of a promissory note, loan or property agreement as a resource is its outstanding principal balance unless the individual furnishes reliable evidence that it has a CMV of less than that (or no CMV at all).

Obtain a copy of the agreement for the file.

Obtain evidence of the outstanding principal balance if including the original balance in countable resources causes ineligibility.

If including the outstanding principal balance in countable resources causes ineligibility, inform the individual that we will use the outstanding principal balance in determining resources unless he or she submits:

- evidence of a legal bar to the sale of the agreement; or

- an estimate from a knowledgeable source, showing that the CMV of the agreement is less than its outstanding principal balance.

  Knowledgeable sources include anyone regularly engaged in the business of making such evaluations: e.g., banks or other financial institutions, private investors or real estate brokers. The estimate must show the name, title, and address of the source.

b. Liberalized Policy

   For MAO Coverage Groups subject to liberalized resource policy, effective 10-01-89, promissory notes, loans and property agreements can be excluded as a resource if the note, loan or agreement produces at least a 6% net annual return of the principal balance. The income produce must be received by the client/spouse and counted as income in order for the exclusion to apply.

NOTE: All Promissory Notes, Loan and Property Agreements (SSI or Liberalized) must be determined to be actuarially sound in the same manner as annuities (outlined in OBRA-93 Trust/Transfers of Assets policy). Even though the 6% rule is in effect that sets a minimum acceptable payment when compared to the principal balance, an additional step is required to determine if the client (or spouse) will reasonably be expected to receive the full payoff of the note or loan during his/her lifetime. As with annuities, the average number of years of life expectancy remaining (based on the Annuity Life Expectancy Charts) must coincide with the payout of the Promissory Note or Loan. If the note or loan is not acceptable, then the amount that is not expected to be paid out is treated as a transfer of resources the same as it is for annuities.

A "loan" to a relative that is immediately declared "uncollectible" isn't a loan at all; it's a transfer of assets for less than fair market value. A financial institution that has no direct interest in the original transaction cannot verify that the "loan" is uncollectible. An uncollectible loan must be documented in the form of a legally binding and enforceable contract with the rate of interest specified and a repayment schedule. Documentation is required on a regular basis to verify that the "loan" is being required by the contract. If the "loan" isn't being repaid, the lender is required to take legal action against the lendee to enforce the contract requirements.

As with annuities, a balloon payment does not meet the standards of being actuarially sound. The payments must be of uniform rate, principal and interest, during the life expectancy of the individual.

RESOURCES
TRUSTS/TRANSFERS OF ASSETS

A. TRUST POLICIES

The following is a discussion of the treatment of income and resources which have been placed in or are being distributed from trusts, guardianships or conservatorships. Trusts are classified as follows:

- OBRA-93 Trusts - applicable to trusts established on or after August 11, 1993, which is the date mandated by OBRA-93 federal legislation. OBRA-93 Trusts must meet certain criteria. If OBRA-93 criteria is not met, refer to the appropriate trust policy.

- Medicaid Qualifying Trusts - applicable to trusts established on or after March 1, 1987 through August 10, 1993 that meet MQT criteria. If MQT criteria is not met, defer to Standard Trust policy.

- Standard Trusts - applicable to trusts established prior to March 1, 1987 and/or trusts that do not meet the criteria of OBRA-93 or MQT trusts regardless of the date established.

Trusts, guardianships/conservatorships must be referred to the State Office for clearance whenever a client or spouse either creates a trust or is the beneficiary of one. All pertinent material must be included.

B. TRUST DEFINITIONS

The following definitions apply to any/all types of trusts.

1. Trust

A trust is a property interest whereby property is held by an individual (trustee) subject to a fiduciary duty to use the property for the benefit of another (the beneficiary).

2. Grantor

A grantor (also called a settlor or trustor) is a person who creates a trust. An individual may be a grantor if an agent, or other individual legally empowered to act on his/her behalf (e.g., a legal guardian, person acting under a power of attorney or conservator), establishes the trust with funds or property that belong to the individual. The terms grantor, trustor, and settlor may be used interchangeably.

3. Trustee

A trustee is a person or entity who holds legal title to property for the use or benefit of another. In most instances, the trustee has no legal right to revoke the trust or use the property for his/her own benefit.

4. Trust Beneficiary

A trust beneficiary is a person for whose benefit a trust exists. A beneficiary does not hold legal title to trust property but does have an equitable ownership interest in it.

a. Primary Beneficiary - the first person or class of persons to receive the benefits of the trust.

b. Secondary Beneficiaries - the person or class of persons who will receive the benefits of the trust after the primary beneficiary has died.

c. Contingent Beneficiary - a person or class of persons who will receive benefits only if a stated event occurs in the future.

5. Trust Principal (Corpus)

The trust principal is the property placed in trust by the grantor which the trustee holds, subject to the rights of the beneficiary plus any trust earnings paid into the trust and left to accumulate.

6. Trust Earnings (Income)

Trust earnings or income are amounts earned by trust principal. They may take such forms as interest, dividends, royalties, rents, etc. These amounts are unearned income to the person (if any) legally able to use them for personal support and maintenance.

7. Totten Trust

A Totten trust is a tentative trust in which a grantor makes himself/herself trustee of his/her own funds for the benefit of another. The trustee can revoke a Totten trust at any time. Should the trustee die without revoking the trust, ownership of the money passes to the beneficiary.

8. Grantor Trust

A grantor trust is a trust in which the grantor of the trust is also the sole beneficiary of the trust.

9.	**Mandatory Trust**	A mandatory trust is a trust which requires the trustee to pay trust earnings or principal to or for the benefit of the beneficiary at certain times. The trust may require disbursement of a specified percentage or dollar amount of the trust earnings or may obligate the trustee to spend income and principal, as necessary, to provide a specified standard of care. The trustee has no discretion as to the amount of the payment or to whom it will be distributed.
10.	**Discretionary Trust**	A discretionary trust is a trust in which the trustee has full discretion as to the time, purpose and amount of all distributions. The trustee may pay to or for the benefit of the beneficiary, all or none of the trust as he or she considers appropriate. The beneficiary has no control over the trust.
11.	**Testamentary Trust**	A trust that is an integral part of a will and takes effect upon the death of the individual making the will.

C. OBRA-93 TRUST POLICY

Section 13611 of the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) amended Section 1917(d) of the Social Security Act to revise the treatment of trusts effective with trusts established after the date of enactment of OBRA-93, which was August 10, 1993. Trusts established before this date, but added to or otherwise augmented after this date are treated under OBRA-93 Trust rules.

Trusts that do not meet the criteria for OBRA-93 trusts or trusts established prior to 08/10/93 must be reviewed under the appropriate trust policy.

OBRA-93 Transfer of Assets policy is used in conjunction with OBRA-93 Trust policy.

1. Definitions

a. Trust -- For purposes of this section, a trust is any arrangement in which a grantor transfers property to a trustee or trustees with the intention that it be held, managed, or administered by the trustee(s) for the benefit of the grantor or certain designated individuals (beneficiaries). The trust must be valid under State law and manifested by a valid trust instrument or agreement. A trustee holds a fiduciary responsibility to hold or manage the trust's corpus and income for the benefit of the beneficiaries. The term "trust" also includes any legal instrument or device that is similar to a trust. It does not cover trusts established by will. Such trusts must be dealt with using Standard Trust policy.

b. Legal Instrument or Device Similar to Trust -- This is any legal instrument, device, or arrangement which may not be called a trust under State law but which is similar to a trust. That is, it involves a grantor who transfers property to an individual or entity with fiduciary obligations (considered a trustee for purposes of this section). The grantor makes the transfer with the intention that it be held, managed, or administered by the individual or entity for the benefit of the grantor or others. This can include (but is not limited to) escrow accounts, investment accounts,

pension funds, and other similar devices managed by an individual or entity with fiduciary obligations.

c. Trustee -- A trustee is any individual, individuals, or entity (such as an insurance company or bank) that manages a trust or similar device and has fiduciary responsibilities.

d. Grantor -- A grantor is any individual who creates a trust. For purposes of this section, the term "grantor" includes:

- The individual;

- The individual's spouse;

- A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; 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.

e. Revocable Trust -- A revocable trust is a trust which can under State law be revoked by the grantor. A trust which provides that the trust can only be modified or terminated by a court is considered to be a revocable trust, since the grantor (or his/her representative) can petition the court to terminate the trust. Also, a trust which is called irrevocable but which terminates if some action is taken by the grantor is a revocable trust for purposes of this instruction. For example, a trust may require a trustee to terminate a trust and disburse the funds to the grantor if the grantor leaves a nursing facility and returns home. Such a trust is considered to be revocable.

f. Irrevocable Trust -- An irrevocable trust is a trust which cannot, in any way, be revoked by the grantor.

g. Beneficiary -- A beneficiary is any individual or individuals designated in the trust instrument as benefiting in some way from the trust, excluding the trustee or any other individual whose benefit consists only of reasonable fees or payments for managing or administering the trust. The beneficiary can be the grantor himself, another individual or individuals, or a combination of any of these parties.

h. Payment -- For purposes of this section a payment from a trust is any disbursal from the corpus of the trust or from income generated by the trust which benefits the party receiving it. A payment may include actual cash, as well as noncash or property disbursements, such as the right to use and occupy real property.

i. Annuity -- An annuity is a right to receive fixed, periodic payments, either for life or a term of years.

2. OBRA-93 Trust Provisions

This section applies to any individual who establishes a trust and who is an applicant for or recipient of Medicaid. An individual is considered to have established a trust if his or her assets (regardless of how little) were used to form part or all of the corpus of the trust and if any of the parties described as a grantor established the trust, other than by will.

When a trust corpus includes assets of another person or persons as well as assets of the individual, the rules in this section apply only to the portion of the trust attributable to the assets of the individual. Thus, in determining countable income and resources in the trust for eligibility and post-eligibility purposes, you must prorate any amounts of income and resources, based on the proportion of the individual's assets in the trust to those of other persons.

The rules set forth in this section apply to trusts without regard to:

- The purpose for which the trust is established;
- Whether the trustee(s), has or exercises any discretion under the trust;
- Any restrictions on when or whether distributions can be made from the trust; or
- Any restrictions on the use of distributions from the trust.

This means that any trust which meets the basic definition of a trust can be counted in determining eligibility for Medicaid. No clause or requirement in the trust, no matter how specifically it applies to Medicaid or other Federal or State programs (i.e., an exculpatory clause), precludes a trust from being considered under these rules. Note: Exceptions to the countability of trusts as a resource do exist and are outlined later in the section.

3. Treatment of Revocable OBRA-93 Trusts

In the case of a revocable trust:

- The entire corpus of the trust is counted as an available resource to the individual;
- Any payments from the trust made to or for the benefit of the individual are counted as income to the individual;
- Any payments from the trust which are not made to or for the benefit of the individual are considered assets disposed of for less than fair market value. Refer to OBRA-93 Transfer of Assets policy.

When a portion of a revocable trust is treated as a transfer of assets for less than fair market value, the look-back period described in OBRA-93 Transfer policy is extended from the usual 36 months to 60 months.

Note: Home property placed in a revocable trust loses its excluded status if the client is in an institution.

4. Treatment of Irrevocable Trust - Payment Can Be Made Under Terms of Trust

In the case of an irrevocable trust, where there are any circumstances under which payment can be made to or for the benefit of the individual from all or a portion of the trust, the following rules apply to that portion:

- Payments from income or from the corpus made to or for the benefit of the individual are treated as income to the individual;

- Income on the corpus of the trust which could be paid to or for the benefit of the individual is treated as a resource available to the individual;

- The portion of the corpus that could be paid to or for the benefit of the individual is treated as a resource available to the individual; and,

- Payments from income or from the corpus that are made but not to or for the benefit of the individual are treated as a transfer of assets for less than fair market value. A 36 month look back period for transfers of assets applies.

5. **Treatment of Irrevocable Trusts-Payment Cannot Be Made Under Terms of Trust**

When all or a portion of the corpus or income on the corpus of a trust cannot be paid to the individual, treat all or any such portion or income as a transfer of assets under OBRA-93 Transfer policy.

In treating these portions as a transfer of assets, the date of the transfer is considered to be:

- The date the trust was established; or,

- If later, the date on which payment to the individual was foreclosed.

In determining for transfer of assets purposes the value of the portion of the trust which cannot be paid to the individual, do not subtract from the value of the trust any payments made, for whatever purposes, after the date the trust was established or, if later, the date payment to the individual was foreclosed. If the trustee or the grantor adds funds to that portion of the trust after these dates, the addition of those funds is considered to be a new transfer of assets, effective on the date the funds are added to that portion of the trust.

Thus, in treating portions of a trust which cannot be paid to an individual, the value of the transferred amount is no less than its value on the date the trust is established or payment is foreclosed. When additional funds are added to this portion of the trust, those funds are treated as a new transfer of assets for less than fair market value.

When that portion of a trust which cannot be paid to an individual is treated as a transfer of assets for less than fair market value, **the usual 36 month look-back period is extended to 60 months.**

6. **Payments Made From Revocable or Irrevocable Trusts**

Payments are considered to be made to the individual when any amount from the trust, including an amount from the corpus or income produced by the corpus, is paid directly to the individual or to someone acting on his/her behalf, e.g., a guardian or legal representative.

Payments made for the benefit of the individual are payments of any sort, including an amount from the corpus or income produced by the corpus, paid to another person or entity such that the individual derives some benefit from the payment. For example, such payments could include purchase of clothing or other items, such as a radio or television, for the individual. Also, such payments could include payment for services the individual may require, or care, whether medical or personal, that the individual may need. Payments to maintain a home are also payments for the benefit of the individual.

Note: A payment to or for the benefit of the individual is counted under this provision only if such a payment is ordinarily counted as income under the SSI program. For example, payments made on behalf of an individual for medical care are not counted in determining income eligibility under the SSI program. Thus, such payments are not counted as income under the trust provision.

7. **Circumstances Under Which Payments Can/Cannot Be Made**

In determining whether payments can or cannot be made from a trust to or for an individual, take into account any restrictions on payments, such as use restrictions, exculpatory clauses, or limits on trustee discretion that may be included in the trust.

For example, if an irrevocable trust provides that the trustee can disburse only $1,000 to or for the individual out of a $20,000 trust, only the $1,000 is treated as a payment that could be made. The remaining $19,000 is treated as an amount which cannot, under any circumstances, be paid to or for the benefit of the individual. On the other hand, if a trust contains $50,000 that the trustee can pay to the grantor only in the event that the grantor needs, for example, a heart transplant, this full amount is considered as payment that could be made under some circumstances, even though the likelihood of payment is remote. Similarly, if a payment cannot be made until some point in the distant future, it is still payment that can be made under some circumstances.

8. Placement of Excluded Assets In Trust

Section 1917(e) of the Act provides that, for trust and transfer purposes, assets include both income and resources. Section 1917(e) of the Act further provides that income has the meaning given the term in Section 1612 of the Act and resources has the meaning given that term in Section 1613 of the Act (income and resources as defined in SSI policy). The only exception is that for institutionalized individuals, the home is not an excluded resource.

Thus, transferring an excluded asset (either income or a resource, with the exception of the home of an institutionalized individual) for less than fair market value does not result in a penalty under the transfer provisions because the excluded asset is not an asset for transfer purposes. Similarly, placement of an excluded asset in a trust does not change the excluded nature of that asset; it remains excluded. The only exception is the home of an institutionalized individual. Because Section 1917(e) of the Act provides that the home is not an excluded resource for institutional individuals, transfer of title to the home of an institutionalized individual in a trust (revocable or irrevocable) results in the home becoming a countable resource.

9. **Exceptions to Treatment of Trusts Under Trust Provisions**

The rules concerning treatment of trusts do not apply to any of the following trusts, i.e., the trusts discussed below are treated differently in determining eligibility for Medicaid. Funds entering and leaving these trusts are generally treated according to SSI rules or more liberal rules under Section 1902(r)(2) of the Act, as appropriate.

As is noted in each exception below, one common feature of all of the excepted trusts is a requirement that the trust provide that upon the death of the individual, any funds remaining in the trust go to the Division of Medicaid, up to the amount paid in Medicaid benefits on the individual's behalf.

a. Special Needs Trusts -- A trust containing the assets of an individual under age 65 who is disabled (as defined by the SSI program) and which is established **for the sole benefit of** the individual by a parent, grandparent, legal guardian of the individual, or a court is often referred to as a special needs trust. To qualify for an exception to the rules in this section, the trust must contain a provision stating that, upon the death of the individual, the State receives all amounts remaining in the trust, up to an amount equal to the total amount of medical assistance paid on behalf of the individual. In addition to the assets of the individual, the trust may also contain the assets of individuals other than the disabled individual.

When a trust is established for a disabled individual under age 65, the exception for the trust discussed above continues even after the individual becomes age 65. However, such a trust cannot be added to or otherwise augmented after the individual reaches age 65. Any such addition or augmentation after age 65 involves assets that were not the assets of an individual under age 65. Thus, those assets are not subject to the exemption discussed in this section.

To qualify for this exception, the trust must be established for a disabled individual, as defined under the SSI Program. When the individual in question is receiving either title II or SSI benefits as a disabled individual, accept the disability determination made for those programs. If the individual is not receiving those benefits, make a determination concerning the individual's disability.

Establishment of a trust as described above does not constitute a transfer of assets for less than fair market value if the transfer is made into a trust established solely for the benefit of a disabled individual under age 65. However, if the trust is not solely for the benefit of the disabled person or if the disabled person is over age 65 transfer penalties may apply.

b. Pooled Trusts -- A pooled trust is a trust containing the assets of a disabled individual as defined by the SSI Program in Section 1614(a)(3) of the Act, that meets the following conditions:

- The trust is established and managed by a non-profit association;

- A separate account is maintained for each beneficiary of the trust but for purposes of investment and management of funds the trust pools the funds in these accounts;

- Accounts in the trust are established solely for the benefit of disabled individuals by the individual, by the parent, grandparent, legal guardian of the individual, or by a court; and,

- To the extent that any amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the Division of Medicaid the amount remaining in the account up to an amount equal to the total amount of medical assistance paid on behalf of the beneficiary. To meet this requirement, the trust must include a provision specifically providing for such payment.

  To qualify as an excepted trust, the trust account must be established for a disabled individual, as defined in Section 1614(a)(3) of the Act. When the individual in question is receiving either title II or SSI benefits as a disabled individual, accept the disability determination made for those programs. If the individual is not receiving those benefits, make a determination concerning the individual's disability.

c. Income Trusts - This type of trust established for the benefit of the individual is limited to institutionalized clients and must meet the following requirements:

- The trust is composed only of pension, Social Security, and other income to the individual, including accumulated interest in the trust; and,

- Upon the death of the individual, the Division of Medicaid receives all amounts remaining in the trust, up to an amount equal to the total medical assistance paid on behalf of the individual. To qualify for this exception, the trust must include a provision to this effect.

To qualify for this exception, the trust must be composed only of income to the individual, from whatever source. The trust may contain accumulated income, i.e., income that has not been paid out of the trust. However, no resources, as defined by SSI, may be used to establish or augment the trust. Inclusion of resources voids this exception.

An individual's total income must go into the Income Trust each month. The only exception is for the types of VA payments that are not considered income, i.e., VA Reduced Pension benefits, VA Aid & Attendance payments and VA Pension payments attributed to Unreimbursed Medical Expenses.

The difference between an individual's total income and an amount that is $1 less than the current institutional income limit funds the Income Trust. The only allowable expenses from the amount funding the trust each month are actual expenses associated with establishing/maintaining the trust. Trustee's fees, if granted, are limited to $10 per month and are intended to cover bank charges associated with maintaining a trust account.

From the amount released from an Income Trust ($1 less than the institutional limit), the usual income deductions apply in the order allowed in post-eligibility (Medicaid Income) budgeting.

Trusts that are not properly funded into an Income Trust account do not meet the criteria for a trust exception.

When an Income Trust as no longer needed due to the client's death, ineligibility or some other change, refer the case to the State Office for a determination of the amount owed from the trust.

10. Undue Hardship Provision

When application of the OBRA-93 Trust provisions would work an undue hardship, the provisions will not apply.

Undue hardship exists when application of the trust provisions would deprive the individual of medical care such that his/her health or his/her life would be endangered. Undue hardship also exists when application of the trust provisions would deprive the individual of food, clothing, shelter, or other necessities of life.

Undue hardship does not exist when application of the trust provisions merely causes the individual inconvenience or when such application might restrict his or her lifestyle but would not put him or her at risk of serious deprivation.

Each case situation must be reviewed individually to determine if undue hardship exists. Generally, this provision is limited to financially and medically needy individuals with no possible means of accessing funds placed in trust.

11. Annuities

Section 1917(d)(6) of the Act provides that the term "trust" includes an annuity to the extent and in such manner as the HCFA Secretary specifies. This subsection describes how annuities are treated under the OBRA-93 trust/transfer provisions.

When an individual purchases an annuity, he or she generally pays to the entity issuing the annuity (e.g., a bank or insurance company) a lump sum of money, in return for which he or she is promised regular payments of income in certain amounts. These payments may continue for a fixed period of time (for example, 10 years) or for as long as the individual (or another designated beneficiary) lives, thus creating an ongoing income stream. The annuity may or may not include a remainder clause under which, if the annuitant dies, the contracting entity converts whatever is remaining in the annuity into a lump sum and pays it to a designated beneficiary.

Annuities, although usually purchased in order to provide a source of income for retirement, are occasionally used to shelter assets so that individuals purchasing them can become eligible for Medicaid. In order to avoid penalizing annuities validly purchased as part of a retirement plan but to capture those annuities which abusively shelter assets, a determination must be made with regard to the ultimate purpose of the annuity (i.e., whether the purchase of the annuity constitutes a transfer of assets for less than fair market value). If the expected return on the annuity is commensurate with a reasonable estimate of the life expectancy of the beneficiary, the annuity can be deemed actuarially sound.

To make this determination, use the following life expectancy tables, compiled from information published by the Office of the Actuary of the Social Security Administration. The average number of years of expected life remaining for the individual must coincide with the life of the annuity. If the individual is not reasonably expected to live longer than the guarantee period of the annuity, the individual will not receive fair market value for the annuity based on the projected return. In this case, the annuity is not actuarially sound and a transfer of assets for less than fair market value has taken place, subjecting the individual to a penalty. The penalty is assessed based on a transfer of assets for less than fair market value that is considered to have occurred at the time the annuity was purchased.

For example, if a male at age 65 purchases a $10,000 annuity to be paid over the course of 10 years, his life expectancy according to the table is 14.96 years. Thus, the annuity is actuarially sound. However, if a male at age 80 purchases the same annuity for $10,000 to be paid over the course of 10 years, his life expectancy is only 6.98 years. Thus, a payout of the annuity for approximately 3 years is considered a transfer of assets for less than fair market value and that amount is subject to penalty.

A balloon payment annuity does not meet the standards of being actuarially sound. The annuity payments must be of uniform rate, principal and interest, during the life expectancy of the individual.

FORMULA TO USE TO DETERMINE UNCOMPENSATED VALUE (UV) OF ANNUITIES

1. **TAKE PURCHASE PRICE, PAYMENT SCHEDULE = ANNUAL RATE**

2. **USE LIFE EXPECTANCY (LE) TABLE & SUBTRACT # OF LE YEARS FROM THE PAYOUT YEARS (PAYMENT SCHEDULE) = DIFFERENCE**

3. **MULTIPLY DIFFERENCE X ANNUAL RATE = UV**

LIFE EXPECTANCY TABLE - MALES

AGE	LIFE EXPECTANCY
0	73.26
1	72.85
2	71.89
3	70.92
4	69.94
5	68.96
6	67.98
7	66.99
8	66.01
9	65.02
10	64.03
11	63.04
12	62.05
13	61.06
14	60.08
15	59.11
16	58.16
17	57.21
18	56.27
19	55.34
20	54.41
21	53.48
22	52.56
23	51.64
24	50.72
25	49.79
26	48.86
27	47.93
28	47.00
29	46.07
30	45.14
31	44.21
32	43.28
33	42.36
34	41.43
35	40.51
36	39.59
37	38.67
38	37.76
39	36.85
40	35.94
41	33.24
42	32.35
43	31.46
44	30.59
45	29.71
46	28.85
47	27.99
48	27.13
49	26.28
50	25.44
51	24.61
52	23.78
53	22.97
54	22.17
55	21.37
56	20.60
57	19.83
58	19.07
59	18.33
60	17.60
61	16.89
62	16.19
63	15.52
64	14.86
65	14.23
66	13.61
67	13.00
68	12.41
69	11.82
70	11.24
71	10.67
72	10.12
73	9.58
74	9.06
75	8.56
76	8.07
77	7.61
78	7.16
79	6.72
80	
81	

AGE	LIFE EXPECTANCY
82	35.03
83	34.13
84	
85	
86	
87	
88	
89	
90	
91	6.31
92	5.92
93	5.55
94	5.20
95	4.86
96	4.55
97	4.26
98	3.98
99	3.73
100	3.49
101	3.27
102	3.06
103	2.88
104	2.71
105	2.55
106	2.41
107	2.29
108	2.17
109	2.05
110	1.94
111	1.84
112	1.74
113	1.64
114	1.55
115	1.46
116	1.37
117	1.29
118	1.21
119	1.14
	1.06
	0.99
	0.93
	0.86
	0.80
	0.74
	0.69
	0.63
	0.58

LIFE EXPECTANCY TABLE - FEMALES

AGE	LIFE EXPECTANCY
0	77.82
1	76.84
2	75.86
3	74.87
4	73.89
5	72.90
6	71.91
7	70.92
8	69.93
9	68.94
10	67.95
11	66.96
12	65.98
13	65.00
14	64.02
15	63.04
16	62.07
17	61.10
18	60.13
19	59.16
20	58.19
21	57.22
22	56.24
23	55.27
24	54.30
25	53.33
26	52.36
27	51.39
28	50.43
29	49.46
30	48.50
31	47.53
32	46.57
33	45.62
34	44.66
35	43.71
36	42.76
37	41.81
38	40.86
39	
40	
41	
42	
43	36.19
44	35.26
45	34.34
46	33.43
37	32.52
48	31.61
49	30.72
50	29.82
51	28.94
52	28.06
53	27.19
54	26.34
55	25.49
56	24.64
57	23.81
58	22.99
59	22.18
60	21.38
61	20.60
62	19.82
63	19.06
64	18.31
65	17.58
66	16.85
67	16.14
68	15.44
69	14.75
70	14.06
71	13.40
72	12.74
73	12.09
74	11.46
75	10.85
76	10.25
77	9.67
78	9.11
79	8.57
80	
81	
82	
83	
84	
85	
86	
87	
88	
89	
90	
91	
92	8.04
93	7.54
94	7.05
95	6.59
96	6.15
97	5.74
98	5.34
99	4.97
100	4.63
101	4.31
102	4.01
103	3.73
104	3.48
105	3.26
106	3.05
107	2.87
108	2.70
109	2.54
110	2.39
111	2.25
112	2.11
113	1.98
114	1.86
115	1.74
116	1.63
117	1.52
118	1.41
119	1.32
	1.22
	1.13
	1.05
	0.97
	0.89
	0.82
	0.75
	0.69
	0.63
	0.58

D. OBRA-93 TRANSFER POLICY

Section 13611 of the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66), herein referred to as OBRA-93, amended Section 1917(c)(1) of the Social Security Act to revise transfer of assets policy previously described in the Medicare Catastrophic Coverage Act (MCCA) of 1988 (P.L. 100-360). Assets disposed of on or before the enactment of OBRA-93, which was August 10, 1993, will be evaluated under MCCA policy. Assets disposed of on or after August 11, 1993 will be evaluated under policy mandated by OBRA-93 and described below.

1. Definitions (Applicable to Transfers & Trusts)

OBRA-93 added and amended the following definitions of terms used in conjunction with transfer and trust policy.

a. Individual -- As used in this instruction, the term "individual" includes the individual himself or herself, as well as:

- The individual's spouse, where the spouse is acting in the place of or on behalf of the individual;

- 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

- Any person, including a court or administrative body, acting at the direction or upon the request of the individual or the individuals's spouse.

b. Spouse -- This is a person who is considered legally married to an individual under the laws of Mississippi.

c. Assets -- For purposes of this section, assets include all income and resources of the individual and of the individual's spouse. This includes income or resources which the individual or the individual's spouse is entitled to but does not receive because of any action by:

- The individual or the individual's spouse;

- A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or

- Any person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

For purposes of this section, the term "assets an individual or spouse is entitled to" includes assets to which the individual is entitled or would be entitled if action had not been taken to avoid receiving the assets.

The following are examples of actions which would cause income or resources not to be received:

- Irrevocably waiving pension income;

- Waiving the right to receive an inheritance;

- Not accepting or accessing injury settlements;

- Tort settlements which are diverted by the defendant into a trust or similar device to be held for the benefit of an individual who is a plaintiff; and

- Refusal to take legal action to obtain a court ordered payment that is not being paid, such as child support or alimony.

The specific circumstances of each case must be examined before deciding whether an uncompensated transfer occurred.

d. Resources -- For purposes of this section, the definition of resources is the same definition used by the Supplemental Security Income (SSI) program, except that the home is not excluded for institutionalized individuals. In determining whether a transfer of assets or a trust involves an SSI-countable resource, use those resource exclusions and disregards used by the SSI program, except for the exclusion of the home for institutionalized individuals.

e. Income -- For purposes of this section, the definition of income is the same definition used by the SSI program. In determining whether a transfer of assets involves SSI-countable income, take into account those income exclusions and disregards used by the SSI program.

f. For the Sole Benefit of -- A transfer is considered to be for the sole benefit of a spouse, blind or disabled child, or a disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.

Similarly, a trust is considered to be established for the sole benefit of a spouse, blind or disabled child, or disabled individual if the trust benefits no one but that individual, whether at the time the trust is established or any time in the future. However, the trust may provide for reasonable compensation for a trustee or trustees to manage the trust, as well as for reasonable costs associated with investing or otherwise managing the funds or property in the trust.

A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is not the spouse, blind or disabled child, or disabled individual is not considered to be established for the sole benefit of one of these individuals. In order for a transfer or trust to be considered to be for the sole benefit of one of these individuals, the instrument or document must provide for the spending of the funds involved for the benefit of the individual on a basis that is actuarially sound based on the life expectancy of the individual involved. When the instrument or document does not so provide, any potential exemption from penalty or consideration for eligibility purposes is void.

An exception to this requirement exists for trusts discussed in "Exemptions to Treatment of Trusts." Under these exceptions, the trust instrument must provide that any funds remaining in the trust upon the death of the individual must go to the Division of Medicaid, up to the amount of Medicaid benefits paid on the individual's behalf. When these exceptions require that the trust be for the sole benefit of an individual, the restriction discussed in the previous paragraph does not apply when the trust instrument designates the Division of Medicaid as the recipient of funds from the trust. Also, the trust may provide for disbursal of funds to other beneficiaries, provided the trust does not permit such disbursals until the State's claim is satisfied.

2. Transfer Penalty Definitions

Under the transfer of assets provisions in Section 1917(c) of the Act, as amended by OBRA 1993, coverage of certain Medicaid services to otherwise eligible institutionalized individuals who transfer (or whose spouses transfer) assets for less than fair market value must be denied. The following definitions apply to transfers of assets.

a. Fair Market Value -- Fair market value is an estimate of the value of an asset, if sold at the prevailing price at the time it was actually transferred. Value is based on criteria used in appraising the value of assets for the purpose of determining Medicaid eligibility.

Note: For an asset to be considered transferred for fair market value or to be considered to be transferred for valuable consideration, the compensation received for the asset must be in a tangible form with intrinsic value. A transfer for love and consideration, for example, is not considered a transfer for fair market value. Also, while relatives and family members legitimately can be paid for care they provide to the individual, Medicaid presumes that services provided for free at the time were intended to be provided without compensation. Thus, a transfer to a relative for care provided for free in the past is a transfer of assets for less than fair market value. However, an individual can rebut this presumption with tangible evidence that is acceptable, such as a written repayment schedule agreed to at the time services were provided.

b. Valuable Consideration -- Valuable consideration means that an individual receives in exchange for his or her right or interest in an asset some act, object, service, or other benefit which has a tangible and/or intrinsic value to the individual that is roughly equivalent to or greater than the value of the transferred asset.

c. Uncompensated Value -- The uncompensated value is the difference between the fair market at the time of transfer (less any outstanding loans, mortgages, or other encumbrances on the asset) and the amount received for the asset.

d. Institutionalized Individual -- An institutionalized individual is an individual who is:

- An inpatient in a nursing facility;
- An inpatient in a medical institution for whom payment is based on a level of care provided in a nursing facility; or
- An inpatient in an ICF-MR facility

3. Effective Date of OBRA-93 Transfer Policy

This section applies to all transfers which are made on or after August 11, 1993. Transfers made before August 11, 1993, are treated under policy in effect prior to OBRA-93. While this section applies to transfers made on or after August 11, 1993, penalties for transfers for less than fair market value under OBRA-93, cannot be applied to services provided before October 1, 1993. Instead, for the period prior to October 1, 1993, apply pre-OBRA-1993 rules regarding transfers of assets to transfers made on or after August 11, 1993, and before October 1, 1993.

4. Individuals To Whom Transfer of Assets Applies

Apply these provisions when an institutionalized individual or the individual's spouse disposes of assets for less than fair market value on or after the look-back date explained below.

For purposes of this section, assets transferred by a parent, guardian, court or administrative body, or anyone acting in place of or on behalf of or at the request or direction of the individual or spouse, are considered to be transferred by the individual or spouse.

5. Look Back Period

The look-back period for transfers other than transfers to a trust is a date that is 36 months from the date the individual both is an institutionalized individual and has applied for Medicaid.

For example:

12/94 - enters nursing facility
02/95 - applies & 36 month look-back begins
11/94 - transfer occurs & penalty begins

The look-back period for assets transferred into certain trusts is 60 months from the date an individual is both institutionalized and has applied for Medicaid. This means that the transfer of assets penalty can apply to the total value of assets placed in a trust (subject to evaluation of trust policy) within 60 months from the time the trust is established and the individual enters an institution and applies for Medicaid.

NOTE: The 36 month look-back period described above does not become fully effective until August 11, 1996. Prior to that date, a 36 month look-back period actually begins at some time before the date transfers are covered by these rules. While the 36 month look-back period is effective for transfers made on or after August 11, 1993, any transfers actually made before that date are treated under the rules described in pre OBRA-93 policy. Thus, the look back period is phased in over the 36 month period ending August 11, 1996.

6. Multiple Periods of Institutionalization and Multiple Applications

When an individual has multiple periods of institutionalization or has made multiple applications for Medicaid (unless the application was withdrawn), the look-back date is based on a baseline date that is the first date upon which the individual has both applied for Medicaid and is institutionalized. Each individual has only one look-back date, regardless of the number of periods of institutionalization, applications for Medicaid (the exception is a withdrawn application), periods of eligibility or transfers of assets.

7. Effective Date of Penalty

The date of the penalty period is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this policy.

8. Penalty Period

The number of months of ineligibility for an institutionalized individual shall be equal to:

a. the total, cumulative uncompensated value (UV) of all assets transferred by the individual (or individual's spouse) on or after the look back period divided by:

b. the average monthly cost to a private pay patient of nursing facility services in Mississippi. The current average private pay rate is $3100 effective 03/01/03. From 04/01/99 - 02/28/03, the average private rate was $2600. From 10/01/93-03/31/99, the average private rate was $2000.

9. Determining the Period of Ineligibility-Penalty Periods Overlap

All countable transfers occurring during the look-back period are totaled and the penalty period determined by dividing the total UV by the private pay rate. The first month of the transfer penalty period is the month in which the first countable transfer occurred. Transfers that occur after a penalty period is in effect are added in full to the end of the penalty period currently in effect. There is no limit on the number of months a transfer penalty can be imposed. The penalty period is always determined by the total UV calculated during the look back period.

10. Determining the Period of Ineligibility-Penalty Periods Do Not Overlap

When multiple transfers are made so that the penalty periods for each do not overlap, treat each transfer as a separate event with it's own penalty period. Exception: Consecutive trans- or transfers that occur on a regular basis must be calculated together. For example, an individual gave a relative $5,199.00 in April and $5,199.00 in May. The two gifts are added together and divided by $2,600 causing a 3 month penalty for April, May and June.

11. Treatment of Income As Asset

Income, in addition to resources, is considered to be an asset for transfer (and trust) purposes. Thus, when an individual's income is given or assigned in some manner to another person, such a gift or assignment can be considered a transfer of assets for less than fair market value.

In determining whether income has been transferred, do not attempt to ascertain in detail the individual's spending habits during the 36 or 60 month look-back period. Absent some reason to believe otherwise, assume that ordinary household income was legitimately spent on the normal costs of daily living.

However, you should attempt to determine whether the individual has transferred lump sum payments actually received in a month. Such payments, while counted as income in the month received for eligibility purposes, are counted as resources in the following month if they were retained. Disposal of such lump sum payments before they can be counted as resources could constitute an uncompensated transfer of assets. Also attempt to determine whether amounts of regularly scheduled income or lump sum payments, which the individual would otherwise have received, have been transferred. Normally, such a transfer takes the form of a transfer of the right to receive income. For example, a private pension may be diverted to a trust and no longer paid to the individual.

When a single lump sum is transferred (e.g., a stock dividend check is given to another person in the month in which it is received by the individual), the penalty period is calculated on the basis of the value of the lump sum payment.

When a stream of income, (i.e., income received in a regular basis, such as a pension) or the right to a stream of income is transferred, calculate the penalty period as you would for a single lump sum. Using this method, a penalty period is imposed for each income payment. When the transfer involves a right to income (as opposed to periodic transfers of income the individual owns) make a determination of the total amount of income expected to be transferred during the individual's life, based on an actuarial projection of the individual's life expectancy, and calculate the penalty on the basis of the projected total income.

12. **Transfer Penalty for Jointly Held Assets**

In the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset (or the affected portion of such asset) shall be considered to be transferred by such individual when any action is taken, either by such individual or by any other person, that reduces or eliminates such individual's ownership or control of such asset.

Under this provision, merely placing another person's name on an account or asset as a joint owner might not constitute a transfer of assets subject, of course, to the specific circumstances of the situation. In such a situation, the individual may still possess ownership rights to the account or asset and thus have the right to withdraw all of the funds in the account or possess the asset at any time. Thus, the account or asset is still considered to belong to the individual. However, actual withdrawal of funds from the account or removal of the asset by the other person removes the funds or property from the control of the individual and so constitutes a transfer of assets. Also, if placing another person's name on the account or asset actually limits the individual's right to sell or otherwise dispose of the asset (e.g., the addition of another person's name requires that the person agree to the sale or disposal of the asset where no such agreement was necessary before), such placement constitutes a transfer of assets.

Use regular Medicaid rules to determine what portion of a jointly held asset is presumed to belong to an applicant or recipient. This portion is subject to a transfer penalty if it is withdrawn by a joint owner.

13. Exceptions to Transfers of Home Property

The transfer penalty will not apply to the transfer of home property by an institutionalized individual to the following family members of such individual:

a. The individual's spouse or child under age 21 or a disabled or blind adult child; or

b. a sibling who is part owner of the home who lived in the home for one (1) year before the individual entered a nursing facility; or

c. a child who lived in the home for up to two (2) years before the individual entered a nursing facility and provided care to the individual which permitted the individual to remain at home.

14. Exceptions to Transfers of Non-Home Property

The transfer penalty will not apply to the transfer of any type of non-home asset in the following situations:

a. Assets transferred to the individual's spouse or to another for the sole benefit of the individual's spouse;

b. Assets transferred from the individual's spouse to another for the sole benefit of the individual's spouse;

c. Assets transferred to the individual's child under age 21 or a disabled or blind adult child;

d. Assets transferred to a trust established solely for the benefit of a disabled individual under 65 years of age.

In determining whether an asset was transferred for the sole benefit or a spouse, child, or disabled individual, ensure that the transfer was accomplished via a written instrument of transfer (e.g., a trust document) which legally binds the parties to a specified course of action and which clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer. A transfer without such a document cannot be said to have been made for the sole benefit of the spouse, child, or disabled individual, since there is no way to establish, without a document, that only the specified individuals will benefit from the transfer.

15. Additional Exceptions (Acceptable Rebuttals)

An individual shall not be ineligible for medical assistance if a satisfactory showing is made to the Division of Medicaid that:

1. the individual intended to dispose of the assets either at fair market value or for other valuable consideration;

2. the assets were transferred exclusively for a purpose other than to qualify for medical assistance;

3. all assets transferred for less than fair market value have been returned to the individual; or

4. the Division of Medicaid determines that denial of eligibility would work an undue hardship on the individual.

16. Undue Hardship

Undue hardship exists when application of the transfer of assets provisions would deprive the individual of medical care such that his/her health or his/her life would be endangered. Undue hardship also exists when application of the transfer of assets provisions would deprive the individual of food, clothing, shelter, or other necessities of life.

Undue hardship does not exist when application of the transfer of assets provisions merely causes the individual inconvenience or when such application might restrict his or her lifestyle but would not put him/her at risk of serious deprivation.

Each case situation must be reviewed individually to determine if undue hardship exists. Generally, this provision is limited to financially and medically needy individuals with no possible means of recovering the asset(s) transferred.

17. **Transfers of Assets & Spousal Impoverishment Provisions**

Section 1924 of the Act sets forth the requirements for treatment of income and resources where there is an in a medical institution with a spouse still living in the community. This section of the Act provides for apportioning income and resources between the institutional spouse and the community spouse so that the community spouse does not become impoverished because the individual is in a medical institution.

The exceptions to the transfer of assets penalties regarding interspousal transfers and transfers to a third party for the sole benefit of a spouse apply even under the spousal impoverishment provisions. Thus, the institutional spouse can transfer unlimited assets to the community spouse or to a third party for the sole benefit of the community spouse.

When transfers between spouses are involved, the unlimited transfer exception should have little effect on the eligibility determination, primarily because resources belonging to both spouses are combined in determining eligibility for the institutionalized spouse. Thus, resources transferred to a community spouse are still to be considered available to the institutionalized spouse for eligibility purposes.

The exception for transfers to a third party for the sole benefit of the spouse may have greater impact on eligibility because resources may potentially be placed beyond the reach of either spouse and thus can not be counted for eligibility purposes. However, for the exception to be applicable, the definition of what is for the sole benefit of the spouse must be fully met. This definition is fairly restrictive, in that it requires that any funds transferred be spent for the benefit of the spouse within a time-frame actuarially commensurate with the spouse's life expectancy. If this requirement is not met, the exemption is void, and a transfer to a third party may then be subject to a transfer penalty.

18. Notice of Transfer of Resources

The client will be notified via DOM-322, Notice of Transfer of Assets, regarding countable transfers and the penalty period. The notice will allow the client or representative 10 days to present evidence to show that the transfer should not count. Evidence should include a written rebuttal plus any pertinent documentary evidence. If no rebuttal is offered, the penalty will be applied and the appropriate adverse action notice issued to deny or terminate payment of nursing home services only. The individual remains eligible for all other Medicaid services if the transfer penalty is the only factor of ineligibility. If the individual is ineligible on other factors as well as the transfer, the application or case must be denied or terminated.

Note: Notice to the client via DOM-322 is required whenever a transfer is being charged. This is true even if the penalty period is expired and the action to be taken is an improper payment. DOM-322 must be issued prior to submitting an improper payment in order to allow the client the chance to rebut the transfer.

19.	**Rebuttal Process**	Written rebuttals along with the Regional Office decision regarding acceptability are to be submitted to the Area Supervisor prior to issuing final notice to the client. The material submitted to State Office should include the rebuttal, a copy of DOM-322 issued to the client, and a summary of the circumstances surrounding the transfer. The Area Supervisor will issue a memorandum to the Regional Office explaining the final decision on the transfer.
20.	**Return of a Transferred Resource**	If a transferred resource is returned to or if compensation is received by the institutionalized individual, the UV is no longer an issue or is reduced as of the date of the return. The resource or compensation is evaluated according to normal resource rules in the month of the return. Any portion of a transferred resource that is not returned continues to count as UV which means the penalty period must be re-evaluated.
21.	**Recalculation of a Penalty Period**	A penalty period must be recalculated from the month a portion of the resource is returned or additional compensation is received.
22.	**Transfer Penalty Involving SSI Months**	The transfer penalty can be imposed during months that an individual receives SSI or is SSI eligible in a nursing home. Notices for SSI eligibles must not be sent verifying eligibility for nursing facility services until the possibility of any transfers have been developed.

E. MEDICAID QUALIFYING TRUSTS

Section 9506 of the Consolidated Omnibus Reconciliation Act of 1985 (P.L. 99-272) established the "Medicaid Qualifying Trust" (MQT) provision. An MQT is defined in federal statute as "a trust, or similar legal device, established (other than by will) by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual."

If a trust meets the definition of an MQT, then federal law states the amounts from the trust deemed available to a grantor is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the grantor, assuming the full exercise of discretion by the Trustee(s) for the distribution of the maximum amount to the grantor.

The MQT provision applies without regard to whether or not the MQT is irrevocable or is established for purposes other than to qualify for medical assistance or whether or not the discretion of the trustee(s) is actually exercised.

The effective date for application of the MQT provision is March 1, 1987. Any trust or similar legal device established on or after this date is subject to MQT rules. The MQT provision also applies to SSI recipients, as discussed in Section B, Special Handling of SSI cases.

1. Policy Principles

In determining whether an MQT exists, look for these 3 main components:

- The grantor is the Medicaid client or his representative (e.g., spouse, parent, guardian or conservator or anyone holding power of attorney for the client);

- The trust was established with property belonging to the client; and

- The client is at least one of the beneficiaries of the trust.

The client is considered to be the grantor even if the trust was established pursuant to court order issued upon the petition of the client or his representative. In this situation, the court acts as the client's agent in establishing the trust.

It is not necessary that there be a trust agreement, as defined by State law, for MQT policies to apply. MQT policies also apply to "similar legal devices," or arrangements having all of the characteristics of an MQT except there is no actual trust instrument. Examples of such devices might be escrow accounts, savings accounts, pension funds, annuities, investment accounts and other accounts managed by agents with fiduciary obligations.

The MQT provision does not apply to trust agreements established by a will. These trusts are treated as standard trusts. If, however, a client inherits resources and in turn establishes a trust, then the MQT provision could apply.

2. Resource Treatment of MQT's

Each trust document must be reviewed individually to determine the resource treatment of the trust but in general:

a. For revocable MQT's, the entire corpus is an available resource to the client. Resources comprising the corpus are subject to the individual resource exclusions since the client can access these resources except for the exclusion of the home for institutionalized recipients. Home property loses its excluded status when transferred to an MQT.

b. For irrevocable MQT's the countable amount of the corpus is the maximum amount the trustee can disburse to (or for the benefit of) the client, using his full discretionary powers under the terms of the trust. If the trustee has unrestricted access to the corpus and has discretionary power to disburse the entire corpus to the client (or to use it for the client's benefits), then the entire corpus is an available resource to the client. Resources transferred to such a trust lose individual resource consideration. For example, home property transferred to such a trust can no longer be excluded as home property but is included in the value of the corpus.

c. If the trust does not specify an amount for distribution from the corpus of the trust or from the income produced by the corpus, but the trustee has access to and use of both corpus and income, the entire amount is an available resource to the client.

d. If the trust permits a specified amount of trust income to be distributed to the client (or to be used for his benefit), but these distributions are not made, the client's countable resources increase cumulatively by the undistributed amount.

3. Income Treatment of MQT's

a. Amounts of trust income distributed to the client are counted as income when distributed.

b. Amounts of trust income distributed to third parties for the client's benefit (including payments for medical services) are countable income when distributed.

c. Exculpatory Clauses which limit the authority of a trustee to distribute funds from a trust if such distribution would jeopardize eligibility for government programs are ignored for MQT purposes if the language explicitly or implicitly links the trustee's discretion to Medicaid requirements.

4.	**MQT's Transfer of Assets Policy**	If the MQT is irrevocable, a transfer of resources has occurred if the resources are no longer available to the client. Resources rendered unavailable are subject to the transfer penalty based on the value of the unavailable resources without consideration of whether the resource would have been excluded under ongoing policy.
5.	**MQT's Undue Hardship**	The MQT provision may be waived if an undue hardship exists. This means Medicaid should not be denied to an individual under this provision if the individual would be forced to go without life sustaining services because the trust funds cannot be released. This does not include situations where the trustee simply chooses not to make the trust funds available.

F. STANDARD TRUSTS

A standard trust is one that does not meet the definition of a Medicaid Qualifying Trust. Trusts or conservatorships established prior to 03/01/87 or testamentary trusts where the Medicaid client is the beneficiary are standard trusts. In all such cases listed below, a copy of the trust agreement or court documents must be obtained for review.

1. Medicaid Client is Trustee

Generally, a person who is appointed as a trustee cannot use any of the funds in the trust for his/her own benefit. Thus, an individual can be a trustee of a valuable trust and not be able to receive money from the trust since he/she has no access to the funds for his/her personal use. Under such circumstances, the trust is not a resource to the Trustee.

If, however, the eligible individual (client) is the trustee and has the legal ability to revoke the trust and use the money for his own benefit, consider the trust a resource to the client. This is true regardless of whose funds were originally deposited into the trust. Also, consider the trust a resource to the client if either the client or living-with spouse (eligible or ineligible) is the person who created the trust and has the right to dissolve it and use the funds for his own benefit. Where the trust principal is considered a resource to the trustee, any withdrawals made from the trust by the trustee are not income to him since the monies have already been counted as a resource. In this situation, any income which is earned from the trust principal (e.g., interest or dividends) is considered income to the client/trustee.

2. Medicaid Client is Beneficiary

If a client is the beneficiary of a trust and the client's access to the trust principal is restricted, meaning only the trustee or court can invade the principal, the principal of the trust does not count as a resource to the client. If the trust is not a resource, payments made to or on behalf of an eligible individual are counted as income.

If the beneficiary has unrestricted access to the principal of the trust, the trust is counted as a resource. In this situation, payments from the trust to the beneficiary are not counted as income since it has already been counted as a resource. The payments from the trust are a conversion of a resource.

The authority for discretion by the trustee in the use of trust funds, including invasion of the principal for support and maintenance of the beneficiary, does not mean that the principal is available to the client/beneficiary and, as such, should not be counted as a resource. Only the income or resource(s) that are available to the client via the trustee's discretion can be counted for purposes of determining eligibility.

In cases where the trustee has "full discretion" in the use of trust funds, the trustee determines the beneficiary's access. Before eligibility can be determined in cases of this nature, the trustee must specify, by way of a written and signed statement for the case record, what arrangements exist or will be made to release funds or resource for the client's use. As outlined above, any payments made to or on behalf of the client are counted as income unless the trustee states the client has unrestricted access to use of trust funds in which case the funds are a countable resource.

3. Conservator-ships (Prior to 03-01-87)

Conservators and legal guardians are court appointed and are usually court controlled. These types of legal arrangements are initiated when the competence of an individual is at issue. Technically, a legal guardian is appointed to serve over an individual and the individual's resources whereas a conservator is appointed only to handle an individual's resources. Regardless of either legal term used, an application or active case involving a conservator or legal guardian is handled as outlined below.

In the absence of evidence to the contrary, conserved liquid and non-liquid resources held by a guardian or conservator on behalf of a Medicaid applicant or recipient are countable resources to the applicant/recipient. If the guardian/conservator manages and controls the conserved funds, the funds are considered available to the client. The fact that the guardian/conservator controls the funds (e.g., makes the actual withdrawals) does not alter the attribution of the resource to the client. Since the guardian/conservator legally acts on behalf of the incompetent individual, it is the same as if the individual is controlling or managing the resource.

"Evidence to the contrary" that may indicate a client does not have total access to conserved resources held by a guardian/conservator is a court order which specified the disbursement of funds and/or disposal of resources. If the court order or decree specifies the amount and frequency of funds which may be disbursed or restricts the disposal of resources, the court's decision in such matters determines the client's access. A "silent" court order, meaning one that does not specify disposition and/or availability of conserved resources, is not considered evidence to the contrary. Therefore, conserved funds controlled by a silent court order are considered available to the client.

In addition, the fact that a guardian/conservator must first petition the court in order to dispose of resources or disburse funds does not constitute "evidence to the contrary." In fact, State law requires such a petition in guardian/conservator cases making petitioning a standard practice. In all cases where petitioning is required, the conserved resources are considered available to the client unless or until the court is petitioned and rules as to the availability/disposition of assets. When a signed and dated petition is presented as evidence that the court has been petitioned for disbursement of funds and/or disposal of resources, the petition is sufficient to exclude the resource(s) in question until the court renders a decision in the matter.

4. **Eligibility Determinations Involving Conservatorships**

To determine how to handle a case involving a legal guardian or conservator, it is necessary to obtain a copy of the original decree appointing an individual as guardian or conservator in addition, obtain copies of any legal documents which may have subsequently been issued by the court to amend or change the original decree, if any have been issued. If a guardianship or conservatorship is in the process of being established, the client's resources are considered available until court documents are presented as outlined below:

- If the court order specifies disbursement of funds, any payments made to or on behalf of the client count as unearned income to the client.

- If the court order does not specify the disbursement of any non-liquid resources conserved by the court, consider the funds as a countable resource.

- If the court order specifies that conserved non-liquid resources, such as property, may be disposed of for the benefit of the client, consider the property, etc., as a countable resource. If the court order is silent on the subject of disposal of non-liquid resources, consider the resources countable unless or until the court is petitioned for disposal.

- A court order may specify the disbursement of liquid resources and not mention disposal of any conserved non-liquid resources or vice versa. In such a case, abide by the court's decision regarding the disbursement or disposal issue specified and count as a resource the unspecified resource. For example, a conservatorship court order specifies the release of $100 per month from a savings account with a $5000

balance and fails to mention the disposal of 50 acres of property owned by the client. In such a case, the $100 would be counted as income while the balance of the account is excluded as a resource. The property would be a countable resource until the court is petitioned for the purpose of disposing of the property.

- Court orders that are not specific on the availability of conserved resources result in the availability of the conserved resources to the client until the month the court is petitioned for use of the conserved funds or resources. A valid petition will exclude the resource provided the petition requests the court to rule as to the disposal and/or disbursement of conserved resources. The exclusion will apply until the court rules in the matter at which time the case must be reviewed in light of the court decision.

RESOURCES
TRUSTS/TRANSFERS OF ASSETS

G. MEDICARE CATASTROPHIC COVERAGE ACT (MCCA) TRANSFER POLICY

The Medicare Catastrophic Coverage Act of 1988 (MCCA) repealed the transfer of resources penalty for noninstitutionalized individuals. New transfer of resources policy created under the MCCA applies only to institutionalized individuals, as defined below, who transfer resources on or after July 1, 1988 through August 10, 1993. Transfers that occur after August 10, 1993 are evaluated under OBRA-93 transfer policy.

An institutionalized individual is an individual who is a nursing facility inpatient, an inpatient at a medical institution receiving a nursing facility level of care; or, a recipient of home and community based waiver services. ICF-MR residents are not included in this definition.

The transfer penalty resulting in ineligibility, as defined below, applies to nursing facility services, medical institution services where the level of care provided is equivalent to nursing facility care. An institutionalized individual remains eligible for all other Medicaid services while a transfer penalty is in effect, provided eligibility is met on all other factors.

1. Transfer Penalty

An institutionalized individual who, at any time during the 30-month period immediately before the individual's application for medical assistance, disposed of resources for less than fair market value shall be ineligible for nursing facility services beginning with the month in which resources were transferred. An institutionalized individual is also prohibited from transferring resources during the period of institutionalization, unless an exception applies.

Effective 10/01/89, the transfer penalty also applies to a community spouse who transfers resources within the 30-month period preceding application and/or during the time his/her spouse remains institutionalized. A transfer of resources by a community spouse to another individual will result in a transfer penalty applying to the institutionalized spouse.

2. The Penalty Period

The period of ineligibility shall be equal to the lesser of:

a. 30 months, or

b. the number of months required to deplete the uncompensated value (UV) based on the total UV of the transferred resources divided by the average monthly cost of nursing facility services to a private pay patient. The cost is specified below.

3. 30-Month Penalty

The 30-month period is calculated using the month of a transfer as the first month continuing through the 30th consecutive month, provided the transfer occurred on or after July 1, 1988. The 30-month period of ineligibility is imposed unless the UV/private-pay calculation results in a period of ineligibility less than 30-months.

4. Private Pay Calculation

This calculation is based on a Statewide average private pay cost of $1456.00 per month. In calculating the period of ineligibility, divide the UV by $1456.00 to determine the number of months that an individual will be ineligible for nursing home services. All calculations are rounded down to the nearest whole number.

For example: If the total UV is $20,000, then $20,000 divided by $1456 = 13.73. The period of ineligibility would be 13 months, which is less than the 30-month penalty.

5. Determining the Period of Ineligibility

The month of the transfer is always month one of the period of ineligibility. As a result, the penalty period may be expired or near expiration as of the month of application. For example, a transfer with UV of $5000 occurs 07-05-88. Using the private-pay calculation, the period of ineligibility for a nursing home vendor payment is 3 months, or, July-September. If application is filed October 1, 1988 or after, the penalty period will have expired, although eligibility for all other Medicaid services is possible in the retroactive period.

If the UV does not result in ineligibility for at least one month, the transfer will not count. For example, if the transfer is for $1000 which is less than the average private pay rate, no penalty applies for the month of the transfer.

Each transfer is evaluated based on the month the transfer occurred. If more than one transfer occurs in the same month, the UV is combined and the penalty period calculated on total UV for a particular month. If transfers crossover into different months, each transfer is evaluated separately and UV is not combined. The possible results would be overlapping penalty periods.

The private-pay calculation is never prorated based on the number of days in a month that the individual is institutionalized. The full month private-pay average is used to calculate the penalty period regardless of the number of days the individual is actually in the facility.

6. Exceptions to Transfer of Home Property

The transfer penalty will not apply to the transfer of home property by an institutionalized individual to the following family members of such individual:

a. the individual's spouse or child under age 21 or a disabled or blind adult child; or

b. a sibling who is part owner of the home who lived in the home for one (1) year before the individual entered a nursing facility; or

c. a child who lived in the home for up to two (2) years before the individual entered a nursing facility and provided care to the individual which permitted the individual to remain at home.

7. **Exception to Transfer of Any Type of Resource Other Than the Home**

The transfer penalty will not apply to the transfer of any type of resource in the following situations:

a. Resources are transferred to or from the individual's spouse. Effective 10-01-89, a transfer of assets from a community spouse to another individual will result in a penalty charged to the institutionalized spouse.

b. Resources are transferred to the institutionalized individual's child who is disabled or blind.

c. Satisfactory evidence is presented to show that the individual intended to dispose of the resource(s) either at fair market value or for other valuable consideration, or, that resource(s) were transferred exclusively for a purpose other than to qualify for Medicaid.

d. Denial of eligibility would result in undue hardship.

e. The resource was excluded under ongoing policy at the time of the transfer.

f. The resource was transferred by an individual other than the institutionalized applicant/recipient and that person had no legal authorization to act in the applicant or recipient's behalf at the time of the transfer.

8. Notice of Transfer of Resources

The client will be notified via DOM-322A, Notice of Transfer of Resources, regarding countable transfers and the penalty period. The notice will allow the client or representative 10 days to present evidence to show that the transfer should not count. Evidence should include a written rebuttal plus any pertinent documentary evidence. If no rebuttal is offered, the penalty will be applied and the appropriate adverse action notice issued to deny or terminate payment of nursing home services only. The individual remains eligible for all other Medicaid services if the transfer penalty is the only factor of ineligibility. If the individual is ineligible on other factors as well as the transfer, the application or case must be denied or terminated.

9. Rebuttal Process

Written rebuttals along with the Regional Office decision regarding acceptability are to be submitted to the Area Supervisor prior to issuing final notice to the client. The material submitted to State Office should include the rebuttal, a copy of DOM-322A issued to the client, and a summary of the circumstances surrounding the transfer. The Area Supervisor will issue a memorandum to the Regional Office explaining the final decision on the transfer.

10. Acceptable Rebuttals

Factors which may indicate that a transfer was made for some purpose other than establishing Medicaid eligibility are listed below. The presence of one or more of the following factors may result in an acceptable rebuttal. This list is not all-inclusive:

a. The occurrence <u>after</u> a transfer of resources of one or more of the following:

(1) Traumatic onset (e.g., traffic accident) of disability or blindness.

(2) Diagnosis of previously undetected disabling condition.

(3) Unexpected loss of other resources which would have precluded Medicaid eligibility.

(4) Unexpected loss of income (including deemed income) which would have precluded Medicaid eligibility.

In general, if the client was healthy and/or financially secure at the time of the transfer, with no expectation of future Medicaid need, then an acceptable rebuttal may be established.

b. Total countable resources that would have been below the resource limit at all times from the month of transfer through the present month even if the transferred resource had been retained.

c. Court-ordered transfer.

d. Resource(s) sold at less than current market value in order to obtain cash quickly to meet expenses or repay a legal debt.

11. Undue Hardship

The transfer penalty can be waived if a period of ineligibility would result in undue hardship for the institutionalized individual. Undue hardship exists if a Medicaid denial of nursing home care would result in the individual's inability to obtain medical care. Each case situation must be reviewed individually to determine if undue hardship exists but the provision is geared toward financially and medically needy individuals with no possible means of recovering their transferred resource(s).

12. Return of a Transferred Resource

If a transferred resource is returned to or if compensation is received by the institutionalized individual, the UV is no longer an issue or is reduced as of the date of the return. The resource or compensation is evaluated according to normal resource rules in the month of the return. Any portion of a transferred resource that is not returned continues to count as UV which means the penalty period must be re-evaluated.

13. Recalculation Of A Penalty Period

A penalty period must be recalculated from the month a portion of the resource is returned or additional compensation is received.

For example: A transfer of $10,000 occurred in 10/88 resulting in a 6-month penalty period, or October 1988 - March 1989. In January 1989, $5,000 is returned to the institutionalized individual. The penalty period is then recalculated using UV of $5,000 transferred in 10/88 which results in a revised period of ineligibility for the 3 months of October 1988 - December 1988.

If the full resource is returned, normal resource rules apply the month of the transfer.

14. Transfer Penalty Involving SSI Months

The transfer penalty can be imposed during months that an individual receives SSI or is SSI eligible in a nursing home.

For example: A MAO application is filed in December 1988. The applicant entered the nursing home in October 1988 as an SSI eligible and SSI eligibility continued until 12/31/88. A transfer is discovered during the MAO application processing that occurred in 10/88 and results in a 4-month period of ineligibility. The penalty can be imposed for October 1988 - January 1989 even though 10/88 - 12/88 are months of SSI eligibility. This would mean that no vendor payment would be authorized for the 4-month penalty period.

As a result, workers will need to postpone sending notices on an SSI to MAO applicant advising of eligibility based on SSI until eligibility for MAO is determined which excludes any transfers for the SSI months.

RESOURCES
RESOURCE COMPUTATIONS

A. SSI FIRST OF MONTH RULE

For cases subject to SSI policy, eligibility with respect to resources is a determination made as of the first moment of each calendar month and applicable to the entire month. Subsequent changes have no effect until the following month's resource determination. Thus, resource eligibility or ineligibility exists for an entire month at a time.

1. Resource Eligible

If resources of an individual or couple are within the applicable limit as of the first day of the month, the individual or couple is eligible based on resources for that month. This does not affect the definition of income in any way. Continue to count the receipt of money/assets as income in the month received and as a resource in the following month. However, consider only what the client owns in the way of countable resources on the first day of any given month in determining eligibility based on resources.

2. Resource Ineligible

If resources of an individual or couple exceed the applicable resource limit as of the first day of the month, the individual or couple will not be eligible for that month and will not be able to establish eligibility based on resources for that month. Eligibility cannot be established during the time excess resources are retained and through the month the individual's/couple's resources are reduced to within the limit. It is not possible to "spenddown" resources within a month in order to establish eligibility for that month under SSI policy.

3. Advance Dated Checks/ Deposits

Do not consider as a resource any advance dated checks or advance posted direct deposit checks received prior to the month of normal receipt. To the extent retained, funds from such checks will be considered a resource as of the first moment of the first day of the month following the month in which the check is normally paid.

B. RESOURCE SPENDDOWN (LIBERALIZED POLICY)

For cases subject to liberalized resource policy, effective 10-01-89, eligibility can exist for an entire month when an individual or couple meets the resource test during the month. This allows an applicant to "spenddown" resources in a month to become eligible for that month. Under the liberalized spenddown provision, resources can be reduced within the applicable limit and as long as resources remain within the limit for that month, eligibility can be established.

Do not allow payment of expenses that will be returned, refunded or reimbursed as legitimate spenddown expenses when calculating resources for a given month. Client owned resources spent for reimbursable expenses count as an available resource in the month paid. Do allow outstanding checks/payments as an expense if proof is provided that the payment was authorized during the spenddown month and the expense is non-reimbursable.

Note: The spenddown provision implies that an individual spends down to the resource limit or below during a month and remains at or below the limit for the remainder of the month. When determining eligibility for a prior period and reviewing the resource situation for a full month, the individual or couple must have depleted resources to an acceptable level and remained eligible for that month for a true spenddown to have occurred. For example: An individual had $5000 in a bank account on the first of the month and spent $3000 on a pre-paid burial contract on the 5th of the month. However, on the 20th, he sold his car, which was excluded as a resource for $2500. The $2500 then becomes a resource (conversion of a resource) in the same month and unless the individual spends the excess $2500 by the end of the month, eligibility cannot be established for that month.

RESOURCES
RESOURCE COMPUTATIONS

1. Resources Earmarked for Private Pay of LTC

Under liberalized resource policy, effective 10-01-89, if excess liquid resources are earmarked for payment of private pay expenses for month(s) prior to a month of Medicaid Eligibility, these excess resources can be excluded as a resource for any potential Medicaid months since these funds are obligated.

If Medicaid will cover any months that have been paid as private pay by the client, the amount subject to reimbursement is a resource in the month paid.

For example: A LTC applicant enters a nursing home in June and applies for Medicaid in August. The applicant's bank account is $6000, but $4500 is earmarked for private pay for June/July. Medicaid is needed for August 1. Since the $4500 is obligated for months prior to Medicaid eligibility, it can be excluded as a resource in determining eligibility for August forward provided the earmarked funds are used to pay for the intended private pay expenses.

2. Accumulated Income Earmarked as Medicaid Income

Under liberalized resource policy, effective 10-01-89, income that accumulates while a Medicaid application is in process and that is obligated for payment of Medicaid Income for months that will be covered by Medicaid can be excluded as a resource if excess resources result from accumulating income.

For example: A LTC applicant enters a nursing home in August and applies for Medicaid in October requesting benefits retroactive to August. The client's income is $1200 per month. In November when the case is being worked up, the bank balance is $5000. Medicaid Income for September and October would be $2312 ($1200-$44= $1156 x 2). November's income of $1200 can be backed out of the balance plus the $2312 obligated for September/October Medicaid Income, thus leaving $1488 as a countable resource for November.

RESOURCES
RESOURCE COMPUTATIONS

C. DEEMING OF RESOURCES

For SSI/Medicaid purposes, an individual's resources is deemed to include any resources of an ineligible spouse or ineligible parent(s). Resources are deemed whether or not they are actually available. Deeming only applies in household situations, i.e., it only applies to an eligible with an ineligible spouse or parent(s).

In deeming resources from one spouse to the other, consider only the resources of those two individuals. In deeming resources from a parent to a child, consider only the resources of the parent. Where there is more than one eligible "child," the resources available for deeming are shared equally among the eligible "children;" for example, if there are two eligible children and $500 in parental resources must be deemed to them, deem $250 to each child.

Do not include the resources of the stepparent who is not legally liable for support of the child under State law in the deeming process.

Exception to deeming of resources: Pension funds owned by an ineligible spouse or parent(s) are excluded from resources for deeming purposes. This exclusion applies in order for an ineligible spouse or parent to provide for their own future support. Pension funds are defined as monies held in a retirement fund under a plan administered by an employer or union, or an individual retirement account (IRA) or Keogh account as described by the Internal Revenue Code. This exclusion is effective September 1, 1987 and cannot be excluded prior to this date.

1. Spouse to Spouse Deeming

Total countable resources are the combination of the resources of the eligible individual and ineligible spouse after all applicable resource exclusions are applied.

Total countable resources are compared with the resource limitation for a couple. If the amount of the resources does not exceed the limit, the applicant/recipient meets the resource eligibility requirement. If countable resources exceed the limit, the applicant/recipient is ineligible.

Verify and document the ineligible spouse's resources as required for an eligible individual.

If an eligible individual and eligible spouse are not living together, the resources of both members (whether owned separately by each or jointly by both) are combined only for the month of separation. Each member of the couple is treated as an eligible individual beginning with the month after the month of separation, i.e., no longer living in the same household, and the resource limit for each is the individual resource limit.

2. Deeming & Changes in Marital Status

When a change in marital status occurs, a new resource limit is established and a new resource determination is made for the first month in which the new resource limit (individual or couple) is effective as a result of the change.

Make a new resource determination for the first month in which a new resource limit (individual/couple) is effective as a result of a change in marital status. For example, if two eligible individuals marry in February, a new resource determination would be required for March, since these two individuals become a couple effective the first day of March as a result of the marriage.

For SSI/Medicaid purposes, the marital relationship of a couple can be ended by death, divorce or annulment. If a marriage ends by death, divorce, or annulment in the same month the marriage began, treat the marriage as though it had not occurred. Beginning with the month following the month of the death of one member of a couple, the surviving member will be an eligible individual if all other eligibility requirements are met. If the marital relationship of a couple terminates by divorce or annulment, each member of the couple should be treated as an individual effective the first day of the month following the month the couple no longer lives in the same household.

3. Parent to Child Deeming

In determining eligibility for a child (under 18 or 21 if a student) who lives with his parent(s), the resources of the child include the value of the countable resources of the parent(s) or parent/stepparent to the extent that the resources of the parent(s) or parent/stepparent exceed the resource limit of:

- an individual, if one parent lives in the household; or
- a couple, if two parents live in the household.

Do not include the resources of the stepparent in the deeming process.

The value of parental resources is subject to deeming whether or not those resources are available to the child.

If there is more than one eligible child under age 18 (or under 21 if a student) in the household, equally divide the value of the deemed resources among those children.

If an eligible child is later determined ineligible for any reason or is no longer subject to deeming (e.g., after attainment of age 18), divide the value of the deemed resources among the remaining eligible children, effective with the first month the child is ineligible or no longer subject to deeming.

A child's total countable resources are the combination of the value of the deemed resources and the nonexcluded resources of the child.

A child's countable resources are compared with the resource limit for an individual with no spouse. If the resources do not exceed the limit, the child meets the resource eligibility requirement. If countable resources exceed the limit, the child is ineligible because of excess resources.

4. Multiple Deeming

When more than one eligible individual lives in the same household and there is a parent-child relationship, a multiple deeming situation may exist.

If a child under age 18 (or under 21 if a student) lives in the same household with a parent(s) applying for Medicaid or an eligible parent(s), determine the countable resources of the parent(s).

If the parent(s) meets the resource eligibility requirement, do not deem the value of any parental resources to the child.

If the parent(s) does not meet the resource eligibility requirements, follow the usual parent-to-child resource deeming rules to determine the value of the deemed parental resources.

RESOURCES
RESOURCE COMPUTATIONS

A. GENERAL

VERIFICATION REQUIREMENTS

Generally, resources must be verified for any month for which you must determine eligibility. Specifically, for initial applications, verify the value of resources for the month of application and each of the month(s) of possible retroactive eligibility. Verify month(s) subsequent to the month of application as necessary.

For redeterminations, verify as needed the value of resources for up to 3 months prior to the review month. It is permissible for resources to be developed as of the last month for which verification is available for regular reviews rather than requiring resource balances for the review month.

If a client appeals a denial related to a particular resource the evidence in file must clearly establish the value of that resource. It must do so even if the issue under appeal is not the value itself (e.g., when the issue under appeal is ownership). This requirement ensures that at each level in the appeals process, the file contains complete documentation of the resource in question.

1. Exceptions to General Requirements

Do not verify the value of resources for a given month if:

- the resource is totally excluded, regardless of its value
  (exception: obtain a tax receipt for property owned by a nursing home client subject to Estate Recovery)
- the alleged value of total countable resources exceeds the applicable limit for that month; or
- the individual is ineligible for that month for a reason other than excess resources.

2. Development of Equity Value

Develop the equity value of a resource (liquid or nonliquid) when an individual alleges a debt against it and the difference between equity and CMV could mean the difference between eligibility and ineligibility.

Verify, at a minimum, the outstanding principal balance, the rate of interest and the schedule and amount of payments (to permit the projection of increases in equity). Obtain a copy of the agreement or note that establishes the debt. If this does not provide all the information needed, use other records of the individual, the creditor, or both.

RESOURCES
RESOURCE COMPUTATIONS

B. FREQUENCY OF VERIFICATION REQUIREMENTS

At a minimum, resources owned by a client are verified at the time of application and at each regular review scheduled annually. However, circumstances may warrant reverification of resource(s) at shorter intervals. The following describes situations which mandate reverification of resources at shorter intervals than annually but it is not an all-inclusive list. Any reported changes in resources or discovery of changes in resources may warrant verification or reverification.

1. Resources Within $100 of Applicable Limit

Individuals/Couples determined eligible for Medicaid who own countable resources valued within $100 of the applicable limit must have resources renewed/verified every 6 months rather than annually. The purpose of the 6-month (special) review will be to verify the value of countable resources in order to determine if the individual/couple remains eligible based on resources. A tickler must be utilized to control the timing of the required review of cases with countable resources close to the resource limit.

2. Long Term Care Recipients in Medicare Beds

Individuals who are placed in Medicare certified nursing facilities are not required to pay any of their income toward the cost of their care which means that income may be allowed to accumulate and result in excess resources during the first 100 days of possible Medicare coverage. This means that it is necessary to reverify resources during the period of Medicare coverage to check for possible excess resources.

3. Cases With VA Income That Is Not Countable

Client cases, especially long term care cases, that receive excess income that is not countable as income must be monitored closely for excess resources. The amount of the monthly income that is not being counted will determine frequency a review/reverification is deemed necessary.

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MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
SSI RETRO AND INTERIM MONTHS DETERMINATIONS

A. GROUP DESCRIPTION

Federal regulations mandate that eligibility for medical assistance begin with the third month prior to the month of application for SSI for all applicants who:

1. Have received services covered by Title XIX during any of the 3 month period; and

2. Meet all eligibility criteria in the retroactive month(s) when the service was provided.

Eligibility for retroactive Medicaid cannot be established unless or until an application for SSI is filed. (The month of application for SSI or MAO locks in the retroactive period.) The applicant may be eligible for Medicaid in the retroactive period regardless of whether the application for SSI is approved or denied. In addition, an application for retroactive benefits may be filed on behalf of a deceased individual provided an application for SSI has been filed.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) requires that SSI payments begin as of the first day of the month following the date application is filed, or if later, the date the individual first meets all eligibility factors. If the individual meets the eligibility requirements for any MAO coverage group during the interim period of time between the date of application for SSI and the month the SSI payment begins, Medicaid coverage must be provided to the individual for this period of time. A separate application is required for coverage of this interim period through a Medicaid Regional Office. This separate application may be filed in conjunction with an application for SSI retroactive benefits or as a separate application.

B. ELIGIBILITY CRITERIA

Eligibility for medical assistance must be established separately for each month of the retroactive and interim month(s) period. An individual may be eligible in one or more months of the retroactive and/or interim period. The individual will be certified for only those prior months in which eligibility can be established. All technical and financial eligibility criteria must be met for each month.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
SSI RETRO AND INTERIM MONTHS DETERMINATIONS

The application for SSI determines the 3 month retroactive time period consideration for coverage, i.e., the 3 months prior to the month the SSI application is filed and the interim period before the SSI payment started. However, the applicant can be considered for coverage under any available coverage group that he/she may qualify for when considering all eligibility factors. For example, if it is to the SSI retro applicant's advantage to use liberalized resource policy available through the Poverty Level Aged & Disabled (PLAD) Coverage Group and the applicant meets all eligibility criteria for PLAD coverage, then it is permissible to place the applicant in PLAD coverage group for the SSI retroactive and interim period.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED FORMER SSI RECIPIENTS

B. HR-1 GROUP

This group of eligibles is referred to as HR-1 because this is the designation of the House of Representatives bill which amended the Social Security Act. This bill required that all persons who were eligible for and receiving Medicaid in August, 1972, and were entitled to Social Security benefits as of that month, must be certified for Medicaid if the only reason for their current ineligibility is the 20% increase made in the Social Security checks for September, 1972.

This does not mean that the 20% increase in SSA benefits received in August, 1972, terminated the client's Medicaid eligibility. It only means that the 20% increase received in September, 1972 will be disregarded in order to determine current eligibility for Medicaid, provided the client is determined to be in the HR-1 group.

1. Eligibility Criteria

To be eligible for HR-1 Medicaid benefits, an individual must meet all three of the following conditions:

- Have been eligible for and receiving Medicaid benefits in the month of August, 1972.
- Have received RSDI benefits for the month of August, 1972. The benefits may have been awarded retroactively.
- Must be eligible for Medicaid using current SSI eligibility requirements when the 1972 20% increase in Social Security benefits is disregarded.

2. Restrictions

The only individuals who can be considered for Medicaid under the HR-1 coverage group are the ones who meet the criteria outlined above. If a couple applies under the HR-1 provision and only one member of the couple is eligible for and entitled to the HR-1 disregard, it is not possible to bring the ineligible spouse into eligibility even though the spouse may be aged, blind, or disabled.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
FORMER SSI RECIPIENTS

No individual or couple can remain eligible or obtain eligibility for Medicaid as a HR-1 recipient if the individual's or couple's income, including the disregarded 1972 20% increase in Social Security, is less than the current SSI Federal Benefit Rate (FBR) appropriate for the case. Persons with total income less than the appropriate FBR are potentially eligible for SSI and should be advised to apply for SSI. Eligibility for Medicaid as a MAO recipient is precluded for these individual's because they do not belong to any MAO coverage group.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED FORMER SSI RECIPIENTS

C. COST-OF-LIVING (COL) ELIGIBLES

Section 503 of P.L. 94-566 (the Pickle Amendment) protects categorical Medicaid eligibility for certain recipients of title II Social Security benefits who have lost eligibility for SSI lost eligibility for SSI benefits. This group of eligibles is limited to all current title II recipients who after April, 1977 were entitled to and received both title II and SSI benefits and who lost SSI eligibility. Medicaid eligibility can be established if the individual would still be eligible for SSI if the title II cost-of-living increase(s) which the individual received since the individual was last eligible for and received SSI and title II concurrently were deducted from income. The reason for loss of SSI benefits is not a factor in determining whether an individual is entitled to Medicaid coverage as COL recipient.

1. Eligibility Criteria

To be eligible under the COL coverage group, the individual must meet all of the following criteria:

- The individual must be currently eligible for title II (RSDI) benefits;
- The individual must have been simultaneously eligible for and received both title II and SSI benefits at some time since April, 1977;
- The individual must have lost SSI eligibility since April, 1977;
- The individual must be currently eligible for SSI (on all factors) after deducting from countable income the title II cost-of-living increase(s) received since the last month of simultaneous eligibility for and receipt of SSI.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
FORMER SSI RECIPIENTS

2. Restrictions

The only individuals who may be considered eligible for COL Medicaid coverage by virtue of applying the COL disregard are the ones who meet the criteria outlined above. If an eligible couple applies and both members of the couple received SSI and title II and were terminated from SSI, then eligibility may be determined for both individuals as an eligible couple. If a couple applies and only one member of the couple meets the criteria outlined above, it is not possible to determine eligibility for the ineligible spouse as a COL even though the ineligible spouse may be aged, blind or disabled. Although the ineligible spouse cannot be determined eligible as a COL, the title II cost of living increase(s) received by the ineligible spouse since the eligible spouse was last eligible for and received SSI will also be disregarded in the budgeting (deeming) process. The same is true of a parent or parents whose title II income is deemed to an eligible child, i.e., the parent(s) title II cost of living increases are disregarded beginning with the date the child was terminated from SSI.

No individual or couple can remain eligible or obtain eligibility for Medicaid as a COL recipient if the individual's or couple's income, including the disregarded cost-of-living amount(s) of Social Security, is less than the current SSI Federal Benefit Rate (FBR) appropriate for the case. Persons with total income less than the appropriate FBR are potentially eligible for SSI and should be advised to apply for SSI. Eligibility for Medicaid as a MAO recipient is precluded for these individuals because they do not belong to any MAO coverage group.

3. Annual Review of Former SSI Recipients

As a result of a federal court case known as Lynch v. Rank, States are required to notify SSI recipients who were terminated from SSI for the previous 3 years about their possible Medicaid eligibility as a COL eligible. SSA provides tapes each year that identify SSI terminations for the previous 3 years and a notice is issued to each living resident of Mississippi identified on the tapes. The individual is informed of the possibility of Medicaid coverage if all COL criteria is met.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED FORMER SSI RECIPIENTS

D. COBRA WIDOW(ER)S

In 1983 Congress amended title II and eliminated the "Additional Reduction Factor" for widow(er)s younger than age 60. This increased title II benefits for some widow(er)s causing SSI ineligibility. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) amended the Social Security Act to restore Medicaid eligibility for these widow(er)s.

The Social Security Administration identified the affected widow(er)s in Mississippi and the affected individuals were notified to apply. This coverage group is limited to the individuals identified by SSA. The deadline for filing for Medicaid existed between July 1, 1987 through June 30, 1988. No new eligibles are possible under this coverage group.

E. DISABLED ADULT CHILDREN (DAC'S)

Section 6 of P.L. 99-654, The Employment Opportunities for Disabled Americans Act, specifies that effective July 1, 1987, when SSI recipients become ineligible for SSI because of entitlement to, or an increase in, title II disabled adult child (DAC) benefits, Medicaid eligibility must continue if these individuals continue to meet SSI criteria except for the change in their title II benefit.

1. Eligibility Criteria

The law applies to individuals who are:

- over 18, and
- received SSI after July 1, 1987, and
- became disabled before age 22, and
- receives or begins receiving child's insurance benefits, i.e., receives benefits from a parent's record

When the child's insurance (DAC) benefits either begin or increase and this results in SSI termination for the individual, then Medicaid continuation as a DAC is possible if eligibility for SSI continues on all factors other than income. The DAC will be entitled to a disregard of either the increase in DAC benefits or the full amount of DAC benefits, whichever caused SSI termination.

2. SDX Notification

SSA has the responsibility to notify States about members of this group through the SDX, The "Medicaid Eligibility Code" field of SDX will contain a "D" for individuals potentially eligible for DAC status. Affected individuals are advised to apply for Medicaid when their SSI eligibility is terminated.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED FORMER SSI RECIPIENTS

F. OBRA WIDOW(ER)S

In the Omnibus Budget Reconciliation Acts of 1987 (P.L. 100-203) and 1990 (P.L. 101-508), Congress permanently revised the special, more restrictive disability standard for disabled widow(er)s to the disability standard that applies to all title II and SSI adult disability applicants.

OBRA-87 mandated Medicaid coverage for certain widow(er)s age 60-65 effective July 1, 1988 and after. OBRA-90 mandated Medicaid eligibility for certain widow(er)s age 50-59 effective January 1, 1991. Both widow(er) groups have the same eligibility criteria.

1. Eligibility Criteria

To be eligible as an OBRA-87 or OBRA-90 widow(er), an individual must:

- continue to be eligible for SSI but for their title II benefits;
- received an SSI payment the month before title II payments began; and
- not be entitled to Medicare.

2. Medicare Eligibility

Normally, age 65 will be the effective date for Medicare entitlement; however, there are exceptions such as:

- A widow/widower aged 60 or over may require renal dialysis or a kidney transplant. If this should occur, she/he could become entitled to Medicare on the deceased spouse's Social Security Number (SSN) under the renal provisions. Entitlement to Part A under these provisions could begin the month the beneficiary enters a hospital in anticipation of a transplant, or a third month after dialysis begins.

- A widow/widower aged 60 or over may be concurrently drawing SSA disability benefits on her/his own SSN. Entitlement to Medicare based on the disability would begin with the 25th month of entitlement to such benefits.

- Section 5103 of OBRA-90 provides that each month of eligibility for SSI will count toward the individual's five-month disability waiting period and 24-month Medicare waiting period. This means that the normal wait for entitlement to disability benefits and/or Medicare can be greatly reduced or even eliminated, depending on the length of time the individual has been receiving SSI benefits. This means that individuals who meet the eligibility criteria described above for OBRA widow(er)s may or may not actually be eligible for Medicaid, depending on when they become entitled to Medicare based on a reduced waiting period.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED

MAO "AT-HOME" COVERAGE GROUPS

A. GENERAL DESCRIPTION

The following coverage groups are limited to those who live "at-home" or in other private living arrangements whose income eligibility is based on a percentage of the Federal Poverty Level (FPL). The FPL is updated annually as required by Sections 652 and 673 of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), and reflects the previous year's change in the Consumer Price Index.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
MAO "AT-HOME" COVERAGE GROUPS

B. POVERTY LEVEL AGED & DISABLED (PLAD) GROUP

Section 9402 of the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) allowed states the option to offer Medicaid coverage to aged and disabled individuals with incomes up to a state-established threshold that does not not exceed 100 percent of the federal poverty level. The resource limits are mandated to be the same as SSI resource limits for this optional group.

Note: Individuals who are blind are ineligible for coverage in this category unless the blind individual is also disabled.

1. Eligibility Criteria

Effective July 1, 1989, an individual or couple must meet all of the following criteria in order to qualify for PLAD coverage:

- The eligible must be aged 65 or over or disabled.
- Income must not exceed the FPL in accordance with the phase-in requirement contained in State law:

85% of the FPL effective 07-01-89
90% of the FPL effective 01-01-90
100% of the FPL effective 01-01-91
135% of the FPL effective 07-01-2000

The income limits apply to countable income, i.e., all appropriate income exclusions apply prior to testing income against the individual or couple level. The income limits for PLAD individuals and couples are listed in the "Chart of Need Standards and Resource Limits" located in the Appendix.

Effective 07/01/00, resources must not exceed $4,000 for an individual and $6,000 for a couple. Effective 07/01/99 - 06/30/00, resources could not exceed $3,000 for an individual and $4,000 for a couple. Effective 07/01/89 - 06/30/99, resources could not exceed SSI resource limits.

- All other non-financial requirements of Medicaid eligibility must be met.

2. **Effective Date of Benefits**

Medicaid benefits for PLAD coverage is effective with the first of the month in which all factors of eligibility are met, which includes up to 3 months prior to the month of application. However, benefits cannot begin any earlier than July 1, 1989, which is the implementation date for this coverage group.

PLAD eligibles receive full Medicaid benefits.

3. **12-Months Continuous Eligibility**

The Balanced Budget Act of 1997, P.L. 105-33, gives states the option to provide continuous eligibility to children under age 19.

Continuous Medicaid applies only to children in any coverage group available to children except children who are only eligible in LTC. When discharged, child would not be automatically eligible for 12 months continuous eligibility from the date last determined eligible.

Children can not be eligible for continuous Medicaid prior to July 1, 1998, which is the effective date of this policy.

After eligibility for Medicaid is determined or redetermined, eligibility will continue for 12 months regardless of changes in circumstances.

4. **Termination of PLAD Program**

House Bill 1104 passed during the 2005 Legislative Session terminated the Poverty Level Aged and Disabled (PLAD) coverage group effective December 31, 2005.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
MAO LONG TERM CARE "AT-HOME" COVERAGE GROUPS

C. HOSPICE CARE

Section 9505 of the Consolidated Omnibus Reconciliation Act of 1985 (P.L. 99-272) amended title XIX of the Social Security Act to permit hospice care benefits to be provided, at State option, to individuals eligible for Medicaid including a newly created hospice care eligibility group. In order for individuals to receive hospice care they must be medically verified as terminally ill and voluntarily elect to receive hospice care in lieu of certain other Medicaid benefits. Upon the election of hospice care, Medicaid begins reimbursement to the hospice provider for each day the election for hospice care is in effect, subject to an overall maximum reimbursable.

Coverage of hospice services by Mississippi Medicaid for individuals eligible under ongoing coverage groups was effective July 1, 1991.

1. Hospice Care Eligibility Group

Section 9505 (b)(2) of Public Law 99-272 established a new optional categorically needy eligibility group for individuals who elect hospice care. Eligibility under this group is determined using the same eligibility criteria and special income standard (300% of the SSI FBR for an individual) that is used for long term care cases regardless of whether the hospice client lives in a private living arrangement or a free standing hospice care facility. Coverage of the optional hospice care eligibility group by Mississippi Medicaid is effective April 1, 1993.

2. Eligibility Criteria

An individual may be eligible under any existing at-home coverage group and elect hospice care benefits if determined to be terminally ill. The election for hospice services is handled by the hospice provider. If eligibility exists under an "at-home" category (SSI, AFDC or PLAD eligibility), there is no need to change the recipient's eligibility to the hospice care group. The recipient can receive hospice services without applying for the hospice care eligibility group.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
MAO LONG TERM CARE "AT-HOME" COVERAGE GROUPS

An application for hospice care eligibility is required if an individual is not already Medicaid eligible and cannot be eligible for Medicaid except by using long term care eligibility criteria. In determining eligibility for hospice care, use the same financial and non-financial rules that apply for long term care (LTC) coverage groups just as if the hospice care applicant was in a medical institution. Spousal Impoverishment income and resource rules apply even though the applicant may live in the same household with his/her spouse. The difference between long term care and hospice care criteria is as follows:

- No DDS decision is required since the hospice provider is required to obtain a medical prognosis of a terminal illness before hospice services can be elected.

- No 260 Form is required. Instead a copy of the "Hospice Membership Form" must be obtained by the Regional Office from the hospice provider.

- The hospice care eligible has no Medicaid Income payable because the Personal Needs Allowance (PNA) is set at the Community Spouse Monthly Maintenance Needs Allowance maximum. Since this maximum standard is higher than the 300% income limit, no Medicaid Income is payable. The CS MMNA is allowed as the PNA for each hospice eligible, regardless of marital status.

If the individual is in LTC prior to converting to Hospice coverage, a 317 is required to discharge the individual from the facility; and the Enrollment Form is required to show the effective date of Hospice. When a Hospice individual enters a nursing facility and wants LTC coverage, an Enrollment Form is required to verify disenrollment from Hospice care.

A 317 is needed to verify admission to the facility. If an individual has Hospice coverage and enters a nursing home but does not want LTC coverage, no action is required.

Any LTC dates in REHF that correspond to Hospice eligibility prevent Hospice claims from paying. Therefore, Hospice coverage must begin the month after LTC Liability has ended. If an individual is changing from Hospice to LTC coverage, the Hospice coverage must end the month prior to the LTC coverage.

3. **Effective Date of Eligibility**

The special income standard (300% of the SSI FBR) is directly related to the 30-consecutive day requirement whereby an individual must remain in long term care for at least 31 days before the higher need standard can be applied. By definition, individuals potentially qualifying under the hospice care eligibility group are not in an institution so they cannot literally fulfill the 30-consecutive day requirement. However, in order to be eligible to receive hospice care, individuals must file an election statement (Hospice Membership Form) with a particular hospice. That hospice will be reimbursed by Medicaid for each day the election for hospice care is in effect, regardless of whether or not the individual actually receives services from the hospice. The beginning date of reimbursement is the effective date of the hospice election.

In applying the 30-consecutive day requirement of the hospice care group, day one is the effective date of the hospice election. If the election is in effect for a full 30-consecutive day period, eligibility using the higher income standard for long term care (300%) may be applied retroactive to the effective date of the hospice election. Eligibility can begin with the first of the month of the hospice election provided the individual is eligible on all other factors. The exception to fulfillment of the 30-consecutive day requirement is death during the 30-day period.

There may be situations where the 30-consecutive day requirement has already been met by an individual. In such cases, the individual electing hospice care does not need to meet the 30-consecutive day requirement again in order to apply the special income standard. For example, an individual living in a medical facility (hospital or nursing facility), who has already been determined eligible using the higher institutional income limit, may elect hospice benefits.

As long as there is no break in time between eligibility in the institution and the effective date of the election for hospice care, eligibility under the hospice care eligibility group can begin the month after the hospice election.

4. **Hospice Membership Form**

When a Medicaid recipient or applicant for hospice care eligibility elects hospice services, the "Hospice Membership Form" must be completed. By completion of this form, the hospice patient elects hospice care in lieu of Medicaid payments made for treatment of the condition for which the hospice care is sought. The hospice provider obtains the client's signature on the form and also obtains the physician's prognosis of the illness.

5. **Termination of Hospice Care Eligibility Coverage Group**

House Bill 1104 passed during the 2005 Legislative Session terminated the eligibility category for the optional hospice care coverage effective May 1, 2005. After May 1, 2005, individuals eligible in another eligibility category may receive hospice as a covered service only. The election for hospice services is handled by the hospice provider.

6.	**Transfers Between** completed **LTC and** must **Hospice**	If an individual is changing from LTC to Hospice or vice versa, the Regional Office must obtain a copy of the and signed Hospice Membership Form. Also, the 317 be obtained from the nursing home to verify admission or discharge.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
MAO LONG TERM CARE "AT-HOME" COVERAGE GROUPS

D. HOME & COMMUNITY BASED SERVICES (HCBS) WAIVER PROGRAMS

The Division of Medicaid has been granted the authority under Section 1915 (c) of the Social Security Act to implement Home & Community Based Services (HCBS) Waiver Programs. The waiver program is limited to individuals who meet the nursing home level of care or ICF/MR level of care but choose to remain at home. Individuals eligible for the waiver programs will receive all regular Medicaid services in addition to the waiver services. The following coverage groups are limited to those who qualify for the waiver program:

1. HCBS Independent Living Waiver (IL)

The approval of the HCBS Handicapped Waiver created a new coverage group for certain individuals who participate in this program. Coverage of this new eligibility group is effective January 1, 1994. The individual must meet the following criteria in order to qualify for the Independent Living coverage:

- Disabled individuals of any age.

- Individuals whose handicap consists of severe orthopedic and neurological impairments that render the individual dependent upon others, assistive devices, other types of assistance or a combination of these to accomplish the activities of daily living. The individual must be able to communicate effectively with the caregiver and service provider.

- Would require a nursing home level of care if assistance is not provided.

The initial point of contact for participation in this program is the Department of Rehabilitation Services (DRS). DRS staff has the responsibility of assessing an individual's medical potential for participation in this group and for completion of Form DOM-260HCBS Physician's Certification for Medicaid Home and Community Based Services Program. A completed DOM-260HCBS Form is then forwarded to the DOM Community Long Term Care Unit where medical review staff will render the final decision regarding medical eligibility for the Independent Living (IL) group.

A list of the Mississippi Department of Rehabilitation Services (MDRS) offices is located in the appendix.

Services offered through this waiver program include personal care attendant services, and case management, as well as all the other benefits that a full service Medicaid recipient would receive.

2. Elderly and Disabled Waiver (E&D)

The Elderly and Disabled Waiver is a satewide program that provides home and community based services to individuals over the age of 21. The individual must meet the following criteria to be eligible for this coverage group:

- Be age 21 or older
- Have deficits in at least three activities of daily living (ADL) such as: Eating, toileting, bathing, personal hygiene, ambulation, transferring and dressing. Must meet a nursing facility level of care.

The initial point of contact for participation in this program is the Area Agency on Aging (AAA). Case Management services are provided by the Area Agencies on Aging/Planning and Development Districts. The case management team is composed of a registered nurse and a licensed social worker who are responsible for identifying, screening and completing an assessment on individuals in need of at-home services.

A listing of the Area Agencies on Aging is located in the Appendix.

Services offered through the E & D coverage group include:

- Case Management
- Homemaker Services
- Adult Day Services
- Home Delivered Meals
- Transportation
- Institutional and In-Home Respite

3. Mentally **Retarded/ Developmentally Disabled Waiver (MR/DD)**

The Mentally Retarded/Developmentally Disabled (MR?DD) coverage group is a statewide program administered directly by the Department of Mental Health, Bureau of Mental Retardation. To be eligible for this waiver, individuals must meet the following criteria:

- Have a diagnosis of mental retardation or developmental disability

- Without assistance, would require ICF/MR level of care

The initial point of contact for participation in this program is the Department of Mental Health. Referrals may be made directly to the local Regional Centers: Boswell, Ellisville, Hudspeth and North Mississippi Regional Center.

Director names and phone numbers of the Regional Centers are listed in the Appendix.

Services provided through this waiver include: Community and in-home respite; Residential habilitation; Day habilitation; Supported employment; Occupational therapy; Behavioral support and intervention; ICF-MR respite; Attendant care aide; Prevocational services; Physical therapy; Speech, language and hearing services; and, Specialized medical supplies.

4. **Assisted Living Waiver**

The 1999 Legislative required the Division of Medicaid to submit an application to the Health Care Financing Administration (HCFA) for an assisted living waiver. This waiver was approved by HCFA effective October 1, 2000, for individuals in the following counties:

Bolivar	Hinds Sunflower
Forrest	Lee
Harrison	Newton

Individuals must meet the following criteria to be eligible for this waiver program:

- Must be 21 years of age or older

- Must require assistance with at least three Activities of Daily Living (ADL)

- Have a diagnosis of Alzheimer's disease or another type of dementia and need help with at least two activities of daily living (ADL)

Services will be offered in a Level I licensed Personal Care Home that has chosen to participate as a Medicaid Waiver Provider. Services provided through this program include the following: Case Management; Attendant Care; Therapeutic Social and Recreational Programming; Intermittent Skilled Nursing Service; Transportation; Incontinence Supplies; Attendant Call System; Chose Services; Medication Administration; Homemaker Services; Personal Care; and, Medication Oversight.

5. **Traumatic Brain Injury and Spinal Cord Injury Waiver (TBI/SCI)**

State Legislation passed during the 2001 session created a waiver program to assist individuals who have a traumatic brain or spinal cord injury, who, but for the provisions of such services, would require the level of care provided in a nursing facility.

Effective July 1, 2001, in order to be eligible for this coverage group, an individual must meet the following criteria:

- Have a diagnosis of a traumatic brain injury or spinal cord injury
- Must be medically stable
- Cannot have an active life threatening condition that would require systematic therapeutic measures, IV drip to control or support blood pressure, intercranial pressure or arterial monitoring.

The initial point of contact for participation in this program is the Mississippi Department of Rehabilitation Services. A list of the Mississippi Department of Rehabilitation Services (MRDS) offices is located in the appendix.

Services offered through the TBI/SCI Waiver include:

- Case Management
- In-Home Nursing Respite
- In-Home Companion Respite
- Institutional Respite
- Attendant Care Services
- Environmental Accessibility Adaptations
- Specialized Medical Equipment and Supplies

The following eligibility groups are potentially eligible for the TBI/SCI Waiver:

- TANF recipients, SSI recipients, Children under age 19, Foster Children, Disabled Children Living at Home, PLAD eligibles (135%), and 300% FBR income (nursing home limit).

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
MAO LONG TERM CARE "AT-HOME" COVERAGE GROUPS

a. **Eligibility Criteria**

Individuals eligible for Medicaid as an SSI recipient, or PLAD eligible may participate in the HCBS Waiver Program if the individual meets the medical criteria. For those not otherwise eligible for Medicaid through the SSI program, or the Poverty Level, Aged and Disabled (PLAD) Program, eligibility for Medicaid under the HCBS Waiver Program will be determined by Medicaid Regional Offices using the same eligibility criteria and special income standard (300% of the SSI FBR for an individual) that is used for Long Term Care coverage groups. An application for MAO eligibility under the HCBS Waiver Programs is required if an individual is not already SSI or PLAD eligible. All factors of eligibility must be met. If the individual is eligible as an SSI recipient, there is no need to change the recipient's eligibility to the HCBS Waiver Program.

Effective July 1, 2001, PLAD eligible cases will need to be changed to the appropriate HCBS coverage group and ensure that all factors of eligibility are met.

b. **Transfer Penalty**

Effective July 1, 2001, all persons applying for a HCBS waiver program will be subject to the transfer of assets policy and the estate recovery policy provisions. This will include individuals already eligible under the PLAD coverage group who enroll in a HCBS Waiver Program after 07-01-01 as well as the individuals qualifying under the 300% guidelines. Any transfers that occurred prior to July 1, 2001, will not be developed for the HCBS Waiver Programs. Any person who entered the HCBS Waiver Program prior to July 1, 2001, will not have their case reviewed for transfers. Those individuals will be "grandfathered". However, if the individual is discharged from the program and is readmitted after July 1, 2001, the "grandfathered" status is lost. The case will be reviewed as a new HCBS recipient.

c. **Application Process**

a. The application process is handled as follows:

To begin the application process, the applicant or representative must be advised to contact the agency that is responsible for the specific waiver program:

- Independent Living Waiver-Department of Rehabilitation Services (DRS)
- Elderly & Disabled Waiver-Area Agency on Aging (AAA)
- MR/DD-Department of Mental Health
- Assisted Living-Community LTC at the Division of Medicaid
- Traumatic Brain Injury and Spinal Cord Injury Waiver - Department of Rehabilitation Services (DRS)

Names and phone numbers for each agency are listed in the appendix.

Only those individuals who meet the age and medical criteria should be referred to agency for participation in this program. Do not refer any individuals to an agency who do not meet the basic criteria.

The appropriate agency will initiate the completion of the DOM-260HCBS Form and will send the completed DOM-260HCBS to the DOM Community Long Term Care Unit for approval. The agency will also notify the individual in writing that an application must be filed with the appropriate Regional Medicaid Office within 45 days.

If the Regional Office receives an approved DOM-260HCBS but no application is on file, the Regional Office will send out an application package to the individual. Note: If an application is not filed within 45 days from the date the DOM-260HCBS is approved, the DOM-260HCBS will no longer be valid. The appropriate agency will notify the individual that a new DOM-260HCBS will be required and the effective date will be subject to change. The Regional Office will receive a copy of this notice.

The Regional Office will process the MAO application for Medicaid under the waiver program in the same manner as nursing home applications are processed:

- Use the same financial and non-financial rules that apply as if the applicant was in a nursing facility

- Spousal Impoverishment rules apply even though the applicant may live in the same household with his/her spouse

- A DDS decision is required unless one of the exceptions for obtaining a DDS decision applies.

An approved DOM-260 HCBS Form is required prior to approval of an application documenting the individual's need for the level of care provided by a nursing facility. The Regional Office will be mailed a copy of the completed DOM-260 HCBS from the DOM Community Long Term Care Unit on any MAO applicant for the HCBS Waiver Program. **NOTE:** Eligibility can not begin until the month the physician signs the DOM-260 HCBS.

Upon initial application for the special income category (300%) under the HCBS programs, if eligibility is denied for any reason, the DOM-260HCBS submitted with the initial application is no longer valid. If the applicant requests eligibility determination at a later date, a new DOM260HCBS will be required.

A HCBS and Medicaid Regional Office Two-Way Communication Form will be used to notify each bureau of the appropriate action to be taken on each case. A copy of the two-way communication form will be made a part of the permanent case record in the regional office.

Eligibility in the Waiver Program must be redetermined every 12 months and all factors of eligibility must continue to be met. This includes obtaining a new DOM-260HCBS Form each year to document the continuing need for participation in this program. The redetermination process is initiated in the same manner as the application process, i.e., the client or representative must contact the appropriate agency to initiate the 260 process.

d. **Effective Date of Benefits**

Eligibility can be established with the month the physician signs the DOM-260HCBS, provided the application was filed timely. Retroactive eligibility is possible (up to 3 months prior to the application month) provided the physician signed the DOM-260HCBS within any of these months. If the DOM-260HCBS is not signed until after the month of application, eligibility cannot begin until the month signed.

e. **Post Eligibility Treatment of Income**

No post-eligibility treatment of income is required for this this eligibility group. The Personal Needs Allowance (PNA) (PNA) for this group is equal to the institutional income limit (300% of the SSI FBR). As a result, no Medicaid Income is payable by the eligible and it is not necessary to issue a 317 Form to authorize any type of payment to a provider. The eligible individual can use the Notice of Approval and/or Medicaid card to notify providers of eligibility.

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BUDGETING FOR AT-HOME ELIGIBILITY
BUDGETING PROCESS

A. GENERAL

A comparison of income to the appropriate need standard unique to the at-home coverage group the client is applying for or otherwise qualifies for, is known as budgeting.

The first step of the budgeting procedure is to determine the coverage group. Medicaid coverage groups are those categories of individuals designated in the State Plan who qualify for Medicaid and for whom Federal Financial Participation (FFP) is available. To be eligible for Medicaid in Mississippi an individual must have his eligibility determined using the criteria for a particular coverage group. Regional Office staff have budgeting responsibility for the MAO coverage groups described in Section G.

This section describes budgeting procedures for individuals who live "at-home." Specifically, those groups known as:

- SSI Retro determinations
- Former SSI Recipients
- MAO "At-Home" Coverage Groups
- MAO Long Term Care "At-Home" Coverage Groups

Budgeting procedures for MAO Long Term Care coverage groups are outlined in the "Institutionalization" section since Long-Term Care budgeting procedures must be used for these groups.

BUDGETING FOR AT-HOME ELIGIBILITY
BUDGETING PROCESS

B. BUDGETING STATUS

Once the decision is made as to which coverage group is applicable to the client, then the budgeting status must be determined. Budgeting status means whether or not to consider the client as an individual or couple.

1. Eligible Individual

An eligible individual is one who is aged, blind or disabled and meets all the technical requirements for receiving Medicaid and is:

- single, widowed, divorced or is a child, or
- physically separated from his/her spouse for a full month.

2. Eligible Individual With Ineligible Spouse

An ineligible spouse is one who is not eligible for or applying for Medicaid, but who is married to, or holding out to be married to, and living with an eligible individual. Deeming of income from the ineligible to the eligible may be appropriate, depending on the type and amount of income received by the ineligible spouse and whether ineligible child(ren) reside in the household.

3. Eligible Couple

An eligible couple consists of an eligible individual and an eligible spouse. An eligible spouse is an aged, blind or disabled individual who meets all the technical requirements for receiving Medicaid and who is the husband or wife of another aged, blind or disabled individual.

C. BUDGET FORMS

Form DOM-337, Eligible Individual/Eligible Couple & Spouse to Spouse Deeming Worksheet, is used to determine income eligibility for adult clients or clients under age 18 who are not subject to the deeming of parental income. DOM-338, Parent to Child Deeming Worksheet, is used to determine income eligibility for a child, i.e., an individual under the age of 18 who is subject to the deeming of parental income.

Depending on the budgeting form used, either DOM-337 or 338, refer to the instructions for the form used for detailed steps to follow in completing the form which determines eligibility based on income.

When completing the at-home budget, the eligible is entitled to all applicable income exclusions before arriving at countable income used to determine eligibility. Refer to Section E, Income, for a discussion of the following types of income exclusions and when to apply the exclusion.

- General Exclusion
- Earned Income Exclusion
- Income Exclusions for Former SSI Recipients
- Student Child Earned Income Exclusion
- Blind Work Expenses Exclusion
- Impairment Related Work Expenses
- Irregular & Infrequent Income Exclusion
- Plan for Achieving Self-Support (PASS) Income Exclusions

NOTE: MEDS performs on-line budgeting using the appropriate budget form depending on information entered into MEDS.

D. INDIVIDUAL BUDGETING

Budgeting for an at-home individual consists of:

- Selecting a coverage group in order to determine the appropriate need standard and income exclusions to apply,
- Determining countable income after applying all income exclusions and/or disregards,
- Comparing income to the appropriate need standard:
  - For cases using the SSI FBR, countable income cannot be equal to or exceed the appropriate FBR,
  - For cases using the FPL, countable income can be equal to but cannot exceed the appropriate FPL.

E. DEEMING PROCEDURES

Deeming applies from spouse to spouse or parent to child only. Since deeming applies only in household situations, for deeming purposes the household comprises the eligible individual, the spouse, and any children of the couple; or the eligible child, the parent(s), and other children of the parent(s).

An eligible individual, an ineligible spouse or parent who is temporarily away from home for economic (employment) or emergency reasons (hospitalization) or vacation or visits is still considered to be a member of the household for deeming purposes. A temporary absence for deeming purposes is one where the individual leaves and returns to the deeming household in the same month or the following month. A child away at school remains a member of the household if the child lives in the household on week-ends, holidays, and summer vacation.

There are instances when, after applying the deeming provision, there is no income to be deemed:

- If the income of the eligible spouse or parent(s) is less than the amount which is deducted for a living needs allowance and allocation to any ineligible children, there is no income to deem.

- If the spouse or parent(s) have no income or have only the type of income that is not deemed, then deeming is not applicable.

Refer to Section E, Income Computations, for a further discussion of deemed income.

BUDGETING FOR AT-HOME ELIGIBILITY

BUDGETING PROCESS

1. Allocating to Ineligible Child(ren) At-Home

If there are ineligible child(ren) in a deeming household, an allocation is deducted from the ineligible spouse's income (DOM-337) or from the parent(s) income (DOM-338) prior to deeming. An allocation is allowed for each ineligible child who lives in the household who is age 18 or under or under age 21 if a student. The amount allocated to each ineligible child is the "Allocation to Each Ineligible Child" amount found in the Appendix page entitled "Chart of Need Standards and Resource Limits" less the child's own income.

Each ineligible child's own income is subtracted from the SSI allocation amount. The remaining total(s) are added together and subtracted from the income of the ineligible spouse (DOM-337) or subtracted from the income of the parent(s) (DOM-338) to arrive at the total amount of income to be deemed to the eligible.

Note: The income of the ineligible spouse, parent(s), and ineligible children must be verified in the same manner the eligible's income is verified.

2. Deeming of Income From An Ineligible Spouse (DOM-337)

After living allowance allocations for ineligible children have been subtracted from an ineligible spouse's income, if the ineligible spouse's remaining income is less than the difference between the Couple and Individual Need Standards or FBR, no deeming applies. This means the following:

- For SSI Retro and Former SSI Recipient Budgeting - The eligible and ineligible spouse's countable income is combined and tested against the couple Poverty Level.

- For Poverty Level Budgeting - The eligible and ineligible spouse's countable income is combined and tested against the couple Poverty Level.

If the ineligible spouse's income is more than the difference between the 2 appropriate need standards, then deeming applies and the ineligible spouse and the eligible individual are treated as an eligible couple, as per instructions for Step 3 of DOM-337.

Note: Refer to the instructions for DOM-337 for a discussion on how to deem income from an ineligible spouse to an eligible individual and an eligible child.

3. **Deeming of Income from Ineligible Parent(s) to An Eligible Child (DOM-338)**

After living allowance allocations for ineligible children have been deducted from the parent(s) earned & unearned income, any remaining income is then subject to income exclusions and a living allowance for the parent(s). Any excess income is then deemed to the eligible child or eligible children (in equal parts). Deemed parental income is counted as unearned income to the eligible child (or eligible children after being equally divided).

Refer to the instructions for DOM-338 for further details on completion of the form.

BUDGETING FOR AT-HOME ELIGIBILITY
BUDGETING METHODOLOGY

A. BUDGETING FOR FORMER SSI RECIPIENTS

The following budgeting rules are unique to former SSI recipients. In all groups, SSI policy must be used and the appropriate SSI FBR used as the need standard in budgeting. Countable income of the eligible cannot be equal to or exceed the appropriate SSI FBR used.

1. SSI Retro

If SSI policy is used to determine eligibility for an SSI retro case, then SSI budgeting rules apply:

- the appropriate SSI FBR must be used for each month of retroactive eligibility,
- countable income cannot be equal to or exceed the SSI FBR

2. HR-1

In addition to all other appropriate income exclusions, an HR-1 eligible receives an income disregard of the 20% increase in title II benefits received in September, 1972. **All HR-1 cases must be referred to the State Office for review prior to approval.**

3. COL

In addition to all other appropriate income exclusions, COL eligibles receive a disregard of all Social Security cost-of-living increases received since the client was last eligible for and received SSI and Social Security then lost SSI eligibility. To determine the COL disregard:

- Verify the SSI Termination Date.
- Determine the aggregate COL disregard amount
  - Divide the current title II benefit amount by the percentage amount of the previous years's COL increase. This will provide the individual's benefit level prior to the COL increase. This computation is then repeated for each title II COL increase received after the individual last lost SSI.

- Do not round down. Use the actual amount calculated for each preceding year.

- When the last computation is completed, the result is the title II benefit amount when SSI was terminated. Subtract this amount from the current title II benefit. The difference is the COL disregard amount to be disregarded in budgeting countable income.

- All possible calculations back to July 1977 are provided in the Appendix "COL Computation History."

- **All COL applications must be referred to the State Office for review prior to approval. State Office will determine the COL disregard, if needed.**

4. **COBRA Widow(er)s**

This limited group of eligibles were allowed a disregard of the increase in their 12/83 title II benefits to restore Medicaid eligibility for a limited group of widow(er)s who lost SSI eligibility as a result of the 12/83 title II adjustment.

5. **DAC**

In addition to all other appropriate income exclusions, DAC's receive a disregard of either the increase in their Disabled Adult (DAC) Child's insurance title II benefits or the full amount of their DAC benefits, whichever caused their SSI eligibility to terminate. **All DAC applications must be sent to the State Office for review prior to approval. State Office will determine the amount of the DAC disregard, if needed.**

6. **OBRA Widow(er)s**

In addition to all other appropriate income exclusions, OBRA Widow(er)s receive a disregard of their title II widow(er) benefits and any other paid title II benefits that resulted in the termination of SSI. **All OBRA Widow(er) applications must be referred to State Office for review and determination of the disregard amount prior to approval.**

BUDGETING FOR AT-HOME ELIGIBILITY
BUDGETING METHODOLOGY

B. BUDGETING FOR MAO AT-HOME CLIENTS

The following MAO At-Home coverage groups have the following in common:

- All groups use the Federal Poverty Level (FPL) as the basis for determining income eligibility, although a different percentage of the FPL is applied depending on the group.

- Countable income can be equal to but cannot exceed the appropriate FPL used in budgeting. Since this is true, anyone whose income is equal to the FPL must be monitored closely for any possible increases in income (such as when State Buy-In occurs).

- Federal Poverty Levels are not published until February or March each year. Since Social Security cost-of-living increases are awarded in January benefit checks, it is mandated by federal law that the title II cost-of-living increase received in January is disregarded for cases using FPL's as the need standard until such time as the new FPL's are published and implemented each year. The title II increase is disregarded for each applicant and recipient and to any ineligible spouse's title II benefits in determining income eligibility in budgeting for January until the time the new FPL's are implemented. After new FPL's are implemented, the client(s) must remain eligible without the title II disregard in order for eligibility to continue.

- Mixed budgeting methodologies are not allowed between Former SSI Recipient budgeting and MAO At-Home budgeting procedures. For example, any disregards allowed for former SSI recipients are not allowed in budgeting for MAO At-Home recipients.

- An individual or couple who would be eligible for SSI based on income may choose to apply for Medicaid only as at-home eligible. The individual is not required to apply for SSI if he/she chooses to apply for MAO at-home coverage.

1. PLAD

PLAD budgeting is based on 100% of the FPL. All appropriate income exclusions apply except for those reserved for former SSI recipients, i.e., no mixed budgeting allowed.

There is no in-kind support and maintenance (ISM) counted as income in PLAD budgeting.

2. QMB

QMB budgeting is based on 100% of the FPL. All appropriate income exclusions apply except for those reserved for former SSI recipients, i.e., no mixed budgeting allowed.

There is no in-kind support and maintenance (ISM) counted as income in QMB budgeting.

3. SLMB

SLMB budgeting is based on 120% of the FPL. All appropriate income exclusions apply (except for those reserved for former SSI recipients). No in-kind support and maintenance (ISM) is counted as income in SLMB budgeting.

4. QWDI

QWDI budgeting is based on 200% of the FPL. All appropriate income exclusions apply; however, SSI policy and not liberalized policy applies to QWDI eligibles. This means that it is possible to count in-kind support and maintenance as income in the QWDI budget.

All applications for QWDI status must be submitted to the State Office for review prior to approval.

BUDGETING FOR AT-HOME ELIGIBILITY
BUDGETING METHODOLOGY

5. **Working Disabled**

Working Disabled budgeting is based on 250% of the FPL. All appropriate disregards and exemptions, including the earned income disregard apply. This is a two step process.

- Step 1 is a net income test based on the family's earned income. The net income must be less than 250% of the FPL for the family of the size involved. (The family size will either be one or two.)

- Assuming the individual has met the net family income test, the second step is a determination of whether the individual meets the unearned income standards to receive an SSI benefit. All earned income received by the individual is disregarded. If the individual has an ineligible spouse, SSI deeming rules apply. The countable unearned income must be less than the SSI income standard.

Policy Liberalization

Effective July 1, 2000, the maximum unearned income limit will be 135% of poverty.

Effective 07/01/99 - 06/30/2000, the unearned income could not exceed the SSI income standard. The Poverty Level chart is located in the Appendix.

BUDGETING FOR AT-HOME ELIGIBILITY
BUDGETING METHODOLOGY

C. BUDGETING FOR MAO LONG TERM CARE "AT-HOME" COVERAGE GROUPS

The following MAO coverage groups are generally considered to be living "at-home" as opposed to an institution; however, each group is budgeted using Long term Care criteria:

- An Institutional Budget, DOM-336, is used to test the client's own income against the institutional income need standard.

- There is no deeming of spousal or parental income in any of these groups.

- The client's own total income cannot equal or exceed the institutional limit. There are no income exclusions or disregards that apply to the client's own income unless the income is the type that cannot be considered income (for example, VA Aid & Attendance).

- There is no "Medicaid Income" payable toward the cost of care for these "at-home" LTC client cases.

1. Disabled Children Living At-Home

DCLH budgeting is based on the child's own income compared to the institutional income limit. There is no deeming of parental income in any month of eligibility.

2. Hospice

For hospice clients who are not otherwise eligible for full Medicaid benefits at-home (SSI, AFDC, PLAD), Hospice budgeting is based on the client's own income compared to the institutional income limit.

There is no deeming of spousal income to the Hospice eligible even if they live together in the same household. However, only the Hospice eligible is entitled to LTC income rules. If the non-Hospice spouse wishes to apply for Medicaid, he/she is treated as a member of a couple whereby total income of both spouses is combined.

There is no Medicaid Income calculated for a Hospice eligible.

Policy Liberalization

Effective 07-01-2000, if a non-Hospice spouse wishes to apply for Medicaid, he/she is treated as an individual. Budgeting is based on the non-hospice spouse's income only.

3. **HCBS Waiver For the Physically Handicapped**

For those not otherwise eligible for Medicaid as an SSI recipient, HCBS for the Physically Handicapped budgeting is based on the client's own income compared to the institutional income limit.

There is no deeming of spousal income to the Handicapped eligible even if they live together in the same household. However, only the Handicapped eligible is entitled to LTC income rules. If the non-Handicapped spouse wishes to apply for Medicaid, he/she is treated as a member of a couple whereby total income of both spouses is combined.

There is no Medicaid Income calculated for a HCBS Handicapped eligible.

Policy Liberalization

Effective 07-01-2000, if the non-Handicapped spouse wishes to apply for Medicaid, he/she is treated as an individual. Budgeting is based on the non-Handicapped spouse's income only.

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INSTITUTIONALIZATION
PUBLIC INSTITUTIONS

A. GENERAL (42 CFR 435.1008 and 1009)

Federal Financial Participation (FFP) is not available for services provided to individuals who are inmates of public institutions. An inmate of a public institution is a person who is living in or under the direct control of a public institution. A public institution means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

B. INSTITUTIONS NOT CONSIDERED PUBLIC INSTITUTIONS

The following are not public institutions and FFP is possible for individuals who reside in such a facility if all other factors of eligibility are met.

1. Medical Institution

A medical institution is one organized to provide medical care, including nursing and convalescent care, that is Title XIX approved, such as hospitals, nursing facilities and extended care facilities.

2. Publicly Operated Community Residence That Serves No More Than 16

In general, this means it is designed to serve no more than 16 residents and provides some services beyond food and shelter such as social services, help with personal living activities, or training in socialization and life skills. Occasional medical or remedial care may also be provided.

Residential facilities located on the grounds of or adjacent to any large institution and correctional or holding facilities for prisoners or individuals being held under court order as witnesses or juveniles are considered public institutions and are not eligible for FFP.

INSTITUTIONALIZATION
PUBLIC INSTITUTIONS

3. **Child Care Institutions**

Child care institution means a non-profit private child-care institution, or a public child-care institution that accommodates no more than twenty-five children, which is licensed by the State in which it is situated, or has been approved by the agency of the State responsible for licensing or approval of institutions of this type, as meeting the standards established for licensing. The term does not include detention facilities, forestry camps, training schools or any other facility operated primarily for the detention of children who are determined to be delinquent.

4. **Foster Family Homes**

Children receiving foster care payments under Title IV-E of the Social Security Act or who receive AFDC-foster care under Title IV-A of the Social Security Act and who reside in a child care institution described above are not residing in a public institution.

5. **Institution for the Mentally Retarded or Related Conditions**

Institution for the mentally retarded or persons with related conditions means an institution (or distinct part of an institution) that -

- Is primarily for the diagnosis, treatment, or rehabilitation of the mentally retarded or persons with related conditions; and

- Provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability.

INSTITUTIONALIZATION
PUBLIC INSTITUTIONS

C. INDIVIDUALS WHO ARE NOT CONSIDERED RESIDENTS OF PUBLIC INSTITUTIONS

Individuals who reside in the following types of facilities are not considered residents of public institutions and can therefore be determined eligible for Medicaid if eligible on all other factors.

1. Persons Receiving Educational or Vocational Training

Persons who reside in public facilities in order to receive educational or vocational training provided by the facility in preparation for gainful employment (e.g., a State school for the blind) are not considered to be "residents" of public institutions and are therefore entitled to Medicaid coverage if determined eligible.

2. Residents of Public Emergency Shelter for the Homeless

A homeless individual is one who is not under the control of any public institution and has no currently usable place to live. temporary residents of an emergency shelter for individuals whose homelessness poses a threat to their lives or health or residents of public institution or that part of a public institution used as an emergency shelter by a governmental unit, are not considered residents of a public institution.

3. Safe Havens Programs

Participants residing in a safe haven program, which is usually low cost housing provided to homeless individuals, are not considered residents of a public institution.

4. "Temporary" Placement in a Public Facility

An individual who is placed in a public institution on a temporary emergency basis pending other arrangements appropriate to his/her needs is not considered a resident of the public institution.

5. **Inpatients of Medicaid Institutions**

Inpatient means a patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or a dentist and who -

- Receives room, board and professional services in the institution for a 24 hour period or longer, or

- Is expected by the institution to receive room board and professional services in the institution for a 24 hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for 24 hours.

6. **SSI Payment Policy for Inpatients of Medical Institutions**

Under the SSI Program, for any full month where Title XIX pays more than fifty percent of the cost of an eligible person's care in a public Title XIX medical facility, the individual will be considered to be a patient in a medical institution for purposes of SSI benefits; such persons are entitled to SSI benefits based on a $30 payment standard. Persons in public medical facilities whose SSI benefits are suspended solely because Title XIX does not pay more than fifty percent of the cost of their care and who thus become ineligible as "SSI recipients" can retain Medicaid coverage under a MAO Long Term Care Coverage Group.

INSTITUTIONALIZATION
PUBLIC INSTITUTIONS

D. PUBLIC INSTITUTIONS

Persons who live in a public institution which is not certified a Title XIX facility, whether admitted or placed on a voluntary basis or committed under some legal process, are considered to be "inmates" and are not entitled to Medicaid as long as they reside in the facility. **Ineligibility for persons classified as inmates begins on the day institutional status commences and ends on the day institutional status ends by discharge, parole or permanent release.** Public institutions include, but are not limited to, the following:

1. Penal Institutions

Penal institutions include jails, prisons, reformatory or correctional (training) schools. Inmate status extends to a person detained by legal process under the penal system during a pre-trial period.

2. Group Homes

Group homes which are owned or leased by a governmental agency and administered through staff employed on a salaried basis by the agency, e.g., as counselors or house parents rather than as foster parents.

3. Institutions for Mental Diseases

These include State mental institutions or the portions thereof not certified as Title XIX distinct parts of the institution, such as,

- Mississippi State Hospital at Whitfield,
- Ellisville State School at Ellisville, and
- East Mississippi State Hospital at Meridian

4. Institution for Tuberculosis

Institution for tuberculosis means an institution that is primarily engaged in providing diagnosis, treatment, or care of persons with tuberculosis, including medical attention, nursing care, and related services. Whether an institution is an institution for tuberculosis is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of tuberculosis, whether or not it is licensed as such.

INSTITUTIONALIZATION
PHYSICIAN'S CERTIFICATION

A. GENERAL

Federal regulations require that Medicaid recipients who enter long term care be in need of the medical care for which payment will be made. In accordance with this requirement, a physician's certification of need and level of care is required for the following types of coverage:

- Nursing Home placement,
- ICF-MR placement,
- HCBS for the Physically Handicapped Waiver participation, and,
- Disabled Child Living At-Home coverage.

A peer review agency under contract with the Division of Medicaid is charged with the responsibility for certifying the medical necessity of long term admissions to:

- Psychiatric Residential placements,
- Swing Bed placements, and,
- Long Term Hospitalizations.

INSTITUTIONALIZATION
PHYSICIAN'S CERTIFICATION

B. POLICY/ PROCEDURES

Prior to the approval of a MAO Long Term Care case (including SSI-only and/or DHS LTC cases), the following documentation of medical necessity must be present in the case record. Note: The physician's certification requirement is in addition to a DDS decision for establishing disability for categorical relatedness.

1. LTC in a Nursing Facility (DOM-260NF)

Individuals who enter LTC in a nursing facility must have a DOM-260NF completed and signed by a physician. The nursing facility must provide the Regional Office with a copy of the completed/signed and dated DOM-260NF before the LTC application can be approved. The physician's signature certifies the medical necessity of the placement for eligibility purposes. The physician must also mark one of the 3 lower "Choice" boxes. If no "Choice" is checked, the 260 is invalid, and eligibility cannot be approved.

If the 2nd block is checked, a Level II screening is required and a memo from the Health Department indicating an approval of a Level II screening which is called PASARR is required. This is the review the Department of Mental Health must complete for a patient who has a diagnosis or related condition of mental illness or mental retardation. The PASARR is Pre-admission Screening Annual Resident Review. The cover memo signed by the Department of Mental Health indicates two types of approvals; however, either type of approval is permissible for eligibility purposes. If the memo is not received or if the memo indicates denial, the 260NF is invalid and eligibility cannot be approved.

The initial DOM-260NF valid at the time of admission remains valid until it is replaced with a new form or rescinded by DOM medical staff.

A new DOM-260NF is required only when a reapplication is filed on an applicant who has been ineligible for Medicaid for a period longer than 2 months and there has been a break in institutional status. No new DOM-260NF is required if the applicant is still in LTC and continuity of patient status has not been interrupted. Periods of ineligibility that exceed 12 months require a new DOM-260NF.

If no DOM-260NF is received by the Regional Office by the end of the application processing period, the application must be denied.

Effective November 1, 1999, in conjunction with the new Long Term Care Alternatives Program, a legible copy of the 260NF must be faxed to the DOM State Office in Jackson within twenty-four hours of completion of the form. This time frame is for any 260NF that does not require a Level II evaluation. A 260NF that requires a Level II evaluation will not be submitted to the DOM until the Appropriateness Review Committee (ARC) with the Department of Mental Health has approved the individual for nursing facility placement.

2. LTC in an ICF-MR (DOM-260MR)

Placement in an ICF-MR requires that a physician sign and a DOM-260MR and medical staff with the Department of Mental Health approve the DOM-260MR. The ICF-MR facility must provide the Regional Office with a copy of an approved DOM-260 MR before the LTC application can be approved for eligibility purposes.

The initial DOM-260MR approved at the time of admission remains valid until replaced with a new form or rescinded by DOM or Department of Mental Health medical staff.

The same procedures for requiring a new DOM-260NF (described above) apply for requiring a new DOM-260MR. Also, if no DOM- 260MR is received or if the DOM-260MR is disapproved for ICF-MR placement, the application must be denied.

INSTITUTIONALIZATION
PHYSICIAN'S CERTIFICATION

3.	**Disabled** **Child Living At-Home (DOM-260DC)**	Disabled children age 18 or under in this coverage group must have a completed/signed DOM-260DC by a physician that is sent for review and approval of this type of care with medical staff within the Division of Medicaid's Maternal Child Health (MCH) Unit. The Regional Office must forward the completed DOM-260DC to the MCH Unit for review along with all relevant medical information. A DOM approved DOM-260DC is required prior to approval of a DCLH case. A disapproved DOM-260DC will result in a medical denial. Completion of a new DOM-260DC is required at either one-year or three year intervals as required by MHC. Refer to Section G, page 7313 for the criteria of each interval.
4.	**HCBS Waiver Programs (DOM-260HCBS)**	Disabled individuals in the Waiver Programs must have a completed/signed DOM-260HCBS by an approved physician. The Regional Office must receive an approved DOM-260HCBS prior to approval of a HCBS Waiver application. A disapproved DOM-260HCBS will result in a medical denial. Completion of a new DOM-260HCBS is required every 12 months. Each year the medical necessity of this coverage must be reapproved by DRS/DOM or AAA/DOM.
5.	**LTC in a PRTF**	Children who enter a Psychiatric Residential Treatment Facility (PRTF) must be certified by the PRO agency under contract with the Division of Medicaid who determines the medical necessity of the placement. This review is performed separate and apart from the eligibility process and it is not necessary for the Regional Office to verify PRO approval before, during or after the application process. The PRTF must issue a DOM-317 to the appropriate Regional Office in order for payment to the facility to be authorized.

6. LTC in a Swingbed

If a facility plans to bill Medicaid for a swingbed admission, the facility must issue a DOM-317 to the Regional Office. However, the PRO agency is responsible for authorizing the medical necessity of the swingbed stay and this is performed separate and apart from the eligibility process. It is not necessary for the Regional Office to verify PRO approval for a swingbed stay.

INSTITUTIONALIZATION
SPOUSAL IMPOVERISHMENT

A. GENERAL

Section 303(a) of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) issued a new Section 1924 of the Social Security Act to mandate specific protection of income and resources for the maintenance needs of a community spouse when the other spouse is in a medical institution in long-term care (LTC). This special treatment of income and resources for certain couples is referred to as Spousal Impoverishment (SI). These rules are designed to assure that a Community Spouse (CS) maintains a certain level of financial security so he/she does not become "impoverished" in order to obtain Medicaid eligibility for the Institutionalized Spouse (IS).

1. SI Income/ Resource Rules - Applicability

The SI income and resource rules described in this subsection apply to an IS with a CS when:

- The IS/CS are legally married under State law. SI rules apply in an IS/CS situation regardless of whether
  - the couple was "separated"prior to the IS entering LTC, or,
  - the couple is considered "separated" after the IS enters LTC, or,
  - a prenuptial agreement exists.
- The IS remains institutionalized for 30-consecutive days or longer.
- The IS enters LTC on or after 09/30/89.

2. **When SI Rules Do Not Apply**

SI income/resource rules do not apply when:

- A change in circumstances occurs resulting in a couple who are no longer an IS with a CS. SI rules no longer apply the first full month following:
  - the death of either the IS or CS
  - divorce of the IS/CS
  - the IS discharged from LTC, or
  - the CS enters LTC.
- The IS is already in LTC as of 09/30/89 unless the IS leaves LTC for 30-consecutive days or longer then reenters LTC.
- The IC/CS are not legally married at the time of institutionalization. SI rules can apply only if the one in LTC leaves LTC for 30-consecutive days or longer and reenters LTC as an IS with a CS.

B. IS/CS RESOURCE COMPUTATION

In order to determine spousal shares of resources owned by an IS/CS, determine the couple's countable resources in the month of institutionalization. The first month the IS enters LTC, compute resources as follows:

1. Combine Countable Resources

To determine resource eligibility for an IS with a CS, combine the value of all countable resources belonging to the IS and/or CS whether owned separately by each spouse or jointly by both spouses. Countable resources include all resources that are counted under ongoing liberalized resource policy.

If a CS or IS own resources jointly with another person or persons, count the proportionate share of the IS or CS ownership interest per ongoing policy for the type of resource involved.

2. Verify Resources

The couple must provide complete resource verification of all countable resources owned as of the month the IS entered LTC. Verify resources per ongoing policy for the type of resource owned. Failure by the CS to verify resources owned by the CS will result in a Medicaid denial for the IS.

3. CS Share of Resources Based on the Federal Maximum

The CS share of total countable resources is the maximum allowed under federal law. In order for a CS to receive a share larger than the federal maximum, a court order would be required granting the CS a greater share of total resources after Medicaid has made a decision regarding spousal shares.

The resource maximum applicable is the resource maximum in effect in the month of institutionalization of the IS, Spousal Impoverishment Resource Maximums in effect since 10-01-89 are located in the Appendix, Page 1.

The CS is assigned his/her share of total countable resources as of the month of IS institutionalization. If total resources are less than the federal maximum, the CS is entitled to all of the total resources owned by the IS/CS.

If total resources are greater than the federal maximum, the IS entitled to the amount in excess of the maximum. The IS resource limit is equal to $3000; therefore, if the IS share of total resources exceeds $3000, the IS is ineligible for Medicaid until the IS share is equal to $3000 or under.

Note: The CS resource maximum is enforceable only at the time of application. Once an IS is determined eligible for Medicaid under SI rules, the CS resource maximum no longer applies. This means a CS can acquire resources in excess of the maximum after eligibility for the IS is established without affecting eligibility for the IS.

4. Protected Period for Transfer of Resources

The IS can transfer resources to the CS to bring resources up to the federal maximum with no penalty. Allow up to 90 days after application or longer if court action is required to complete a transfer. Resources that are not transferred out to the IS name within 90 days (or longer-if good cause exists) will be used to determine eligibility for the IS. The 90-day period begins after the IS/CS or representative is informed in writing of the need to transfer resources to the CS.

The exception for requiring resources to be transferred to the CS is when the IS dies prior to transferring resources to the CS.

During the 90-day period, the case may be approved and a tickler set for 90 days after approval. Also, during the 90-day grace period, do not count as income to the IS any income generated by a resource that is being transferred to the CS. If the resource is not transferred to the CS by the end of the 90-day period (and no good cause exists), then resources and income are counted toward the IS.

Exception for Long Term Hospitalization Applicants. Require resources of the IS to be transferred to the CS prior to approval of the LTC application.

5. **Undue Hardship**

If the CS holds resources at the time of application that exceed the CS maximum and does not make the excess resources available to the IS, the excess will continue to be counted as the IS share of resources unless undue hardship exists. That is, if a denial of Medicaid eligibility for the IS would result in life sustaining services being denied, counting the excess toward the IS share may be waived.

Undue hardship situations must be reviewed individually. A statement for the CS is required in this situation citing the reason for the refusal to make resources available as required under federal law.

The statement must be submitted to the State Office along with other pertinent income and resource information for a review of the circumstances.

6. **SI Rules for CS Living Out of State**

There is no requirement for a CS to live in Mississippi; however, SI resource/income rules are more restrictive in that:

- home property located out of state must be transferred to the CS' name during the 90-day protected period for transferring resources.

- any income allocated to the CS must be closely monitored to ensure the allocation is actually sent to the CS.

C. **ASSESSMENT OF RESOURCES VS. APPLICATION FOR MEDICAID**

When requested by either member of a couple (the IS or the CS) or by a representative acting on behalf of either the IS or CS, the Regional Office must complete an assessment of the couple's resources:

- An assessment is a "snap-shot" of the couple's total countable resources in the month of institutionalization, i.e., what was true in the month the IS entered an institution for 30-consecutive days or longer on or after 09/30/89. If one spouse has not yet entered an institution on the date the assessment is requested, an assessment cannot be provided.

- An assessment is separate from an application for Medicaid. If the IS wishes to apply for Medicaid, an "assessment" is not required. Resources will be evaluated under Spousal Impoverishment rules and the appropriate Medicaid notice used to approve or deny eligibility. However, if the couple only wants to know how Medicaid would evaluate their total resources if application were filed, an assessment is required.

- An assessment provides a written evaluation of resources to the couple giving the following information:

  - the total value of countable resources;

  - the basis for the determination;

  - the CS share based on the maximum standard allowed as of the month of the assessment;

  - whether the IS would be currently resource eligible if application were to be filed

  A "Resource Assessment Notice" will be used to document the information specified above.

INSTITUTIONALIZATION
SPOUSAL IMPOVERISHMENT

1. Verification of Resources for Assessments

In order to provide an accurate assessment of a couple's resources, verification must be provided to determine current market value and the couple's ownership interest in the resources. The couple must provide accurate verification of the resources owned in the month of institutionalization in order for an assessment to be completed. Failure to provide necessary verification means the assessment cannot be completed. Allow 45 days for an assessment to be completed. If verification is not received within the 45 day time frame, no further action is necessary.

If verification is provided for an assessment, complete the "Resource Assessment Notice" and provide copies to each member of the couple while retaining a copy in the Regional Office Correspondence File (if an application is later filed, the copy becomes part of the case record). The notice documents the value of resources at the time of institutionalization and specified the CS and IS share of total resources.

2. Changes in Assessments

The assessment completed to document resources as of the month of institutionalization remains intact unless:

- The agency obtains proof that accurate information was not provided at the time of the initial assessment which means another assessment must be completed.
- The couple alleges that the initial assessment was inaccurate and provides proof to show otherwise, in which case a new assessment must be completed.
- The IS leaves the institution for 31 days or longer and then reenters an institution in which case a new assessment must be completed evaluating resources as of the month of reinstitutionalization.

3. Application After Assessment or Instead of Assessment

When an IS applies for Medicaid, all countable resources held by either spouse at the time of institutionalization are considered in order to determine the amount to count as the CS and IS share:

1. If an assessment has been completed, the value of countable resources attributed to the CS and the IS have been determined and all that remains to do is evaluate remaining resources available to the IS to determine if the IS is resource eligible.

2. If an assessment was not requested or completed, the IS and CS shares are determined in the same manner described under the IS/CS Resource Computation.

D. INCOME COMPUTATIONS FOR IS/CS CASES

Use the following rules governing couples' ownership of income to determine the IS share of income to be counted in determining eligibility based on income. These income rules also apply in the Post Eligibility computation (Medicaid Income) for the IS.

1. Income From Non-Trust

Unless evidence to the contrary is presented:

- Consider income paid to one spouse to be the income of that spouse.
- Consider available to each member of the couple one-half of any income paid to both spouses.
- Consider available to each member of a couple amounts equal to each spouse's proportionate share of income paid in the name of either spouse, or both and at least one other party. When income is paid to both spouses and the couple's individual interests are not specified, consider available to each spouse one-half of their joint interest in the income.
- Consider available to each member of the couple one-half of any income which has no instrument establishing ownership.

2. Income From Trust Property

Use ongoing policy regarding trust income except as provided below:

- Consider available to each member of a couple income from trust property in accordance with the specific terms of the trust.
- When a trust instrument is not specific as to the couple's ownership interest, follow the rules specified in Income from Non-Trust Property.

3. **Deeming of IS/CS Income Prohibited**

Do not deem any CS income to be available to the IS for the purpose of determining the IS eligibility for any month of institutionalization, including the month of entry. Note: If the CS applies for Medicaid under an at-home coverage group, do not deem or combine income of the IS to the CS in the month of entry or any month thereafter. SI income rules apply in this instance.

INSTITUTIONALIZATION
RESOURCE/INCOME COMPUTATIONS-NON SI RULES

A. CURRENT POLICY-NON SI LTC CASES

Spousal Impoverishment (SI) rules apply only in LTC cases where one member of a married couple is in an institution and the other spouse remains non-institutionalized in the community. For all other LTC cases that do not fall under SI rules, the following policy is applicable.

1. Children Who Enter LTC

There is no deeming of resources or income from parents to a child under age 18 who enters an institution, not even for the month of entry. Resource and income eligibility is based on resources owned and income received by the child or his/her proportionate share of jointly owned resources or income. Income eligibility is based on the Institutional Income limit and resources are tested against the individual resource limit.

2. Individuals Over Age 18 who Enter LTC

Each individual who enters LTC is tested against the Institutional income limit and the individual resource limit using the individual's own income/resources or his/her proportionate share of jointly owned income/resources.

3. Couples Who Enter LTC

Couples who enter institutions are each treated as individuals effective with the month of entry. Each member of the couple is tested against the individual income and resource limit based on each individual's own income or his/her proportionate share of jointly owned income or resources. This is true regardless of whether the couple enters the same or separate institutions in the same month or different months.

INSTITUTIONALIZATION
RESOURCE/INCOME COMPUTATIONS-NON SI RULES

B. INCOME & RESOURCE POLICY FOR COUPLES PRIOR TO SI POLICY

The income and resource rules specified below apply to individuals who applied for Medicaid prior to 10-01-89. The resource policy specified below continues to apply to individuals institutionalized (for 30-consecutive days or longer) prior to 09-30-89 who remain institutionalized.

1. Eligible Couples

a. One at home, one in an institution

(1) Deeming of income ceases the month after the month of separation. The institutionalized spouse is treated as an individual for income purposes effective with the first full month of institutionalization.

(2) Resources are combined for the first 6 months following the month the couple no longer live together in the same household. An institution is not considered a household. The couple resource limit is used during the 6 month period.

b. Both are in an institution, same facility or different facilities

(1) Income and resources are combined for 6 full months following the month of entry into an institution. The couple resource and income limit applies.

(2) Effective with the 7th month, each member of the couple is treated as an individual for income and resource purposes. The individual income and resource limit applies.

(3) If a couple is ineligible as a couple for income or resource purposes, it is possible to test one member of the couple as an individual with no deeming of income or resources from the ineligible spouse effective with the first full month of institutionalization.

2. Eligible With An Ineligible Spouse

These rules apply regardless of living arrangements.

a. The eligible is treated as an individual for income and resource purposes effective the month after the month the couple no longer share the same household.

b. Consider only the resources owned by the eligible or his/her proportionate share of a jointly owned resource.

INSTITUTIONALIZATION
LTC BUDGETING PROCESS

A. INSTITUTIONAL BUDGET FORM, DOM-336

For each client in LTC, an Institutional Budget (DOM-336) is completed, either in MEDS or on paper, at the time of application and at each Redetermination. The budget form determines:

- eligibility based on income
- coverage group and fulfillment of the 30-consecutive day requirement
- the monthly maintenance needs allowance for a community spouse and/or other dependent family members
- the amount of Medicaid Income

1. Eligibility Based On Income

All individuals applying will have their total income received in the month counted as income for each month eligibility is being determined. Income for eligibility purposes does not include:

- any averaged income. Income subject to averaging is counted in its entirety in the month received for eligibility purposes.
- any VA Aid & Attendance
- gross rental income (consider only net rental income)

When testing total income of the eligible individual against the appropriate Federal Institutional Income limit, the income must be less than the Federal income limit in order for the applicant to be eligible in any month. If the total income is equal to or greater than the appropriate Federal maximum, eligibility must be denied for that month (unless an Income Trust is in effect).

2. **Coverage Group Determination & 30-Consecutive Day Requirement**

For institutional purposes, an individual falls into one of 2 categories:

- Individuals who would be eligible for SSI at-home
- Individuals who would not be eligible for SSI at-home

A determination as to which coverage group the individual would fit into is used for statistical purposes only.

Since there is no deeming of income from parent(s) or an ineligible spouse in any month of institutionalization, the SSI coverage group determination is based on the eligible's income only. If the individual or couple applying already receive SSI at-home, the coverage group is predetermined.

The 30-consecutive day requirement must be documented for any individual who is not Medicaid eligible at home. If the 30-consecutive day requirement is met for those who are not Medicaid eligible at home, the beginning date of Medicaid eligibility is potentially the first of the month of admission provided the applicant is eligible on all other factors for the first partial month.

3. **Monthly Maintenance Needs Allowance For A CS and/or Dependents**

This budgeting is completed only if the institutionalized individual has a community spouse. If the community spouse has other dependents residing in the same home with him/her, an additional allocation to the other dependent(s) may be allowed. Refer to the following subsection, "Medicaid Income Computation," for a complete discussion of this budgeting step.

4. **Medicaid Income**

If an institutional client is determined eligible based on income, then the client's income is then used to determine the client's cost of care, known as Medicaid Income. Refer to the following subsection on the "Medicaid Income Computation" for a complete discussion of this budgeting step.

B. SSI ELIGIBLES ENTERING LTC (SSI-ONLY)

An SSI recipient with no income or gross income less than $50 per month will continue to be eligible for SSI/Medicaid while in a nursing facility. No separate application for Medicaid is required of SSI eligibles who enter LTC whose SSI will continue; however, a review of the client's financial factors of eligibility is required to determine if the SSI recipient is eligible for a vendor payment.

1. SSI-Only Case Record

Each Regional Office is responsible for maintaining an SSI-only case record for each SSI eligible who enters a LTC nursing facility in the region. A Master Card on each SSI-only client must also be prepared.

The case record will consist of:

- Form DOM-260 from the nursing facility to document need for LTC,
- SVES Response and/or TPQ response verifying SSI-status and income from SSA,
- Form DOM-317 from the nursing facility,
- MEDS budget information or DOM-336, Institution Budget,
- Any relevant resource information,
- Notices to the client (DOM-305 or 306).

2. Financial Review of SSI-Only Cases

An independent review of the SSI eligible's income and resources is required to determine if income or resources are available to the client that may or may not affect his/her SSI status but would affect eligibility for a vendor payment or affect payment of Medicaid Income.

SSI payments are not counted as income so it is unlikely that an SSI eligible will have any Medicaid Income payable; however, it is possible that the SSI eligible receives countable income unknown to SSA that must be counted in Institutional budgeting (such as sheltered workshop earnings). If income is received, Medicaid Income for an SSI-only would be payable. Notify SSA of the income via DOM-319.

A vendor payment for an SSI eligible will not be authorized until the ownership of countable resources is developed. Resources must be developed to determine if:

- **excess countable resources exist, or**
- **any transfers of resources exist within 36 months of entering LTC,**
- **a trust or conservatorship exists with excess countable resources.**

If the SSI eligible is determined to be ineligible for a vendor payment based on resources, issue a Notice of Adverse Action, DOM-306, explaining the denial of vendor payments. Notify SSA via DOM-319 of the denial.

Note: Any appeals involving SSI eligibility must be filed with SSA. Any appeals regarding Medicaid Income or a denial of vendor payment must be handled by Medicaid.

3. **Approvals**

A Notice of Approval, DOM-305, must be issued for SSI-only cases determined eligible for a vendor payment. The Notice will report any Medicaid Income payable. DOM-317 must also be issued to the facility verifying the beginning date of eligibility for the vendor payment.

4. Redeterminations An annual review of SSI-only case records must be performed to update all case record information and verify patient status.

5. Changes Any changes that are discovered after the approval of an SSI-only case are handled as follows:

- An increase in Medicaid Income or the subsequent denial of nursing home vendor payments due to excess resources must be handled with a DOM-306, Notice of Adverse Action. Issue DOM-317 to the nursing facility.

- Closures due to death or termination of an SSI payment are handled by SSA but the Regional Office must take appropriate action to close out LTC and Liability in MEDS and issue a DOM-317. The same action is required if the SSI-only recipient is discharged from the facility.

- Any changes that become known to the Regional Office concerning an SSI-only recipient that would affect SSI eligibility must be reported to SSA via DOM-319 and monitored by the Regional Office.

C. SSI ELIGIBLE ENTERS LTC BUT SSI TERMINATES (SSI TO MAO)

SSI eligibles whose SSI terminates upon entry into LTC or anytime after entry require a redetermination of their eligibility for continued Medicaid coverage as LTC. If the SSI recipient is terminated by SSA due to income or resources will be issued an SSI Redetermination Form, DOM-300B, as outlined in Section C, Applications/Redeterminations. If the SSI terminates for any reason other than income or resources, a MAO application is required to establish LTC coverage for the former SSI recipient.

MAO LTC coverage cannot be approved until SSI/Medicaid terminates. However, Medicaid Income must be calculated during the SSI to MAO period if the client is eligible for a vendor payment. Note: An SSI to MAO client who is ineligible based on excess resources (or a trust or conservatorship) will not be eligible for a vendor payment, the same as for an SSI-only client.

If the SSI to MAO client is determined resource eligible during the SSI months, handle as follows:

- Issue DOM-305 to the client reporting Medicaid Income payable and the effective date of vendor payment eligibility. Do not count any SSI payment received by the client as Income or Medicaid income.

- Issue DOM-317 to the nursing facility

- Issue DOM-319 to SSA to inform SSA that the recipient is in a nursing facility.

The MAO portion of the application or redetermination process will be completed per ongoing policy.

D. AFDC OR FOSTER CHILDREN ENTERING LTC

When an AFDC, AFDC-related or Foster Child receiving Medicaid with DHS as the source enters LTC, a separate application for LTC coverage is required, or is not required, as follows:

- If the admission is to a PRTF (Psychiatric Residential Treatment Facility), no separate application for Medicaid as MAO is required as long as the DHS source of eligibility remains open. A vendor payment to the PRTF can be authorized by entering the case in MEDS as "SSI/DHS Only."

- If an admission to a LTC Nursing Facility or ICF-MR will be or is less than 30-consecutive days, no separate application for LTC Medicaid is required. A vendor payment to the facility can be authorized by entering the case in MEDS as "SSI/DHS Only."

- If an admission to a LTC Nursing Facility or ICF-MR will be or is more than 30-consecutive days, a separate application for MAO or SSI as a disabled individual must be filed for the child. DDS must determine that the child is disabled and the child must be income/resource eligible before the nursing facility vendor payment will be authorized.

1. MAO or SSI Application Filed

If a LTC Nursing Facility or ICF-MR placement will exceed 30-consecutive days, an application for MAO coverage in LTC must be filed with the Regional Office that handles the county either where the parent(s) live or where the county DHS office with custody is located.

If preferred, the parent or DHS office with custody can file an application for SSI for the child. The Regional Office handling the case for vendor payment purposes must verify with SSA that an application for the child has been filed.

2. Authorizing LTC Vendor Payment for Nursing Facility or ICF-MR Placements

During the application period for MAO or SSI the case can be set up in MEDS the same as an "SSI/DHS only" case. An approved 260 Form must be obtained (if appropriate) and the child's income and resources verified prior to authorizing the vendor payment. A notice to the representative and a 317 to the facility is then required.

If the child is determined eligible for LTC on all factors, the Regional Office must advise the county DHS office to terminate the child's Medicaid eligibility through AFDC or foster care if they have not already done so. Once the DHS is closed, the MAO application can be approved in MEDS.

If the child is not eligible for LTC, the vendor payment must be terminated by the Regional Office regardless of whether DHS closes out the child's Medicaid eligibility for AFDC or foster care.

3. DHS-Only Case Records for PRTF Admissions

The PRTF facility, whether in State or out of State, must issue a DOM-317 to the appropriate Regional Office advising of the admission. Upon receipt of the DOM-317, the Regional Office will:

- Set up a "DHS-Only" case record for the purpose of calculating liability and LTC and filing notices/317's. The child's income must be verified only if the child receives income in his/her own name. Do not count any portion of a TANF payment or Foster Care payment as Medicaid Income unless the income is made available to the child. Issue the DOM-317 to the PRTF.

- The case will be set up in MEDS as "SSI/DHS-Only." DO NOT ENTER THE PRTF ADDRESS AS EITHER THE CARD MAILING OR NOTICE MAILING ADDRESS. All notices and the Medicaid card must be issued to the parent or representative of the child or to the DHS county office with custody of the child.

- Check with the PRTF at least every 3 months to make sure the child is still a resident of the facility.

E. MAO AT-HOME ELIGIBLES ENTERING LTC

If a MAO eligible at-home enters a nursing home, a redetermination of eligibility is required, i.e., the MAO at-home case will not close if the eligible remains Medicaid eligible in the institution. This means a level of care decision is required via DOM-260 and a 317 Form from the nursing home is required documenting the date of entry.

If the recipient remains MAO eligible, send a DOM-305 advising of the amount of Medicaid Income payable. If the at-home eligible is ineligible for LTC, issue advance notice to close the case.

F. MAO APPLICATION NO PREVIOUS ELIGIBILITY

An application for LTC Medicaid coverage is required for anyone entering LTC who is not already Medicaid eligible as an MAO at-home eligible or SSI eligible.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

A. GENERAL

Once an individual has been determined eligible for Medicaid in a medical institution, the individual must pay toward the cost of his/her care provided his/her income exceeds allowable deductions outlined in this subsection. The payment the client is liable for is referred to as Medicaid Income (MI). It is paid to the medical facility and consists of the client's total income less allowable deductions. The Medicaid Income computation is part of the institutional budgeting process; however, it is a post-eligibility computation used only to determine the client's liability amount for the cost of care. The Medicaid Income computation process differs from the eligibility budgeting process as outlined in this subsection.

1. Eligible Couples Treated as Individuals

Each eligible individual is treated as an individual in determining the amount of MI payable, even though the individual may be marred to another individual who is also in LTC and Medicaid eligible. Each member of a couple is treated as an individual for MI purposes effective with the month of entry.

2. Medicare Covered Days - No MI Payable

Medicare covers skilled nursing home care for up to 100 days per calendar year provided the facility is Medicare (Title XVIII) certified and the individual is hospitalized at least 3 days before admission to a skilled nursing facility. Medicare covers the first 20 days at 100% of the expense. For the 21st-100th day, there is a co-insurance charge which Medicaid will pay if the individual is Medicaid eligible.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

Medicaid applications for long term care are handled as per ongoing policy for individuals in skilled care where Medicare is the primary payor. Medicaid Income is computed for these individuals and reported to the facility; however, Medicaid Income is not payable until Medicaid begins reimbursement (not co-insurance) for nursing home care. As a result, income for a Medicaid eligible may accumulate during his/her Medicare covered days and excess resources may result. For this reason, explanations should be made to a client or representative regarding income that may accumulate and cause Medicaid ineligibility during this time. The worker should explain allowable means of spending excess resources.

Note: No MI is payable by a Medicaid client during the first 100 days of care as long as Medicare is the primary payer of the nursing care. No MI is payable during co-insurance days. The only instance where MI is payable is if Medicaid becomes primary payer during the 100-day period. This can occur if client is admitted to a hospital and the nursing facility holds the client's bed. In this situation, the nursing facility must "discharge" the client as a Medicare patient and "admit" the client as a Medicaid patient, thus making MI payable.

B. INCOME USED IN THE MI COMPUTATION

In computing MI, only the eligible individual's income is considered. Deemed income is never included in the MI computation. The MI computation begins with the eligible's income only.

The eligible's income to consider is the total income received in the month of the computation with the exception of the following:

- Total income does not include any SSI payments received by the eligible. Do not count any SSI payment received for any month of institutionalization in the Medicaid Income computation.

- Total income does not include the full amount of any irregular or infrequent income subject to averaging. Income of this type is averaged first before adding the averaged amount to the eligible's total income.

1. Nonrecurring Lump Sum Payments

Certain lump sum payments are excluded from income determinations (for eligibility purposes) while others are not excluded. Income eligibility policy specifies the types of payments considered as income in the eligibility computation. However, in determining whether income, such as a lump sum payment, should be counted as income in the Medicaid Income computation, the general rule is to determine whether the payment has previously been counted as income for MI purposes. Two examples will illustrate:

- A former SSI recipient currently in a nursing home receives a retroactive title II payment that meets the qualifications for excluding the payment from income in the Eligibility Test, i.e., the payment has been reduced by the amount of SSI payments previously received, so it is not counted as income according to SSI policy. Although the payment can be excluded as income for eligibility purposes, it cannot be excluded as income in the Medicaid Income computation because the retroactive title II payment has not previously been counted as income for Medicaid Income purposes. In this instance, the lump sum title II payment is counted as income in the month received in the Medicaid Income computation only if there is sufficient time to count the payment.

- A nursing home recipient who receives a VA pension has his VA benefits suspended for failure to verify medical expenses. The recipient remains entitled to his full VA payment, therefore, the full basic pension amount of the VA benefit continues to count as income in both the Eligibility Test and the MI computation. However, when the recipient receives a lump sum payment from VA which represents payments previously suspended, the lump sum payment is not counted as income for eligibility or Medicaid Income purposes. This is because the payment has previously been counted as income in both computations.

2. Recurring Lump Sum Payments

If a payment is recurring, such as annual rental payments, the policy governing irregular and infrequent income applies, which means the payment is subject to averaging.

One-time (nonrecurring) lump sum payments are not subject to averaging and are handled according to the lump sum payment policy described above. If a payment has not been previously counted as income, the payment is subject to being counted as income in the month received in the Medicaid Income computation.

C. AVERAGING INCOME IN THE MI COMPUTATION

Recurrent income that varies in amount and/or frequently be averaged in the MI computation provided the client is eligible based on income in the month the payment is received without averaging. For eligibility purposes, all income is counted in the month it is received. If the client is eligible based on income in the Eligibility Test, the provision requiring averaging for Medicaid Income purposes applies. If the client is ineligible based on income when counting irregular or infrequent income in the month of receipt, do not average the payment in the Medicaid Income computation.

Averaging applies in the Medicaid Income computation since it is a post-eligibility budgeting procedure. Income averaging is applicable only when determining the amount of the client's gross income for Medicaid Income purposes and when determining the amount of income for a community spouse or dependent for allocating purposes. The computation used to obtain an average, as explained below, must be documented in the case record.

1. Monthly Income That Varies

Income received monthly in amounts that vary must be averaged over a 12-month period using the 3 most recent monthly payments available to obtain the averaged amount. When projecting the averaged amount over a 12-month period, allow for any known changes that will occur in the income.

If the 3 most recent payments are not available, document the case and use the best available information. In certain instances, it would not be appropriate to use the most recent 3 months payments. For example, the monthly payment may not have started being paid until a month or 2 before the average is being determined. Or, the payment may have been reduced drastically over the 3 most recent payments and there is no reason to suspect that the monthly payment would ever again increase to a higher level. In either case or in similar situations, justify the reason for using a different average from the most recent 3 payments.

2. Infrequent Income

Income received non-monthly is averaged over the period of time the payment is intended to cover provided the payment was counted as income in the month last received and the client was eligible when counting the payment. Infrequent income that is not counted as income in the month received is treated as a countable resource in subsequent months.

The stipulation that infrequent income must be counted as income in the month received before it is subject to averaging avoids averaging "after the fact" when the income may no longer be available to the client for averaging. When infrequent income is treated as income in the month received and subsequently averaged, the client must be notified that the payment will be averaged over the period it is intended to cover and availability will not be an issue.

An example of infrequent income averaging as explained above would be an applicant who receives annual land rent income. The last payment was received six months prior to application and another payment is expected in six months. When determining eligibility, the land rent payment is not subject to averaging since it was not counted in the month received. However, a tickler must be set so that the next rent payment received can be counted and, if eligible, averaged over the next 12 months.

Infrequent payments are averaged over the period of time the payment is intended to cover, i.e., annual payments are averaged over 12 months, quarterly payments over three months, and so on. One-time payments are not recurrent income and are not subject to averaging but are counted as income in the month received, if applicable, for Medicaid Income purposes.

D. PROTECTION OF INCOME

FOR MONTH OF ENTRY

Individuals determined eligible for long-term care in the month of entry into a medical facility are entitled to protection of income. This means that if the recipient is eligible for the month of entry, the recipient pays no Medicaid Income for any partial month of entry. The purpose of protecting income is to allow for essential expenses incurred by the recipient in connection with admission to a medical facility. Protection of income does not apply for recipients who transfer into a medical facility from another medical facility.

Income is "protected" by reducing MI to $0 for the month of entry into a nursing facility. Medicaid Income is payable, if applicable, effective with the first full month in the facility (if determined eligible for that month). Medicaid Income amounts are shown on the DOM-317 and the notice to the client.

For the month of discharge from or death in a medical facility, a recipient's income is not reduced to zero (protected). Medicaid Income is, however, prorated based on the number of days the recipient resided in the facility during the last month.

The fiscal agent determines the amount of Medicaid Income payable from a recipient in any partial month of institutionalization due to death, discharge or transfer. Form DOM-317 notifies the fiscal agent and the facility of the necessity to prorate the patient's income since the income figure shown represents a full month's income.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

E. PERSONAL NEEDS ALLOWANCE (PNA) DEDUCTION

The first type of deduction from a client's total income is the allowance of a PNA deduction. The PNA is intended to cover the cost of personal needs on a monthly basis (such as toiletries, etc.) that are not covered by Medicaid. The amount of each individual's PNA is determined as follows:

1. $44 PNA

Each individual in LTC is entitled to at least a $44 monthly PNA provided income equals $44. Individuals in LTC who have income less than $44, such as SSI eligible individuals who receive a $30 monthly SSI payment, are entitled to keep the full amount of their income up to $44 per month to meet their personal needs.

2. $88 PNA

Each individual engaged in work or work therapy programs (such as enrollment in a sheltered workshop) and individuals who engage in activities such as the making of handicrafts for sale on a regular basis are entitled to a higher PNA of $88 per month. The higher PNA is allowed for these individuals to allow for increased personal need expenses related to their work.

Note: Individuals who earn in excess of the increased PNA per month will have the excess counted in determining the remaining deductions and the resulting Medicaid Income. Individuals who earn less than the PNA of $88 per month are entitled to the full $88 allowance nonetheless.

For example, an individual in an institution with $90 per month in average earnings will be entitled to an $88 PNA the same as an individual with only $30 per month in average earnings.

Earned income must be shown in MEDS as wages in order for the $88 PNA to apply.

3. Additional Work Deduction

Effective July 1, 2000, individuals with wages greater than $44 will have their wages reduced by an amount that is 2 the SSI FBR, less the $44 PNA. The resulting amount is added to any other income and the $44 PNA is deducted from the remaining income. Each year, as the SSI FBR increases, the deduction for wages will increase.

Example: An institutional individual has $450 in wages and $550 Social Security.

$450 - Wages
-212 - 2 FBR ($512. 2 = $256) - $44 PNA
$238 - Excess (countable) earnings
+550 - RSDI benefits
$788 - Total Income
- 44 - PNA
$744 - Medicaid Income

Individuals with wages less than $44 will continue to receive the $88 PNA.

4. $90 PNA

For single veterans and surviving spouses of veterans in nursing homes who are subject to the reduced pension, the PNA is equal to the reduced pension payment. If the pension payment is $90, the PNA is $90. Note: If the pension payment is less than $44 (or $88 if the client works), the PNA would be $44 or $88, whichever applies and is greater than the reduced pension.

The client gets to keep the entire payment for personal needs but does not receive an additional PNA along with the pension. Note: Receipt of a lump sum retroactive reduced pension payment is not reflected in the client's budget. Do not adjust the PNA retroactively. Instead, the payment is free and clear. The payment may affect resources in subsequent months.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

A. GENERAL

Once an individual has been determined eligible for Medicaid in a medical institution, the individual must pay toward the cost of his/her care provided his/her income exceeds allowable deductions outlined in this subsection. The payment the client is liable for is referred to as Medicaid Income (MI). It is paid to the medical facility and consists of the client's total income less allowable deductions. The Medicaid Income computation is part of the institutional budgeting process; however, it is a post-eligibility computation used only to determine the client's liability amount for the cost of care. The Medicaid Income computation process differs from the eligibility budgeting process as outlined in this subsection.

1. Eligible Couples Treated as Individuals

Each eligible individual is treated as an individual in determining the amount of MI payable, even though the individual may be marred to another individual who is also in LTC and Medicaid eligible. Each member of a couple is treated as an individual for MI purposes effective with the month of entry.

2. Medicare Covered Days - No MI Payable

Medicare covers skilled nursing home care for up to 100 days per calendar year provided the facility is Medicare (Title XVIII) certified and the individual is hospitalized at least 3 days before admission to a skilled nursing facility. Medicare covers the first 20 days at 100% of the expense. For the 21st-100th day, there is a co-insurance charge which Medicaid will pay if the individual is Medicaid eligible.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

Medicaid applications for long term care are handled as per ongoing policy for individuals in skilled care where Medicare is the primary payor. Medicaid Income is computed for these individuals and reported to the facility; however, Medicaid Income is not payable until Medicaid begins reimbursement (not co-insurance) for nursing home care. As a result, income for a Medicaid eligible may accumulate during his/her Medicare covered days and excess resources may result. For this reason, explanations should be made to a client or representative regarding income that may accumulate and cause Medicaid ineligibility during this time. The worker should explain allowable means of spending excess resources.

Note: No MI is payable by a Medicaid client during the first 100 days of care as long as Medicare is the primary payer of the nursing care. No MI is payable during co-insurance days. The only instance where MI is payable is if Medicaid becomes primary payer during the 100-day period. This can occur if client is admitted to a hospital and the nursing facility holds the client's bed. In this situation, the nursing facility must "discharge" the client as a Medicare patient and "admit" the client as a Medicaid patient, thus making MI payable.

B. INCOME USED IN THE MI COMPUTATION

In computing MI, only the eligible individual's income is considered. Deemed income is never included in the MI computation. The MI computation begins with the eligible's income only.

The eligible's income to consider is the total income received in the month of the computation with the exception of the following:

- Total income does not include any SSI payments received by the eligible. Do not count any SSI payment received for any month of institutionalization in the Medicaid Income computation.

- Total income does not include the full amount of any irregular or infrequent income subject to averaging. Income of this type is averaged first before adding the averaged amount to the eligible's total income.

1. Nonrecurring Lump Sum Payments

Certain lump sum payments are excluded from income determinations (for eligibility purposes) while others are not excluded. Income eligibility policy specifies the types of payments considered as income in the eligibility computation. However, in determining whether income, such as a lump sum payment, should be counted as income in the Medicaid Income computation, the general rule is to determine whether the payment has previously been counted as income for MI purposes. Two examples will illustrate:

- A former SSI recipient currently in a nursing home receives a retroactive title II payment that meets the qualifications for excluding the payment from income in the Eligibility Test, i.e., the payment has been reduced by the amount of SSI payments previously received, so it is not counted as income according to SSI policy. Although the payment can be excluded as income for eligibility purposes, it cannot be excluded as income in the Medicaid Income computation because the retroactive title II payment has not previously been counted as income for Medicaid Income purposes. In this instance, the lump sum title II payment is counted as income in the month received in the Medicaid Income computation only if there is sufficient time to count the payment.

- A nursing home recipient who receives a VA pension has his VA benefits suspended for failure to verify medical expenses. The recipient remains entitled to his full VA payment, therefore, the full basic pension amount of the VA benefit continues to count as income in both the Eligibility Test and the MI computation. However, when the recipient receives a lump sum payment from VA which represents payments previously suspended, the lump sum payment is not counted as income for eligibility or Medicaid Income purposes. This is because the payment has previously been counted as income in both computations.

2. Recurring Lump Sum Payments

If a payment is recurring, such as annual rental payments, the policy governing irregular and infrequent income applies, which means the payment is subject to averaging.

One-time (nonrecurring) lump sum payments are not subject to averaging and are handled according to the lump sum payment policy described above. If a payment has not been previously counted as income, the payment is subject to being counted as income in the month received in the Medicaid Income computation.

C. AVERAGING INCOME IN THE MI COMPUTATION

Recurrent income that varies in amount and/or frequently be averaged in the MI computation provided the client is eligible based on income in the month the payment is received without averaging. For eligibility purposes, all income is counted in the month it is received. If the client is eligible based on income in the Eligibility Test, the provision requiring averaging for Medicaid Income purposes applies. If the client is ineligible based on income when counting irregular or infrequent income in the month of receipt, do not average the payment in the Medicaid Income computation.

Averaging applies in the Medicaid Income computation since it is a post-eligibility budgeting procedure. Income averaging is applicable only when determining the amount of the client's gross income for Medicaid Income purposes and when determining the amount of income for a community spouse or dependent for allocating purposes. The computation used to obtain an average, as explained below, must be documented in the case record.

1. Monthly Income That Varies

Income received monthly in amounts that vary must be averaged over a 12-month period using the 3 most recent monthly payments available to obtain the averaged amount. When projecting the averaged amount over a 12-month period, allow for any known changes that will occur in the income.

If the 3 most recent payments are not available, document the case and use the best available information. In certain instances, it would not be appropriate to use the most recent 3 months payments. For example, the monthly payment may not have started being paid until a month or 2 before the average is being determined. Or, the payment may have been reduced drastically over the 3 most recent payments and there is no reason to suspect that the monthly payment would ever again increase to a higher level. In either case or in similar situations, justify the reason for using a different average from the most recent 3 payments.

2. Infrequent Income

Income received non-monthly is averaged over the period of time the payment is intended to cover provided the payment was counted as income in the month last received and the client was eligible when counting the payment. Infrequent income that is not counted as income in the month received is treated as a countable resource in subsequent months.

The stipulation that infrequent income must be counted as income in the month received before it is subject to averaging avoids averaging "after the fact" when the income may no longer be available to the client for averaging. When infrequent income is treated as income in the month received and subsequently averaged, the client must be notified that the payment will be averaged over the period it is intended to cover and availability will not be an issue.

An example of infrequent income averaging as explained above would be an applicant who receives annual land rent income. The last payment was received six months prior to application and another payment is expected in six months. When determining eligibility, the land rent payment is not subject to averaging since it was not counted in the month received. However, a tickler must be set so that the next rent payment received can be counted and, if eligible, averaged over the next 12 months.

Infrequent payments are averaged over the period of time the payment is intended to cover, i.e., annual payments are averaged over 12 months, quarterly payments over three months, and so on. One-time payments are not recurrent income and are not subject to averaging but are counted as income in the month received, if applicable, for Medicaid Income purposes.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

D. PROTECTION OF INCOME

FOR MONTH OF ENTRY

Individuals determined eligible for long-term care in the month of entry into a medical facility are entitled to protection of income. This means that if the recipient is eligible for the month of entry, the recipient pays no Medicaid Income for any partial month of entry. The purpose of protecting income is to allow for essential expenses incurred by the recipient in connection with admission to a medical facility. Protection of income does not apply for recipients who transfer into a medical facility from another medical facility.

Income is "protected" by reducing MI to $0 for the month of entry into a nursing facility. Medicaid Income is payable, if applicable, effective with the first full month in the facility (if determined eligible for that month). Medicaid Income amounts are shown on the DOM-317 and the notice to the client.

For the month of discharge from or death in a medical facility, a recipient's income is not reduced to zero (protected). Medicaid Income is, however, prorated based on the number of days the recipient resided in the facility during the last month.

The fiscal agent determines the amount of Medicaid Income payable from a recipient in any partial month of institutionalization due to death, discharge or transfer. Form DOM-317 notifies the fiscal agent and the facility of the necessity to prorate the patient's income since the income figure shown represents a full month's income.

E. PERSONAL NEEDS ALLOWANCE (PNA) DEDUCTION

The first type of deduction from a client's total income is the allowance of a PNA deduction. The PNA is intended to cover the cost of personal needs on a monthly basis (such as toiletries, etc.) that are not covered by Medicaid. The amount of each individual's PNA is determined as follows:

1. $44 PNA

Each individual in LTC is entitled to at least a $44 monthly PNA provided income equals $44. Individuals in LTC who have income less than $44, such as SSI eligible individuals who receive a $30 monthly SSI payment, are entitled to keep the full amount of their income up to $44 per month to meet their personal needs.

2. $88 PNA

Each individual engaged in work or work therapy programs (such as enrollment in a sheltered workshop) and individuals who engage in activities such as the making of handicrafts for sale on a regular basis are entitled to a higher PNA of $88 per month. The higher PNA is allowed for these individuals to allow for increased personal need expenses related to their work.

Note: Individuals who earn in excess of the increased PNA per month will have the excess counted in determining the remaining deductions and the resulting Medicaid Income. Individuals who earn less than the PNA of $88 per month are entitled to the full $88 allowance nonetheless.

For example, an individual in an institution with $90 per month in average earnings will be entitled to an $88 PNA the same as an individual with only $30 per month in average earnings.

Earned income must be shown in MEDS as wages in order for the $88 PNA to apply.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

3. **Additional Work Deduction**

Effective July 1, 2000, individuals with wages greater than $44 will have their wages reduced by an amount that is 2 the SSI FBR, less the $44 PNA. The resulting amount is added to any other income and the $44 PNA is deducted from the remaining income. Each year, as the SSI FBR increases, the deduction for wages will increase.

Example: An institutional individual has $450 in wages and $550 Social Security.

$450 - Wages
-212 - 2 FBR ($512. 2 = $256) - $44 PNA
$238 - Excess (countable) earnings
+550 - RSDI benefits
$788 - Total Income
- 44 - PNA
$744 - Medicaid Income

Individuals with wages less than $44 will continue to receive the $88 PNA.

4. **$90 PNA**

For single veterans and surviving spouses of veterans in nursing homes who are subject to the reduced pension, the PNA is equal to the reduced pension payment. If the pension payment is $90, the PNA is $90. Note: If the pension payment is less than $44 (or $88 if the client works), the PNA would be $44 or $88, whichever applies and is greater than the reduced pension.

The client gets to keep the entire payment for personal needs but does not receive an additional PNA along with the pension. Note: Receipt of a lump sum retroactive reduced pension payment is not reflected in the client's budget. Do not adjust the PNA retroactively. Instead, the payment is free and clear. The payment may affect resources in subsequent months.

E. PERSONAL NEEDS ALLOWANCE (PNA) DEDUCTION

The first type of deduction from a client's total income is the allowance of a PNA deduction. The PNA is intended to cover the cost of personal needs on a monthly basis (such as toiletries, etc.) that are not covered by Medicaid. The amount of each individual's PNA is determined as follows:

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2. $88 PNA

Each individual engaged in work or work therapy programs (such as enrollment in a sheltered workshop) and individuals who engage in activities such as the making of handicrafts for sale on a regular basis are entitled to a higher PNA of $88 per month. The higher PNA is allowed for these individuals to allow for increased personal need expenses related to their work.

Note: Individuals who earn in excess of the increased PNA per month will have the excess counted in determining the remaining deductions and the resulting Medicaid Income. Individuals who earn less than the PNA of $88 per month are entitled to the full $88 allowance nonetheless.

For example, an individual in an institution with $90 per month in average earnings will be entitled to an $88 PNA the same as an individual with only $30 per month in average earnings.

Earned income must be shown in MEDS as wages in order for the $88 PNA to apply.

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Effective July 1, 2000, individuals with wages greater than $44 will have their wages reduced by an amount that is 2 the SSI FBR, less the $44 PNA. The resulting amount is added to any other income and the $44 PNA is deducted from the remaining income. Each year, as the SSI FBR increases, the deduction for wages will increase.

Example: An institutional individual has $450 in wages and $550 Social Security.

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-212 - 2 FBR ($512. 2 = $256) - $44 PNA
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Individuals with wages less than $44 will continue to receive the $88 PNA.

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For single veterans and surviving spouses of veterans in nursing homes who are subject to the reduced pension, the PNA is equal to the reduced pension payment. If the pension payment is $90, the PNA is $90. Note: If the pension payment is less than $44 (or $88 if the client works), the PNA would be $44 or $88, whichever applies and is greater than the reduced pension.

The client gets to keep the entire payment for personal needs but does not receive an additional PNA along with the pension. Note: Receipt of a lump sum retroactive reduced pension payment is not reflected in the client's budget. Do not adjust the PNA retroactively. Instead, the payment is free and clear. The payment may affect resources in subsequent months.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

F. CS MONTHLY MAINTENANCE NEEDS ALLOWANCE (MMNA)

A Monthly Maintenance Needs Allowance (MMNA) is calculated for a CS provided:

- The Institutionalized Spouse (IS) and the Community Spouse (CS) are legally married under State law; and,
- The MMNA is actually made available to or for the benefit of the CS and this can be documented, and,
- The CS remains in a private living arrangement and remains married to the IS. The MMNA ends the month after a CS enters an institution or is no longer a CS through death or divorce.

If the IS refuses to make the MMNA available to his/her CS, discontinue the MMNA in the current month.

The Maximum MMNA Allowed By Federal Law Is the need standard used to calculate the MMNA for the CS. The MMNA standard applicable is the maximum in effect in the budget month. The "Community Spouse Monthly Maintenance" limits in effect since 10-01-89 are located in the Appendix, Page 1.

The MMNA is reduced by:

- the CS' own income. Use "gross" income of the CS, whether earned or unearned, to determine the MMNA. Infrequent or varying monthly income of the CS is averaged to obtain the CS' monthly income amount.
- the income limit for a long term care recipient, i.e., the federal maximum
- the PNA of the IS which must be deducted from the income of the IS first before a CS allowance can be deducted.

G. OTHER FAMILY MEMBERS (MMNA)

Certain other family members are entitled to a Monthly Maintenance Needs Allowance (MMNA). The calculation of the allowance differs depending on whether there is also a CS living with the other family members or no CS.

1. Family Members and CS Live Together

Certain other family members are entitled to an MMNA provided the dependent resides with the CS and provided the IS has income remaining after deducting the PNA and CS allowance from the income of the IS.

Deduct allowance(s) for other family members regardless of whether the allowance is made available to such persons by the IS. This is the opposite of the CS allowance requirement whereby the CS allowance must be made available to the CS by the IS before the deduction is allowed.

Other Family Members Include:

- children under age 21 who live with a CS
- children age 21 and older who live with a CS and who may be claimed as dependents by either the IS or CS for tax purposes
- dependent parent(s) of either the IS or CS. who reside with the CS and who may be claimed as dependent(s) by either the IS or CS for tax purposes
- dependent sibling(s) of either the IS or CS (brother, sister, half siblings or adopted siblings) who reside with the CS and who may be claimed as dependent(s) by either the IS or CS for tax purposes

The family member maximum, which is the need standard used to calculate each family member's MMNA, is listed in the "Chart of Need Standards and Resource Limits" located in the Appendix under Spousal Impoverishment Maximums.

The MMNA for each family member is an amount equal to 1/3 of any deficit remaining after gross income is applied to a family member maximum.

Each family member's MMNA is calculated separately, as follows:

Family Member Maximum
-Family Member's Own Income
Difference divided by 1/3 = that Family Member's MMNA

Note: The dependent family member has the same option as the CS to refuse all or a portion of the MMNA if the extraincome will result in SSI or Medicaid ineligibitliy. If any dependent refuses his/her allowance, obtain the refusal in writing for the case record.

2. Dependent Child(ren) At-Home - No CS

The MMNA for dependents cited above applies only when there is a community spouse living in the household with the dependent(s). If an IS has a dependent child or children under 18 who live in the community but no community spouse due to death or divorce or abandonment, the MMNA for the child(ren) is based on AFDC requirements for the number of dependent children (including step-children) of the IS. The AFDC requirements are listed in the Appendix.

To determine the appropriate allowance for child(ren) when there is no CS, use the AFDC requirement for the total number of children of the IS and subtract the total income of the child(ren) to arrive at the monthly allowance to be deducted from the IS income. Do not reduce this amount by 1/3.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

Liberalized Policy

Effective 07-01-99, to determine the appropriate allowance for child(ren) when there is no CS, use the following calculation:

Family Member Maximum
- Family Member's Own Income
Difference divided by 1/3 = that Family Member's MMNA

When a child reaches age 18, the allowance must be discontinued in these types of cases.

H. HEALTH INSURANCE PREMIUM DEDUCTION

A health insurance premium incurred by a recipient that is not subject to payment by a third party is an allowable deduction from the recipient's Medicaid Income. This deduction is limited to one health insurance premium per recipient provided the recipient pays the premium out of his own funds. If a recipient owns more than one health insurance policy, the recipient must choose the one premium that is to be claimed as a deduction.

1. Verification Required

Before a health insurance premium is allowed as a deduction, the recipient or representative must verify that the recipient is the one who pays the expense. In addition, verification must be submitted to show that the recipient is the insured, the amount of the premium and the period of time the premium covers. Failure to verify the expense properly will result in the disallowance of the expense.

The recipient or representative must submit any and all official documentation necessary to verify the information specified above. Copies of premium notices, the health insurance policy, and/or other official notices may be required. All verification submitted must be photocopied and filed in the case record to clearly document the allowance of the expense.

Form DOM-339, Statement Regarding Payment of Health Insurance Premiums and Non-Covered Medical Expenses, will be used in conjunction with the client's own records, to verify payment of a health insurance premium. A DOM-339 will be issued on an annual basis, in accordance with the instructions for the form, even if the expense is paid monthly.

2. Retrospective Budgeting of Health Insurance Premiums

The premium that the recipient claims will be allowed as a one-time deduction in the third month following the month in which the premium is billed. Recipient cases with premiums claimed are reworked quarterly, if applicable (if a premium was billed in the previous quarter). Quarters are divided as follows:

Oct	Jan	Apr	July
Nov	Feb	May	Aug
Dec	Mar	June	Sept

Premiums billed in October are allowed as a one-time expense in January. Likewise, premiums billed in November are allowed in February. Premium expenses billed monthly are deducted retrospectively, also; however, it is only necessary to verify and recalculate amounts on a quarterly basis. Premiums are deducted in one month only (in Institutional budgeting) in the month which is the third month following the month billed. If the premium amount exceeds the recipient's Medicaid Income, any excess is not carried over into subsequent months.

Health Insurance will be verified once per year regardless of whether the expense is allowed monthly, quarterly, semi-annually or annually.

Policy Liberalization

Effective April 1, 2001, health insurance premiums will be allowed in the current month that the premium is billed. Retrospective budgeting will no longer be used.

3. **Effective Date of Premium Deduction**

For newly approved Medicaid eligibles, i.e., the client was not Medicaid eligible upon entry into LTC, the first month a health insurance premium is allowed is the third month following the month in which the premium is billed. The premium must be billed in or after the month of initial eligibility. For example, if an annual premium is billed in October and eligibility does not begin until November, the premium cannot be allowed until the quarter after the quarter of the next billing.

For Medicaid eligibles who enter LTC, i.e., the client enters LTC eligible as SSI or MAO (any existing MAO coverage group), a health insurance premium billed in the quarter prior to entry can be allowed in the quarter of entry into LTC. The premium is deducted retrospectively; however, a premium billed in the quarter prior to entry is an allowable deduction in the first quarter provided the client was eligible (as SSI or MAO) in the month billed. For example, a PLAD eligible is billed for a quarterly health insurance premium in August and enters a nursing home in October. The August premium is an allowable expense in November if properly verified.

Note: Allow a health insurance premium deductions to begin in the first quarter following the expiration of a transfer penalty provided the client was eligible for all other services during the transfer penalty and was billed in the previous quarter for the premium.

Effective April 1, 2001, a health insurance premium deduction will be allowed in the current month that premium is billed provided the transfer penalty has expired.

4. **Reconciliation in Last Quarter of Eligibility**

When an institutionalized recipient becomes ineligible for Medicaid, dies or leaves the institution, the worker must make a final one time adjustment to reconcile the allowable expenses from the previous quarter and the expenses incurred in the last quarter of eligibility. This one time adjustment will allow the previous quarter's expenses and the final quarter's expenses as a one time deduction in the month of ineligibility.

For example: Client dies in January. In the month of January, the current budget reflects actual expenses incurred in October. A one-time adjustment must now be made to allow expenses that would have been deducted for November, December and January in order to reconcile all expenses that would have been allowed had the client lived and remained eligible.

This will require verification of the final quarter's allowable expenses up until the client become ineligible or dies. Verification will be obtained via DOM-339 allowing 10 days for verification to be submitted.

Note: If the client was ineligible in the previous quarter, allow only final quarter expenses in the reconciliation. For example, if a client becomes eligible and dies in the same quarter, allow expenses in the month(s) prior to and including the month of death as a one time deduction.

A reconciliation for health insurance will be completed in order to bring the budget in line with allowing the premium in the current month. After this reconciliation has been completed, there will not be a reconciliation during the month of death. Applications approved after April 1, 2001, will not require a reconciliation.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

I. NON-COVERED MEDICAL EXPENSE DEDUCTION

Certain incurred non-covered medical expenses that a recipient must pay out of funds belonging to the recipient can be allowed as a Medicaid Income deduction provided the expenses are not subject to payment by any insurance policy or any other individual. The only allowable "non-covered" medical expenses are those that are covered under the State Plan but, due to service limits placed on these services, the expenses were not covered by Medicaid. In other words, allowable expenses are limited to "covered" non-covered medical expenses.

1. Allowable Expenses

Expenses that can be allowed are limited to the following:

- Physician visits in excess of the 12-per-year limit. This is limited to those few recipients who are not eligible for Medicare since there are no physician visit limits on Medicare/Medicaid recipients. If a Medicare claim is non-assigned (which means the doctor did not accept assignment thereby preventing a claim from crossing-over to Medicaid for payment of the deductible and/or coinsurance) do not accept the expense as non-covered. The Medicaid Program will pay the Medicare deductibles and coinsurance on any assigned claim; therefore, it is necessary for the recipient to find a participating physician so as to benefit from the unlimited coverage of Part B physician services under the Medicare Program.

- Inpatient hospital days in excess of 30 per year.

Non-covered Medicaid expenses, such as eyeglasses, dentures, hearing aids, durable medical equipment or any expense paid by a third party, are not allowed as deductions from Medicaid Income. (Mississippi's non-covered medical expense policy is based on recognized State Plan Services; therefore, the above-listed expenses are not allowed as a deduction, as they are not covered items under Mississippi's State Plan.)

2. Verification Required

An allowable expense must be verified via Form DOM-339, Statement Regarding Payment of Health Insurance Premiums and Non-Covered Medical Expenses, before it is allowed as a deduction. In accordance with the instructions for the form, the expenses billed to the recipient must be verified by the Doctor or Hospital rendering the service. In addition, the recipient or representative must verify that the recipient is the one who will pay or has paid for the expenses submitted via DOM-339.

The completed DOM-339 Form must be submitted to the Regional Office by the 5th day of the month following the end of the previous quarter. For example, expenses for October - December must be submitted to the Regional Office via Form DOM-339 by January 5th. If the form is mailed in, it must be postmarked by the 5th day of the month in order to be considered timely received. Note: If the 5th day of a new quarter falls on a weekend, allow until the following Monday as the deadline for submitting expenses.

Form DOM-339 must be filed in the case record for each quarter that expenses are allowed. When a completed DOM-339 is received for a given quarter, another DOM-339 must be mailed to the recipient or representative and the file documented as to the date mailed.

3. Retrospective Budgeting of Non-Covered Medical Expenses

Expenses are calculated on a quarterly basis. Actual expenses incurred in one quarter are not budgeted as a deduction until the next quarter. Quarters are divided as follows:

Oct	Jan	Apr	July
Nov	Feb	May	Aug
Dec	Mar	June	Sept

Regardless of when an allowable medical service is rendered, an expense is considered incurred in the month billed. Specifically, the month that the recipient is billed for his/her portion of an allowable medical expense, i.e., after all other third parties have paid, is the month the recipient incurs the expense. For the purpose of the non-covered medical expense provision, the month an expense is billed to the recipient determines the month the expense is allowed.

An allowable expense billed in October is allowed in January. Likewise, expenses billed in November are allowed in February. All verified expenses billed in a given month are allowed as a one-time deduction in the third month. Expenses are allowed (deducted) in one month only. If the recipient's Medicaid Income is reduced to zero after all allowable expenses are deducted, any excess is not carried over into subsequent months.

When the completed DOM-339 for a previous quarter's expenses is received by the 5th day of the month following the end of a specified quarter, the worker has until the 20th of the month to rework Medicaid Income for the current quarter. For example, expenses for October - December must be submitted by January 5. The worker then has until January 20 to budget the expenses submitted for January - March and possibly increase Medicaid Income for January. This would allow time for advance notice to be issued 10 days prior to the first of the month, in accordance with policy governing increasing Medicaid Income. If there will be no increase in Medicaid Income for the current month after allowing expenses submitted, the worker has until the last day of the first month of each quarter to rework Medicaid Income computations.

4. **Effective Date of Medical Expense Deduction**

For newly approved Medicaid eligibles, i.e., the client was not Medicaid eligible upon entry into LTC, the first month a non-covered medical expense deduction is allowed is the third month following the month in which the expense is billed. The expense must be billed in or after the month of initial eligibility. For example, if a non-covered expense is billed in October and eligibility does not begin until November, the expense cannot be allowed.

For Medicaid eligibles who enter LTC, i.e., the client enters LTC eligible as SSI or MAO (any existing MAO coverage group), a non-covered medical expense billed in the quarter prior to entry can be allowed in the quarter of entry into LTC. The expense is deducted retrospectively; however, an expense billed in the quarter prior to entry is an allowable deduction in the first quarter provided the client was eligible (as SSI or MAO) in the month billed. For example, a PLAD eligible is billed for a non-covered medical expense in August and enters a nursing home in October. The August expense is an allowable expense in November if properly verified.

Note: Allow a non-covered medical expense deduction to begin in the first quarter following the expiration of a transfer penalty provided the client was eligible for all other services during the transfer penalty and was billed in the previous quarter for the expense.

5. **Reconciliation in the Last Quarter of Eligibility**

When an institutionalized recipient becomes ineligible for Medicaid, dies or leaves the institution, the worker must make a final one time adjustment to reconcile the allowable expenses from the previous quarter and the expenses incurred in the last quarter of eligibility. This one time adjustment will allow the previous quarter's expenses and the final quarter's expenses as a one time deduction in the month of ineligibility.

For example: Client dies in January. In the month of January, the current budget reflects actual expenses incurred in October. A one-time adjustment must now be made to allow expenses that would have been deducted for November, December and January in order to reconcile all expenses that would have been allowed had the client lived and remained eligible.

This will require verification of the final quarter's allowable expenses up until the client become ineligible or dies. Verification will be obtained via DOM-339 allowing 10 days for verification to be submitted.

Note: If the client was ineligible in the previous quarter, allow only final quarter expenses in the reconciliation. For example, if a client becomes eligible and dies in the same quarter, allow expenses in the month(s) prior to and including the month of death as a one time deduction.

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HEARINGS

RESPONSIBILITIES

A. LEGAL BASE

The Mississippi Medicaid Law governing the administration of medical assistance makes provision under Section 43-13-116 of the Mississippi Code of 1972 for fair and impartial hearings in full implementation of the Federal statutory and regulatory requirements.

Section 1902(a) (3) of the Federal Social Security Act requires that a State Plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly. The Federal Regulations, 42 CFR 431.200, also prescribe procedures for an opportunity for a hearing if the Medicaid agency takes action to suspend, terminate or reduce services.

B. SOCIAL SECURITY ADMINISTRATION

The Social Security Administration is the Federal agency charged under the Federal Social Security Act with the responsibility of determining who is eligible for Supplemental Security Income (SSI). In Mississippi, individuals who are eligible for SSI are automatically eligible for Medicaid. Applicants who are denied SSI are also denied Medicaid. Recipients whose entitlement to SSI is terminated also lose Medicaid. These individuals denied or terminated from SSI may apply for Medical Assistance Only provided the application qualifies under one of the Medicaid only coverage groups covered by the Medicaid Regional Offices.

If an SSI applicant or recipient disagrees with the decision to deny or terminate SSI benefits, the individual must contact the Social Security office which issued the adverse decision. A request for a hearing must be lodged with the Social Security Administration when the issue at hand is SSI benefits and automatic Medicaid eligibility.

C. DEPARTMENT OF HUMAN SERVICES

The Mississippi State Department of Human Services is the State agency charged with the responsibility of determining eligibility for Foster Care and adoption assistance.

HEARINGS
RESPONSIBILITIES

Those individuals who are eligible for assistance through DHS are automatically eligible for Medicaid. If an applicant's application for Medicaid is disapproved or a decision is made to terminate a recipient's benefits under any DHS Program, and he/she disagrees with the decision, the individual must contact the local County Department of Human Services. The State Department of Human Services has adopted local and State hearing procedures relating to adverse determinations of financial assistance for the programs they administer.

Effective January 1, 2005, the Department of Human Services (DHS) is not responsible for determining eligibility for families and children and CHIP. DHS is not responsible for State and local hearings related to Medicaid eligibility for any programs transferred to the Division of Medicaid.

D. DIVISION OF MEDICAID

The Division of Medicaid is charged with the responsibility of determining Medicaid eligibility for certain aged, blind and disabled individuals who are not eligible for or receiving Supplemental Security Income. These individuals are outlined in Section A, Coverage Groups and Section G, MAO Coverage Groups.

The Division of Medicaid is responsible for conducting fair hearings relating to any suspension, termination or reduction in medical services unless the suspension, termination or reduction is brought about through Federal or State law or policy. The Medicaid Agency need not grant a hearing if the sole issue is a Federal or State law or policy requiring an automatic change adversely affecting some or all recipients.

Recipients of Medical Assistance Only are informed of their right to request a hearing by statements included on all notification forms issued to the client. Informational pamphlets which discuss hearing procedures are available at each regional office and are to be included with notification forms issued to the client which involve an adverse action.

Effective January 1, 2005, the Division of Medicaid is responsible for State and local hearings related to Medicaid eligibility for families and children.

HEARINGS
HEARING PROCEDURES

2. Filing A Request In Writing

The client may make the written request for a hearing by letter. A simple statement requesting a hearing that is signed by the client or legal representative is sufficient; however, if possible, the client should state the reason for the request. The letter may be mailed to the Regional Office or it may be mailed to the State Office. If the letter does not specify the type of hearing desired, either local or State, the worker will contact the person making the request to determine the level of hearing desired. If contact cannot be made within three (3) days of receipt of this request, assume the request is for a local hearing and schedule accordingly unless a State hearing is required. If a State hearing is specified or required, the letter will be forwarded to the Eligibility Division in the State Office.

3. Oral Requests For A Hearing

An oral request must be put into written form. When an oral request is made, the worker will to the person requesting the hearing that the request must be put in a letter (or signed statement) and mailed to the Regional Office or the worker will mail the appropriate form to the client for signature. The worker will explain that a hearing will not be scheduled until either a letter or the appropriate form is received by the Regional or State Office.

D. TIME LIMIT FOR FILING A HEARING

The client has 30 days from the date the worker signs and mails the appropriate notice to the client to request either a State or local hearing. This 30-day filing period may be extended if the client can show good cause for not filing within 30 days. Good cause includes, but may not be limited to, illness, failure to receive the notice, being out of state, or some other reasonable explanation. If good cause can be shown, a late request may be accepted provided facts in the case remain the same. If a client's circumstances have changed or if good cause for filing a request beyond 30 days does not exist, a hearing request will not be accepted. If the client wishes to have his eligibility reconsidered, he may reapply.

HEARINGS
HEARING PROCEDURES

E. CONTINUATION OF BENEFITS

If a client or representative requests a hearing within the advance notice period, benefits must be continued or reinstated to the benefit level in effect prior to the planned adverse action. Benefits will continue at the original or former level until the final hearing decision is rendered. In order to determine if a request for a hearing is timely made in order for benefits to continue, the request must be dated and the Regional Office contacted during the 10-day advance notice period. If a hearing is requested by telephone, the client must be advised to put the request in writing prior to the 10-day period specified.

Any hearing requested or dated after the 10-day period will not be accepted as a timely request in order for continuation of benefits to apply.

Note: The client may request a State hearing if the local hearing decision is adverse. If benefits have been continued pending the local hearing, then benefits will continue pending a State hearing decision provided the request for the State hearing is made in writing within 15 days of the date on Notice of Local Hearing Decision. Refer to the discussion later in this section on "Request for a State Hearing Following Adverse Local Decision."

IF THE AGENCY'S ACTION IS SUSTAINED BY THE HEARING DECISION (LOCAL AND/OR STATE) MEDICAID HAS THE RIGHT TO INITIATE RECOVERY PROCEDURES AGAINST THE CLIENT TO RECOUP THE COST OF ANY SERVICES FURNISHED THE CLIENT, TO THE EXTENT THEY WERE FURNISHED SOLELY BY REASON OF THE CONTINUATION OF BENEFITS PROVISION.

HEARINGS
HEARING PROCEDURES

F. DESIGNATING A REPRESENTATIVE

The client may be represented by anyone he designates. The client must give the designation to the Medicaid Regional Office in writing if the person is not the legal representative, legal guardian, or authorized representative. If another person states that the client has designated him as the client's representative and the client has not provided written verification to this effect, the Regional Office will ask the person to obtain the written designation from the client. Otherwise, the Regional Office or the State Office would be put in the position of releasing confidential information about the client without assurance that this person is the client's designated representative.

G. BOTH MEMBERS OF COUPLE APPEAL

When both members of an eligible couple wish to protest the action or inaction of the Regional Office that affects both applications or cases similarly and arose from the same issue, one or both members may file the request for a hearing. The couple will be assured that both may present evidence at the hearing and that the Agency's decision will be applicable to both.

If both file a request for a hearing, two hearings will be registered but they will be conducted on the same day and in the same place, either consecutively or jointly, according to the wishes of the couple. If it is their wish for only of them to attend the hearing, this is permissible.

H. REGIONAL OFFICE HANDLING REQUEST

The client will ordinarily file an appeal in the Regional Office which is responsible for the adverse decision or the delay in action. If the client has moved to another Regional Office jurisdiction at the time the appeal is made, it is possible for the Regional Office which serves the client's current county of residence to act for the former Regional Office. However, the hearing officer may request the attendance of the worker in the Regional Office in which the action was taken if necessary or advisable.

HEARINGS
HEARING PROCEDURES

I. SCHEDULING THE HEARING

Upon receipt of a written request for a hearing, the request will be acknowledged in writing and the hearing scheduled. If a local hearing is requested, the Regional Office will notify the client or representative in writing of the time and date of the local hearing. The letter scheduling a local hearing will be prepared in duplicate. The original is given or mailed to the client or representative and the copy is filed in the case record. If a State hearing is requested, the State Office will notify the appropriate person in writing of the time and date of the State hearing. The letter scheduling a State hearing will be prepared in triplicate with the original mailed to the client or representative, a copy mailed to the appropriate Regional Office to be filed in the case record, and a copy filed in the State hearing folder.

A hearing pamphlet will be included with the letter scheduling either a local or a State hearing.

The notice scheduling the time and date of the hearing, either local or State, must be mailed to the client at least five (5) days before the day the hearing is scheduled.

J. ATTENDANCE AT THE HEARING

A State or local hearing is not open to the public. All persons attending the hearing will attend for the purpose of giving information on behalf of the claimant or rendering him assistance in some other way, or for the purpose of representing the Medicaid Agency. All persons attending the hearing will be asked to give information pertinent to the issues under consideration.

K. WITHDRAWN ABANDONED HEARINGS

The hearing process is initiated by a written request and can be terminated only by a written statement whereby the client or representative withdraws the request for a hearing. A State or local hearing request may be withdrawn at any time prior to the scheduled hearing, or after the hearing is held but before a decision is rendered. The withdrawal must be in writing and signed by the client or representative.

A hearing request will be considered abandoned if the client or representative fails to appear or is unavailable for a scheduled hearing without good cause. If no one is available for a hearing, the appropriate office will notify the client in writing that the hearing is dismissed unless good cause is shown for not attending. The proposed adverse action will be taken on the case following failure to appear for a hearing if the action has not already been effected.

L. RIGHTS OF THE CLIENT

The client or his/her representative has the following rights in connection with a local or State hearing:

- The right to examine at a reasonable time before the date of the hearing and during the hearing the content of the applicant's or recipient's case record.
- The right to have legal representation at the hearing and to bring witnesses.
- The right to produce documentary evidence and establish all factors and circumstances concerning eligibility.
- The right to present an argument without undue interference.
- The right to question or refute any testimony or evidence, including an opportunity to confront and cross-examine adverse witnesses.

HEARINGS
HEARING PROCEDURES

M. REGIONAL OFFICE RESPONSIBILITY IN HEARING PROCEDURES

When a request for a local or State hearing is received by the Regional Office or if the Regional Office is notified by the State Office that a hearing request was mailed directly to the State Office, staff in the Regional Office is responsible for the following:

1. Supervisor Review

The Supervisor will review the case record and re-examine the action taken on the case to determine if policy has been followed. If any adjustments need to be made to the case, the Supervisor will ensure that corrections are made. If continuation of benefits applies because the hearing request was made timely, the Supervisor will ensure that benefits continue at the level prior to the proposed adverse action that is under appeal. In reviewing the case record, the Supervisor will also ensure that all needed verification is present in the case and will secure any additional evidence needed for the hearing, if necessary.

2. Preparation of Hearing Record

The Regional Office is responsible for preparing the hearing record to be used for a State Hearing. It is not necessary to prepare a hearing record for a local hearing since the claimant is entitled to examine the entire case record prior to or during a hearing. The State hearing folder is forwarded to the appropriate Hearing Officer. The hearing folder prepared for a State hearing will be forwarded to the Hearing Officer no later than five (5) days after receipt of the request for a State hearing.

The State hearing record will consist of all pertinent information relating to the issue under appeal, including:

- The written hearing request submitted by the claimant or representative.
- A statement prepared by the worker explaining the action taken on the case and the date of the action. The worker must explain any corrective action taken on the case subsequent to the hearing request.

- Copies of portions of the case record which constituted the basis for the action taken on the case. All hearing records will contain a copy of:

  DOM-300, Application Form or DOM-300A, or 300B Redetermination Form, whichever is applicable.

  Notice to Client, DOM-305 or DOM-306, whichever is applicable.

- If an application has been rejected or a redetermination completed and action taken on one factor of eligibility, but other factors have not been ascertained, include a statement as to the other factors of eligibility. For example, if the issue is disability, but the client's income has not been established, a hearing held on the disability factor will have limited value if the Regional Office then finds that the client was also ineligible on income or some other factor.

3. **Holding the Local Hearing**

The Regional Office is responsible for scheduling, conducting, and rendering decisions on local hearings. Refer to "Holding the Local Hearing" below.

4. **Taking Action on the Case**

The Regional Office is responsible for taking any corrective action required as a result of a local or State hearing decision rendered in the client's favor, or for processing the original planned action on the case which was the basis for the appeal if continuation of benefits applied pending the hearing decision.

N. LOCAL HEARINGS

When a request for a local hearing is received, the Regional Office will schedule the local hearing no later than 20 days after receipt of the request. The client will be allowed time to obtain additional information or request an attorney, relative or friend to attend the hearing and give evidence. The Regional Office may not schedule a local hearing without giving 5 days advance notice to the client unless the client waives the advance notice time. The case record will be documented if the client waives the advance notice.

1. Holding the Local Hearing

The Regional Office staff member who conducts the hearing must be one who has not participated in determining eligibility or who has directed the decision. Although the Medicaid Specialist Supervisor may have officially signed all forms authorizing eligibility, if he/she has not actually taken part in the eligibility decision, the Supervisor will hold the hearing.

If the Supervisor made the actual determination of eligibility on the case, he/she cannot hold the local hearing but must designate another Medicaid Specialist in the Regional Office to hold the local hearing.

The purpose of the local hearing is to provide an informal proceeding to allow the client or representative to present new or additional information, to question the action taken on the client's case, and to hear an explanation of the eligibility requirements as they pertain to the client's situation.

After the local hearing is held, a summary of the hearing procedure will be prepared by the worker or Supervisor holding the hearing. The summary serves the same purpose as a transcript of a tape-recorded State hearing and is filed in the case record.

2. Issuing Local Hearing Decision

The Regional Office staff member who held the hearing will carefully consider the facts presented at the local hearing in rendering the local hearing decision. When a decision has been reached by the worker, the client must be notified of the local hearing decision via DOM-351. This form must be used in notifying the client since it advises the client of the right to request a State hearing. Form DOM-351 must clearly state the reason for the decision and the policy which governs the decision. Also, if the hearing is denied, the new effective date of closure or reduced benefits must be included on the form if continuation of benefits applied during the hearing process. (A second Notice of Adverse Action is not required.) The new effective date of closure or reduced benefits must include a date in effect at the end of the 15-day advance notice period allowed via DOM-351. If a State hearing is requested within the 15-day advance notice period and continuation of benefits applies, the State Office will notify the client of any new effective date of closure, reduced benefits, or other revised eligibility dates via the State hearing decision letter.

O. REQUEST FOR STATE HEARING FOLLOWING ADVERSE LOCAL DECISION

The client has the right to appeal a local hearing decision by requesting a State hearing, but the State hearing request must be made in writing within 15 days of the mailing date of the DOM-351. This means that the written request for the State hearing must be received by the Regional or State Office Eligibility Division on or before the 15th day after the local hearing notice is mailed. If the State hearing is requested orally, then the claimant must be informed that the request be put into writing and received within the allotted time period of 15 days.

If benefits have been continued pending the local hearing decision, then benefits will continue throughout the 15-day advance notice period for an adverse local hearing decision. If a State hearing is timely requested within the 15-day period, then benefits will continue pending the State hearing decision.

State hearings requested after the local hearing advance notice period will not be accepted unless the 30-day period for filing a hearing request has not expired because the local hearing was held early. Refer to "Time Limit for Filing a Hearing Request."

HEARINGS
HEARING PROCEDURES

P. STATE HEARINGS

When a request for a State hearing is received in the Regional Office, the request will be dated as to the date of receipt, the request will be photocopied so that a copy can be placed in the State hearing record, then the request will be forwarded to the appropriate Hearing Officer. The Regional Office will proceed with preparation of the State hearing folder and mail the hearing folder to the Hearing Officer for that region within five (5) days of receipt of the State hearing request.

If a State hearing request is mailed directly to the State Office, a copy of the request will be forwarded to the appropriate Regional Office so that the State hearing record can be set up and forwarded to the Hearing Officer for that region.

Upon receipt of the hearing record, the hearing will be assigned to an impartial Hearing Officer who will conduct the hearing. Impartial means that the Hearing Officer has not been involved in any way with the action or decision on the case.

The Hearing Officer will review the material submitted as the State hearing record. If the review shows that an error was made in the action of the Regional Office, or in the interpretation of policy by the Regional Office, or that a change in policy has been made, the Hearing Officer will discuss this fact with the Area Supervisor and ask that an adjustment be made, if appropriate. The Regional Office worker will discuss the matter with the client and if he/she is agreeable to the adjustment of the claim, the worker will request withdrawal of the hearing in writing and state the reason thereof.

If the action of the Regional Office is in order, the Hearing Officer will request any additional information that appears to be needed in holding the hearing and making a new decision.

HEARINGS
RESPONSIBILITIES

1. **Holding the State Hearing**

The State hearing will be scheduled by the Hearing Officer in accordance with policy set forth in "Scheduling the Hearing."

In conducting the hearing, the Hearing Officer will inform those present of the following:

- The Hearing Officer will explain that the hearing will be recorded on tape so that a transcript of the proceedings can be typed for the record.

- The reason for the hearing will be stated (i.e., the action taken by the Regional Office which prompted the appeal).

- An explanation will be made concerning the client's rights during the hearing as outlined in "Rights of the Client" and that the purpose of the hearing is an opportunity for the client to express dissatisfaction and present additional information or evidence. Note: Although the State hearing uses a State hearing folder to conduct the State hearing, the actual case record must be available for review by the client or representative before, during, or after the State hearing as outlined in "Rights of the Client."

- An explanation will be made that the final hearing decision will be rendered by the Executive Director of the Mississippi Division of Medicaid on the basis of facts discussed at the hearing and that the claimant will be notified by letter of this decision.

During the hearing the client/representative will be allowed an opportunity to make a full statement concerning his appeal and will be assisted, if necessary, in disclosing all information on which the claim is based. All persons representing the claimant and those representing the Regional Office will have the opportunity to state all facts pertinent to the appeal. When all information has been presented, the Hearing Officer will close the hearing and stop the recorder.

Immediately following the hearing, the Eligibility Division will transcribe the hearing.

2. **Review By DDS Staff**

When the issue under appeal is disability or blindness, following the State hearing the Hearing Officer will forward all medical information to the Disability Determination Service for reconsideration. A review team consisting of medical staff who were not involved in any way with the original decision will review the medical and hearing transcript and give a decision on the disability or blindness factor. The DDS decision will be final and binding on the Agency.

3. **Recessing or Continuing A State Hearing**

If additional information is needed and this information is readily available, the hearing officer will recess the hearing for the time required to obtain the facts. If the information is not readily available, the hearing officer will continue the hearing to a suitable later date. If the time at which the information will be obtained is known, the hearing officer, before adjourning the original hearing, will set the time and place for the continued hearing at the earliest possible date, notifying the principals that there will be no further written notice. The hearing officer will reach an agreement with the client and any person attending in his/her behalf about bringing the needed information to the continued hearing. The hearing cannot be extended beyond the time limit for completion of a hearing.

4. Changes Which Occur During The Hearing Process

If at any time during the hearing process the Regional Office becomes aware of a change in the client's circumstances which will result in an adverse action other than the issue presently under appeal, the client must be notified in writing. The notice to the client must be the usual 10-day notice. If a State hearing has not yet been held, the client may choose to have the new adverse action issue incorporated into the current appeal; however, the client must request the appeal in the normal manner. If the new hearing request is filed in time for the issue to be included with the hearing currently in process, the Regional Office will notify the hearing officer of the additional issue under appeal. The hearing may need to be rescheduled in order to allow the client time to prepare for the hearing.

If a change in the client's circumstances is discovered during the actual hearing, the hearing officer will recess the hearing and notify the Regional Office to send the appropriate 10-day notice. The hearing will be reconvened after the adverse action is mailed and the advance notice period expired. The client may opt for the new issue to be included in the hearing when reconvened. The hearing will be reconvened following the usual procedure for setting the time and place.

5. Recommendation of State Hearing Officer

After a hearing has taken place, the final decision must be based on the oral and written evidence, testimony, exhibits, and other supporting documents which were discussed at the hearing. The decision cannot be based on any material, oral or written, not available to and discussed with the claimant. The decision cannot be based on any written material not available to the claimant.

Following the hearing, the hearing officer will make a written recommendation as to the decision to be rendered as a result of the hearing. The recommendation, which becomes part of the State hearing record, will cite the appropriate policy which governs the recommendation.

	6. **Decision of The Agency**	The Executive Director of the Division of Medicaid, upon review of the recommendation, proceedings and the record, may sustain the recommendation of the hearing officer, reject the same, or remand the matter to the hearing officer to take additional testimony and evidence, in which case, the hearing officer thereafter will submit to the Executive Director a new recommendation. The Executive Director will prepare a written decision summarizing the facts and identifying policies and regulations that support the decision, which will be mailed to the client or the representative, with a copy to the regional office as soon as possible after submission of a recommendation by the hearing officer. The decision notice will specify any action to be taken by the agency, specify any revised eligibility dates or, if continuation of benefits applies, will notify the claimant of the new effective date of reduction or termination of benefits or services, which will be fifteen (15) days from the mailing date of the notice of decision. The decision rendered by the Executive Director of the Division of Medicaid is final and binding. The client is entitled to seek judicial review in a court of proper jurisdiction.
Q.	**TIME FRAME FOR COMPLETION OF HEARINGS**	The Division of Medicaid must take final administrative action on a hearing, whether State or local, within 90 days from the date of the initial request for a hearing. Although regulations allow 90 days for the completion of the hearing, the Agency will make every effort to hold hearings promptly and render decisions in a shorter time frame.
R.	**SECOND REQUEST**	The decision of the Executive Director of the Division of Medicaid is final. Should a client appeal a second time without a change in circumstances or Agency policy, the client will be notified in writing by the appropriate office explaining that the appeal cannot be honored. If the client's circumstances or Agency policy has changed, then the client should be advised to file a new application.

S. GROUP HEARINGS

A group hearing can be held for a number of clients under the following circumstances:

- The Division of Medicaid may consolidate the cases and conduct a single group hearing when the only issue involved is one of a single law or Agency policy.

- The clients may request a group hearing when there is one issue of Agency policy common to all of them.

In all group hearings, whether initiated by the Division of Medicaid or by the clients, the policies governing fair hearings must be followed. Each individual client in a group hearing must be permitted to present his own case and be represented by his own lawyer, or to withdraw from the group hearing and have his/her appeal heard individually.

As in individual hearings, the hearing will be conducted on the issue being appealed, and each client is expected to keep his testimony within a reasonable time as a matter of consideration to the other clients involved.

STATE HEARING COVER SHEET

REGIONAL OFFICE:_____

RO SUPERVISOR/DESIGNEE'S SIGNATURE:_____

CLIENT'S NAME:_____ ID # _____

CLIENT'S COVERAGE GROUP AT ISSUE:_____

IS CLIENT ELIGIBLE UNDER ANY OTHER GROUP (specify)_____

_____

DATE OF APPLICATION(S):_____

DATE(S) OF ELIGIBILITY UNDER APPEAL:_____

_____

DATE(S) 305 or 306 NOTICE(S) ISSUED:_____

WAS LOCAL HEARING HELD:_____

IF YES, DATE LOCAL HEARING REQUEST REC'D IN WRITING:_____

DATE STATE HEARING REQUEST REC'D IN WRITING:_____

STATUS OF CASE: ☐ OPEN UNDER CONT. OF BENEFITS ☐ REJECTED

☐ CLOSED EFFECTIVE _____ ☐ OTHER

BRIEFLY DESCRIBE ISSUES UNDER APPEAL:_____

_____

_____

NAME/ADDRESS/PHONE # OF CLIENT OR DESIGNATED REP REQUESTING HEARING:

NAME:_____PHONE#_____

ADDRESS:_____

REP'S RELATIONSHIP TO CLIENT:_____

FOR STATE OFFICE USE ONLY

DATE RECEIVED BY STATE LEVEL REVIEWER:_____

DATE ASSIGNED APPOINTMENT FOR HEARING:_____

HEARING DATE:_____

DUE DATE:_____ END OF 90 DAY PERIOD:_____

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IMPROPER MEDICAID BENEFITS & QUALITY CONTROL
QUALITY CONTROL

A. INTRODUCTION

A Medicaid Eligibility Quality Control (MEQC) review on a random sample basis is required by federal regulations on all Non-SSI aged, blind, and disabled actions handled by the Medicaid Eligibility Division, Regional Office. To carry out this function, it will be necessary that staff follow the procedures set out below.

B. MEQC PROCEDURES

MEQC reviews are accomplished by MEQC Management Staff, Medicaid Investigators with Quality Control and Medicaid Regional Office staff.

1. MEQC Management Responsibilities

The MEQC Management Staff will:

- Submit MEQC Sampling Plan information to the HCFA Regional and Central Offices for approval as required by federal regulations.
- On a monthly basis, identify the cases to be reviewed by using a HCFA approved scientific random sampling method of the aged, blind, disabled Medicaid only cases in the MMIS Recipient file.
- Assign the sampled cases to the appropriate Medicaid Investigator who will conduct the field audit on the cases.
- Review the Medicaid Investigator's MEQC findings and clear with the Medicaid Investigator as necessary.
- Notify the Medicaid Regional Office of the MEQC findings with a copy of this notification to the Medicaid Eligibility Division.
- Submit the appropriate MEQC findings to the HCFA Regional and Central Offices in the time and manner as required by federal guidelines.

2. Medicaid Investigator Responsibilities

The Medicaid Investigator of the MEQC Unit will:

- Instruct the Medicaid Regional Office to mail the case record to his/her attention in the State Medicaid office.
- Analyze the case record, make copies of pertinent material, record information on the MEQC work forms.
- Return the case record to the appropriate Regional Office no later than two weeks after it is received.
- Conduct a field investigation in accordance with the MEQC policy.
- Complete the review with decisions based on MEQC findings and federal and state policy.

3. Medicaid Regional Office Responsibilities

The Medicaid Regional Office will:

- Immediately upon receipt of a request for a case record from MEQC, mail the case record to the appropriate Medicaid Investigator.
- Upon receipt of the notice of MEQC findings, review the report and determine if agreement exists.
- If the Regional Office disagrees with the MEQC findings, a memorandum should be sent immediately to the Medicaid Eligibility Division stating the reason for the disagreement and providing any relevant documentation. The disagreement will be resolved as described below.

4. Disagreement Resolution With MEQC Findings

When the Medicaid Eligibility Division receives a reconsideration request from a Regional Office within the two week period from mailing of the MEQC findings to the Regional Office, staff in the Medicaid Eligibility Division will review the information provided by the Regional Office and forward to the MEQC Unit for reconsideration.

The MEQC Unit will:

- Review the Regional Office reconsideration request and accompanying documentation and make a final decision on the review.

- Make corrections on the MEQC worksheets if necessary.

- Provide a written notice of the decision to the Medicaid Regional Office.

- Report final MEQC findings to the HCFA Regional and Central Offices in a time and manner as required by federal regulations.

NOTE: A reconsideration cannot be made on a MEQC finding if the request for the reconsideration is received more than two weeks after the mailing of the MEQC notice to the Medicaid Regional Office.

C. CORRECTIVE ACTION

A corrective action committee at the Division of Medicaid will be responsible for reviewing the overall MEQC findings after the data has been compiled at timely intervals.

The four areas of corrective action and analysis are:

1. Program Analysis

Program analysis uses the analyzed MEQC findings as well as other relevant information to identify causes of errors in eligibility and claims processing. Often, this involves selecting a particular concentration of error types for further analysis. The data and program analysis findings are combined with other relevant information for corrective action planning.

2. Corrective Action Planning

This activity identifies, evaluates, and selects ways to eliminate or reduce errors in each program process. Corrective actions are designed to make changes in agency policies. Some resulting changes may take substantial deployment of resources and lead time for implementation while others may be short range in nature. However, both types of corrective action measures require the same process of planning, development, and implementation.

3. Corrective Action Implementation

Corrective action implementation represents the point at which the State agency translates all the preceding information, analysis, and decisions into action. The implementation process includes assignment of responsibility for specific tasks, tracking of task completion, and measurement of progress.

4. Corrective Action Evaluation

This activity analyzes whether the implemented corrective action has eliminated or reduced the error rates and misspent dollars in the areas of eligibility and liability determinations or claims processing.

IMPROPER MEDICAID BENEFITS & QUALITY CONTROL
IMPROPER MEDICAID BENEFITS

A. INTRODUCTION

When Medicaid benefits are made available to the recipients improperly, the State and Regional Offices must identify and take action to recover the amounts thus paid.

Improper payments arise from the following sources:

- Cases of suspected fraud. That is, the individual at the time of application or during the period of eligibility willfully falsifies, misrepresents, or withholds information which, if known, would have resulted in denial or reduction of Medicaid benefits to that recipient or a difference amount of Medicaid Income.

- Cases involving misunderstanding by the recipient (client error) or agency error.

- Cases involving the improper use of a Medicaid card by a person other than the eligible recipient.

B. TYPES OF IMPROPERLY PAID MEDICAID BENEFITS

When the Regional Medicaid Office becomes aware of a possible improper eligibility situation through contact with the client, quality control report, State Office referral or other source, the Regional Office will establish the facts and initiate appropriate steps to correct the case. The Regional Office will also determine the type of improper Medicaid eligibility situation.

The types are explained below. After determining the type of improper payment involved, the Regional Office will initiate an Improper Payment Report (DOM-354) to the State Medicaid Eligibility Division.

IMPROPER MEDICAID BENEFITS & QUALITY CONTROL
IMPROPER MEDICAID BENEFITS

1. Suspected Fraud

A decision of suspected fraud will be determined using the following principals:

- Whether the applicant or recipient obtained Medicaid by making a willfully false statement or by knowingly withholding information bearing on his eligibility. The worker must be alert to indications as to whether or not the client understood that the information he gave or withheld had a bearing on his receipt of Medicaid or the amount of his Medicaid Income.

- Whether the applicant or recipient had given information on other factors of eligibility or at other times which appeared to contradict the later statements he made, and whether it appeared that he made the later statements knowing that they are different.

- Whether the Regional Office relied on the client's statement of his action, and granted or continued Medicaid to him on the basis of his statement.

Section 43-13-129 Mississippi Code of 1972 states: "Any person making application for benefits under this article for himself or for another person, and any provider of services, who knowingly makes a false statement or false representation or fails to disclose a material fact to obtain or increase any benefit of payment under this article shall be guilty of a misdemeanor, and upon conviction thereof, shall be punished by a fine not to exceed Five Hundred Dollars ($500.00) or imprisoned not to exceed one year, or both such fine and imprisonment. Each false statement or false representation of failure to disclose a material fact shall constitute a separate offense. This section shall not prohibit prosecution under any other criminal statutes of this State or the United States."

Since fraud is a serious charge to make against a person, and the results can be serious, the facts in such a case must be clearly and accurately stated. The Mississippi courts have ruled, "There is a presumption against fraud, dishonesty, and bad motive, and evidence to overcome this presumption must be more than a mere preponderance; it must be clear and convincing."

The application form which the person signs carries with it a warning about the penalty for giving false information, so that when the individual gives the information completing the application and signs it, he/she has been put on warning about giving incorrect or incomplete information.

2. **Client Error**

These are situations in which there is no evidence that the client willfully misrepresented or withheld information, but all indications are that he misunderstood, was unable to comprehend the relationship of the facts about his situation to eligibility requirements, or there was other inadvertent failure on his part to supply the pertinent or complete facts affecting his receipt of Medicaid.

3. **Agency Error**

Agency errors occurs when:

The worker overlooks a clue which, if pursued to conclusion, would have led to a finding of ineligibility. Examples are:

- Failure to follow-up when the client reports that he expects a definite stated change in his income, living arrangement, other area affecting his eligibility.

- Failure to follow-up when the client is asked to apply for a possible benefit, such as Social Security, veteran's benefit, unemployment compensation, or other retirement or disability benefit.

- Failure to follow-up when the client or someone on his behalf reports a plan to sell, transfer, or otherwise dispose of his property, real or personal, or to buy or acquire property otherwise.

- Redeterminations are not timely completed. When the review is made and the worker finds information leading to ineligibility, then all the benefits received following the required review date are improper because of agency error. Had the review been completed on time, the worker would have been aware of the information and improper benefits would not have been received.

- The worker misrepresents a policy which if correctly applied to the client's situation would have resulted in denial or closure.

- The worker makes a mathematical error in the test for financial need; used the wrong figure in this test, selects the incorrect test for financial need for the client's situation or computes net income incorrectly, etc.

- The State or Regional Office makes a mathematical error. That is, through machine or human oversight or failure, eligibility is authorized or continued to an ineligible person or the amount of Medicaid Income is improperly computed.

C. IMPROPER PAYMENT REPORT

Form DOM-354, Improper Payment Report will be prepared by the Medicaid Regional Office to report instances of improperly paid Medicaid benefits. Prepare the form in accordance with the instructions for the form, including the following vital information:

- Which factor of eligibility is involved and how the information given or withheld affects eligibility or Medicaid Income.

- What the client said about the factor in question and the date on which the information was given, whether the client gave statements on the DOM-300 or made them verbally to the worker; and the reason the client gave for withholding or falsifying the information.

- The date on which and the circumstances under which the worker learned of the correct information; that is, who gave difference statements, when, and why, or in what way the worker discovered the suspected fraud and the facts.

- What additional steps the worker has taken to secure more or more correct information. For example, bank clearances, checking of property records, interviews with persons in a position to know the facts or involved with the client in the matter, etc.

- Why the worker considered the withholding of giving of incorrect information willfully; that is, whether the client was able to understand his responsibility for giving full and accurate statements and the meaning of his failure to do so.

- Whether the client or client and spouse have resources from which they might repay the amounts improperly received.

- If a transfer of resources is involved, DOM-322 must be issued and an opportunity for rebuttal offered prior to issuing an improper payment. Delay the preparation of DOM-354 until after the rebuttal period is over.

- Delay the preparation of DOM-354 until all appeals have been exhausted and a final decision on the factor of ineligibility, etc. has been determined.

1. Handling of DOM-354 By Eligibility Division

Upon receipt of the improper payment report, the staff of the Medicaid Eligibility Division will:

- Review the report from the Regional Office to ensure that it is complete and that the Regional Office has properly applied policy. This may involve further clearance with the Regional Office.

- Enter the initial information on the periods of ineligibility or improper amount of Medicaid Income on Form-355, This form is referred to the Program Integrity Division for entry of amount of benefits erroneously received.

- Prepare a memorandum to the Program Integrity Division setting out the facts in the case. The memorandum is transmitted to the Program Integrity Division along with a copy of the Regional Office DOM-354 report as appropriate.

2. Handling of DOM-354 By Program Integrity

The Program Integrity Division upon receipt of the material from the Medicaid Eligibility Division will assign the case to a Medicaid Auditor/Investigator for Investigation in order to obtain documentation of the information bearing on the factor of ineligibility and the circumstances surrounding the fraudulent receipt of Medicaid services, or the collection of additional information when indicated.

The investigation into the improper payment may be handled by way of a letter requesting repayment, an in-person interview with the client or a referral to the county or district attorney, or a combination of all three, in order to obtain repayment of the benefits improperly paid by Medicaid.

3. **Claims Against Estates**

When the Regional Office determines that a recipient has received benefits for which he was not eligible and the recipient is deceased, the case should be reported immediately to the Medicaid Eligibility Division. If the case has already been reported and the Regional Office learns of the death of the person, this fact should be reported immediately.

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Application for Mississippi's Aged, Blind or Disabled Medicaid Program

- Please read each question carefully before answering. The answers given will determine whether or not the person applying will be eligible for Medicaid.
- A friend or relative may help the applicant complete this form. A Medicaid worker is also available if any help is needed.

WHEN THE FORM IS COMPLETED AND SIGNED, YOU SHOULD EITHER MAIL IT OR BRING IT TO YOUR MEDICAID REGIONAL OFFICE AT THE FOLLOWING ADDRESS:

For Medicaid Regional Office Use Only

☐ LTC ☐ PLAD ☐ QMB-Only ☐ SLMB ☐ SSI RETRO ☐ DISABLED CHILD

☐ QWDI ☐ HOSPICE ☐ HANDICAPPED ☐ SS PASS-ALONG _____

Worker _____ Nursing Home/Hospital _____

Date of Interview ____/____/____

Case Name _____ Case Number _____

Spouse Case Name _____ Case Number _____

Rights and Responsibilities explained at time of interview? ☐ Yes ☐ No

Pamphlets given at time of interview: ☐ P1, ☐ P2, ☐ P3, ☐ P4, ☐ P5, ☐ P6, ☐ EPSDT

DOM 300 -Revised 01-01-95

***IMPORTANT* ANSWER ALL QUESTIONS**

1. APPLICANT IDENTIFICATION

- Applicant's Full Name _____
  (First) (Middle) (Maiden) (Last)
- Social Security Number: ___-___-___ If none, have you applied for one?_____
- Date of Birth: (mo) _____(day) _____(year) _____ Sex (check one): ☐ Male ☐ Female
- Race (check one): ☐ White ☐ Black ☐ American Indian ☐ Hispanic ☐ Asian ☐ Indo-Chinese
- Does applicant have Medicare Part A? ☐ Yes ☐ No; Part B? ☐ Yes ☐ No Medicare Claim #_____

  Does applicant have any other health insurance? ☐ Yes ☐ No
- Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced
- Has applicant ever applied for, or received Medicaid before now? ☐ Yes ☐ No If you marked "Yes", when and where was application filed? (date)_____ (location) _____
- If someone other than the applicant is filling out this application, please complete the following:

  Name of Designated Representative: _____

  Address: _____

  Telephone #: _____ Relationship to applicant: _____
- Has applicant given written power of attorney to anyone? ☐ Yes ☐ No If you marked "Yes", please answer the following:

  Name/Address: _____
- Does applicant have a court appointed guardian or conservator? ☐ Yes ☐ No If you marked "Yes", please answer the following:

  Name / Address: _____
- Is the applicant the beneficiary of a trust? ☐ Yes ☐ No If you marked "Yes", please give the trustee's:

  Name / Address: _____
- If applicant is under the age of 65, what is disability?_____
- What is applicant's current living arrangement?_____
- What is applicant's current mailing address?_____ City_____

  County_____ State_____ Zip _____ Telephone Number _____-_____
- List members of applicant's household. If applicant is in a nursing facility, list the people living in the house prior to applicant entering the nursing facility:

Name of Household Member	*Age*	*Relationship to Applicant*

2. SPOUSE OR PARENT IDENTIFICATION - Complete even if spouse is deceased.

If applicant is a child 18 years or under, give parent(s) information.

- Full Name of Spouse/Parent(s) _____
- Social Security No. _____-_____-_____ Date of Birth _____ /_____ /_____ Death Date_____/_____/_____
- Current Address_____
- City _____ State _____ Zip_____ Telephone #_____-_____
- Is spouse or parent applying for Medicaid? ❑ Yes ❑ No
- Has spouse or parent ever received Medicaid? ❑ Yes ❑ No
- If applicant has ever been widowed or divorced, give the following information for **all** previous marriages.

Former Spouse's Name *First*	*Middle*	*Maiden*	*Last*	*How Long Married*	*How Marriage Ended (Death, Divorce)*	*Date of Death or Divorce*

3. VETERAN STATUS

- Is applicant a veteran? ❑ Yes ❑ No
- Has applicant ever been married to a veteran? ❑ Yes ❑ No
- Is applicant a dependent of a veteran? ❑ Yes ❑ No

If you answered "Yes" to any of the above questions, please complete the following:

Name of Veteran_____

Applicant's Relationship to Veteran_____

Veteran's Service Number or Claim Number_____

Branch of Service_____ Date(s) of Service_____

Has applicant ever applied for VA benefits under the new Veterans and Survivors Improvement Act? ❑ Yes ❑ No

If applicant is in a nursing home, has applicant ever applied for VA Aid & Attendance? ❑ Yes ❑ No

4. RETROACTIVE MEDICAID

Medicaid may be able to cover the applicant in the 3 months prior to the date of this application or the date the application was filed for SSI if the applicant is eligible & received services covered by Medicaid during the 3 month retroactive period

- Does applicant want to apply for retroactive Medicaid? ❑ Yes ❑ No

/

5. RESOURCES - This is real or personal property owned or being bought by the applicant, spouse or parent(s) of a child.

Does applicant or spouse / parent(s) **own** or is applicant / spouse / parent(s) **buying** any of the following types of resources:

- **RETIREMENT FUNDS** (IRA, Keough Plan, state, federal or municipal retirement or private pension funds)
  ☐ Yes ☐ No If yes, has applicant applied for income from retirement funds? ☐ Yes ☐ No

- **SAFE DEPOSIT BOX** ☐ Yes ☐ No If yes, at what bank?_____

- **BANK ACCOUNTS** (checking, savings, CDs, Christmas Club, Patient Accounts, etc.) ☐ Yes ☐ No
  If yes, complete the following:
  Name of Bank_____

Type of Account /Account Number	*Balance*	*Type of Ownership*	*Interest Paid How Often*
_____	_____	☐ Joint ☐ Individual	_____
_____	_____	☐ Joint ☐ Individual	_____
_____	_____	☐ Joint ☐ Individual	_____

- **PROMISSORY NOTES, LOANS OR PROPERTY AGREEMENTS** ☐ Yes ☐ No If yes,
  Principal balance_____ Does note produce income? ☐ Yes ☐ No
  Amount of income $_____ How often_____

- **STOCKS, BONDS & SAVINGS BONDS** ☐ Yes ☐ No If yes, describe the type and number owned_____
  _____ value _____

- **HOME PROPERTY** ☐ Yes ☐ No If yes, what state_____ county_____
  Address / location_____
  Type of ownership ☐ Sole ☐ Shared ☐ Life Estate ☐ Other (describe)_____

- **OTHER REAL PROPERTY** ☐ Yes ☐ No If yes, number of other properties _____
  Address/location_____
  County _____ State_____
  Type of ownership. ☐ Sole ☐ Shared ☐ Life Estate ☐ Heir Interest ☐ Other
  Explain how property is used: _____
  Does property produce income? ☐ Yes ☐ No
  If yes, include amount of income $_____ . How often _____

- **HOUSEHOLD GOODS / PERSONAL PROPERTY** (Includes boats, campers, recreational vehicles, or any other personal effects of substantial value.) ☐ Yes ☐ No If yes, what is owned?_____
  Describe: make_____ model_____ year_____ value_____

- **AUTOMOBILE (S)** - (This includes any cars, trucks, motorcycles or farm machinery). ☐ Yes ☐ No If yes,

Type of Vehicle	*Model / Year*	*Amount Owed*	*Use of Vehicle*
_____			☐ Employment ☐ Medical ☐ Other
_____			☐ Employment ☐ Medical ☐ Other
_____			☐ Employment ☐ Medical ☐ Other

- **LIFE INSURANCE** ☐ Yes ☐ No If yes,

Insured	*Owner*	*Face Value*	*Insurance Company*	*Type of Policy*
				☐ Whole Life ☐ Term
				☐ Whole Life ☐ Term
				☐ Whole Life ☐ Term

- **BURIAL SPACES** (Includes burial plots or spaces) ☐ Yes ☐ No

  Number of gravesites owned_____ Location of cemetery_____

  Are these gravesites used / intended for use by applicant's family? ☐ Yes ☐ No

- **BURIAL FUNDS** Are there funds set aside for burial? ☐ Yes ☐ No

  How are the funds set up? ☐ Cash ☐ Burial Insurance or Contract ☐ Other

  Value of funds $_____ Can funds be cashed in? ☐ Yes ☐ No

- **OTHER** Are there any other resources owned or being bought that are not shown above? ☐ Yes ☐ No

  If yes, specify _____

- Has applicant or spouse sold or given as a gift any resource (including cash) to **anyone** in the last 36 months?

  ☐ Yes ☐ No If yes, specify:_____

Type of Resource Transferred	*Date*	*Person to Whom Transferred*	*Amount of Compensation*

6. INCOME AND WORK HISTORY

- Does applicant, spouse or parent(s) work? ☐ Yes ☐ No

  If yes, name of person who works_____

  Employer_____

  Total wages (before deductions) $_____ Paid how often_____

  If paid weekly or biweekly, what is day of week check is received? _____

- Was applicant, spouse or parent(s) self-employed at any time this or last year? ☐ Yes ☐ No

  If yes, type of business_____

  Amount earned $_____ Paid how often_____

- If applicant, spouse or parent(s) do not currently work, what is date last employed?_____

  Employer_____

- Did applicant / spouse file state or federal income tax last year? ☐ Yes ☐ No

- Complete the next two questions only if applicant is in a nursing facility or facility for the mentally retarded.

  - -If applicant has a spouse living at home, does applicant wish to make income available to the community spouse?

    ☐ Yes ☐ No

  - -Does applicant receive sheltered workshop earnings or any income from work therapy? ☐ Yes ☐ No

    If yes, what are the monthly earnings? $_____

List below all other types of money received by the applicant, his/her spouse, or any dependent child If this is an application for a child, each parent must account for his/her income

	Source of Income	*Applicant*	*Parent(s) or Spouse*	*Children (Under 18)*	*Claim Numbers*
☐ Yes ☐ No	Social Security	$_____	$_____	$_____	_____
☐ Yes ☐ No	SSI	$_____	$_____	$_____	_____
☐ Yes ☐ No	VA Pension/Compensation	$_____	$_____	$_____	_____
☐ Yes ☐ No	VA Insurance	$_____	$_____	$_____	_____
☐ Yes ☐ No	Military Retirement	$_____	$_____	$_____	_____
☐ Yes ☐ No	Railroad Retirement	$_____	$_____	$_____	_____
☐ Yes ☐ No	State Retirement	$_____	$_____	$_____	_____
☐ Yes ☐ No	Municipal Retirement	$_____	$_____	$_____	_____
☐ Yes ☐ No	Civil Service Retirement	$_____	$_____	$_____	_____
☐ Yes ☐ No	Private Retirement	$_____	$_____	$_____	_____
☐ Yes ☐ No	Unemployment Compensation	$_____	$_____	$_____	_____
☐ Yes ☐ No	Rental Income	$_____	$_____	$_____	_____
☐ Yes ☐ No	Workers' Compensation	$_____	$_____	$_____	_____
☐ Yes ☐ No	Interest Income	$_____	$_____	$_____	_____
☐ Yes ☐ No	Trust Income	$_____	$_____	$_____	_____
☐ Yes ☐ No	Dividends	$_____	$_____	$_____	_____
☐ Yes ☐ No	Income from Promissory Note or Loan	$_____	$_____	$_____	_____
☐ Yes ☐ No	Oil, Gas, Mineral Royalties	$_____	$_____	$_____	_____
☐ Yes ☐ No	Child Support/Alimony	$_____	$_____	$_____	_____
☐ Yes ☐ No	Cash Contributions	$_____	$_____	$_____	_____
☐ Yes ☐ No	Other	$_____	$_____	$_____	_____

7. STATEMENT OF CITIZENSHIP OR ALIENAGE - In order to receive Medicaid, each applicant must certify, under penalty of perjury, whether he/she is a citizen or national of the United States or is in a satisfactory immigration status. Satisfactory immigration status means that the person is living in the U.S. legally.

Is applicant a United States citizen by birth or naturalization? ☐ Yes ☐ No

If no, is applicant lawfully admitted for permanent residence in the U.S.? ☐ Yes ☐ No

If not lawfully admitted, when did applicant first enter the U.S.? _____

Is the Immigration & Naturalization Service (INS) aware of applicant's presence? ☐ Yes ☐ No

Does applicant plan to remain in Mississippi? ☐ Yes ☐ No

BY SIGNING THIS APPLICATION, THE APPLICANT IS STATING THAT THIS STATEMENT OF CITIZENSHIP IS TRUE

8. ASSIGNMENT OF RIGHTS TO THIRD PARTY PAYMENT, COOPERATION REQUIREMENT & ESTATE RECOVERY REQUIREMENT

- Medicaid does not pay medical expenses that a third party, such as a private health insurance company, is supposed to pay. All persons applying for Medicaid benefits are required to assign the Division of Medicaid any rights they may have to medical support or other third party payments for medical care. When you sign this application for Medicaid benefits, you are assigning the Division of Medicaid all rights to collect or receive any such payments for the time you are (were) on Medicaid.
- *I understand that by applying for Medicaid benefits I agree to cooperate with the Division of Medicaid in identifying and providing information to help pursue any third party who may be responsible for providing medical support for me. If I am signing this application on behalf of another person, I agree to cooperate in identifying and obtaining information to pursue any third party who may be responsible for providing medical support for them.*
- I understand that if I am eligible to enroll in any insurance or benefit plan offered by my employer or my spouse's employer, I am required to enroll in that plan.
- *I understand that upon my death the Division of Medicaid has the legal right to seek recovery from my estate for services paid by Medicaid in the absence of a legal surviving spouse or a legal surviving dependent. Consideration will be made for hardship cases. An estate consists of real & personal property. Estate recovery applies to nursing home clients age 55 and older.*

9. PRIVACY ACT AND COMPUTER MATCHING NOTICE - The Division of Medicaid is authorized to request the information on this form. The primary use of this information is to determine eligibility for Medicaid and is protected by law from disclosure to unauthorized persons. It is possible that this form may be used to determine another person's right to Medicaid benefits. Also, to comply with federal law, the applicant's Social Security Number(s) will be computer matched with other agencies, such as the Social Security Administration and the Internal Revenue Service, to obtain information about income and resources available to the applicant. These matches may also be done on an individual basis.

10. APPLICANT RESPONSIBILITIES

- I know that anyone who makes or causes to be made a false statement or misrepresentation of material in an application or for use in determining eligibility for Medicaid commits a crime, punishable by federal and/or state law. I affirm that all information given in this document or in support of it is true.
- *If this application or other information shows that the recipient may be eligible for any payments or benefits from other sources, the applicant is required to file for other benefits when notified by the Division of Medicaid.*
- The Medicaid regional office must be notified immediately if there is a change in the applicant's address, living arrangement, family size, income or resources. Also, the regional office must be notified if the recipient is discharged from a hospital or nursing home or if the client moves from one medical facility to another.
- *If this application is for someone who is blind or disabled, the regional office must be notified of any improvement in the recipient's medical condition or if the recipient returns to work.*
- The recipient's case may be selected for quality control purposes in a state and/or federal review. If his/her case is selected, the applicant's full cooperation is required.

Does the applicant and/or designated representative accept these responsibilities and agree to notify the Medicaid regional office of any and all changes listed above? ☐ Yes ☐ No

_____ _____

Signature of applicant or designated representative *Date*

_____ _____

Signature and address of witness (if applicant signs with a mark) *Date*

The Division of Medicaid complies with all state and federal policies which prohibit discrimination on the basis of race, age, sex, national origin, handicap or disability - as defined through The Americans with Disabilities Act of 1990.

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-300 - APPLICATION FORM

PURPOSE & USE

Form DOM-300, Application Form for Mississippi Aged, Blind or Disabled Medicaid, is used to determine initial eligibility for Medicaid. The form may be completed by the applicant or his designated representative, or the Medicaid Specialist or Supervisor may complete this form in behalf of the client. For a detailed discussion on the various means of making application, refer to Section C.

INSTRUCTIONS

Prepare an original. Form DOM-300 will be filed in the case record upon completion of the form. The form must be signed by the applicant or designated representative before it can be accepted as a filed application.

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-300B - SSI REDETERMINATION FORM

PURPOSE & USE

Form DOM-300B, SSI Redetermination Form, is used to determine continuing Medicaid eligibility for individuals terminated from SSI due to excess income and/or resources. The form is computer generated by the fiscal agent and issued along with the SSI Notice of Termination. Refer to Section C for policy governing the SSI Redetermination process.

INSTRUCTIONS

The completed DOM-300B will be filed in the case record upon receipt of the completed/signed form. The form must be signed by the client or designated representative before the redetermination process is completed.

DOM-TPL 406 DIVISION OF MEDICAID Initial___
Rev.01/01/92 MEDICAL INSURANCE FORM Updated___

Regional Office_____ Recipient_____

Specialist_____ Med ID # _____

1. MEDICARE INFORMATION

Claim # _____

2.A. HEALTH INSURANCE (OTHER THAN MEDICARE AND MEDICAID)

Relation of Policy Owner to Insured	Insurance Company Name and Address	Policy #	Begin Date	End Date

Policy is limited to: ___Cancer ___Indemnity ___Intensive Care ___Dread
___Medicare Supplement ___Accident ___Other (Explain_____)

FOR MEDICAID STATE OFFICE USE ONLY
Benefits:__Inp-Med __Inp-Surg __Inp-Psych __Inp-Hosp __Outpat-Ill
__Outpat-Surg __Outpat-Psych __Outpat-Acc __Phys-Med __Phys-Off
Phys-Psych __Phys-Acc __Pharm __Dental __Oral Surg __Psych-Res
__Transp __Eyeglass __Mental Hlth __Lab/Xray __Anesth
__Acc __Cancer __Hom Hlth __NF-SNF __NF-ICF __Medicare Supp

Policy Owner Name/Address	PolicyOwner Employer/Group Name&Address
SSN_____	Ph #_____
Absent Parent Yes__No__	Group #_____Mo'ly Prem $_____

2.B. ABSENT PARENT INFORMATION

Name_____	Employer Name_____
Address_____	Address_____
SSN_____	IV-D Status _____

3. REMARKS_____

Attach separate sheet if needed giving requested information for each additional item; i.e., multiple absent parents, health insurance policies, etc.

_____ _____ _____
Signature of Recipient or Representative Ph # Date

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-TPL-406 - THIRD PARTY LIABILITY INFORMATION

PURPOSE & USE

The purpose of this form is to collect third party liability (TPL) information which is used to ensure that Medicaid is the payer of last resort. The information obtained on the DOM-TPL-406 is used to update the Resource Information Module (RIM) in the MMIS. If the MMIS Recipient Subsystem indicates that there is other health insurance, claims either pay or reject based on the information contained in the RIM. In order to ensure that the claims pay correctly and not reject to the provider unnecessarily, the medical insurance information must be accurate.

This form must be completed at the time of application. The 406 is not required to go out for Redeterminations. The worker will document the telephone contact on the 300A. If the client obtained/dropped health insurance since the last contact, pull up the previous 406 and complete and then send to TPL.

INSTRUCTIONS

The worker will include this form with each DOM-300.

The worker will complete the top portion of the form identifying the Regional Office, the Specialist handling the case, the Medicaid recipient's name, his/her unique identifying number. In the space provided, the worker will indicate whether the form represents initial information or an update to previously reported medical insurance information. The Medicaid recipient or his/her representative is to complete the medical insurance information, sign/date the form, and list his/her telephone number. Since the assignment of rights to any third party source and cooperation is a factor of eligibility, all requested information must be completed in detail, if applicable.

If the application or redetermination results in approval and the DOM-TPL-406 indicates a third party source other then Medicare, mail the original to the DOM TPL Unit. File the copy in the case record. If the form indicates no third party source, file both original and copy in the case record.

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

This form is not considered complete if all applicable medical insurance information is not indicated. The DOM TPL Unit will return any incomplete form to the client or designated representative for completion.

DOM-TPL-410

Issued 10-01-90

Medicaid RO _____

Address _____

_____

Absent Parent Referral

Responsible Relative Information

(1) _____
(2) _____
(3) _____
Child(ren)'s Case Number

Name _____ Relationship to Child _____

Address _____ City _____ State _____ Zip Code _____

Telephone Number _____ Social Security Number _____

Absent Parent Information

AP Name _____ Social Security Number _____ Date of Birth _____

Address [ ] Current [ ] Last Known _____ City _____ State _____ Zip Code _____

Telephone Number _____ Employer Name [ ] Current [ ] Last Known _____

Emp. Addr. [ ] Current [ ] Last Known _____ City _____ State _____ Zip Code _____

Absent Parent's Children Information

1. Name _____ SSN _____ Date of Birth ___/___/___ Med. Elig. Date ___/___/___

2. Name _____ SSN _____ Date of Birth ___/___/___ Med. Elig. Date ___/___/___

3. Name _____ SSN _____ Date of Birth ___/___/___ Med. Elig. Date ___/___/___

Support Information

Is there a current court order involving paternity, divorce, child support payments, or medical support? Yes ____ No ____ Copy Attached: Yes ____ No ____

Medicaid Specialist _____ Date _____ Date Received by IV-D _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-TPL-410 - ABSENT PARENT REFERRAL

PURPOSE & USE

The purpose of this form is to refer to the Child Support Enforcement Agency all living absent parents whose child(ren) receive medical assistance through the Division of Medicaid. Federal law requires the Child Support Enforcement Agency to provide all appropriate IV-D services, including the petition for medical support, to families with an absent parent when these families include a child who receives Medicaid and has assigned rights to medical support to the State Medicaid Agency.

The form must be completed at application or redetermination when the worker discovers there is a living absent parent. A onetime referral should be all that is necessary.

INSTRUCTIONS

The worker will determine at application or redetermination if there is a living absent parent. If so, the worker must complete information requested on the form sign and date. Prepare an original and one copy. Mail the original to the Department of Human Services (DHS) in the county of the child's residence, attention to Child Support Enforcement. Retain a copy in the case record. If available, include a copy of the current court order with the original form to DHS.

NOTE: There may be a rare instance where a worker will handle cases involving multiple children with the same absent parent. In this instance, if there is one responsible relative for all children, use only one form to identify the absent parent as well as the children of that absent parent.

There also may be an instance of a child with two absent parents. In this instance, complete two referral forms, one for each absent parent.

Responsible Relative Information - include information on the parent or other relative who has custody of the child or children receiving Medicaid.

Absent Parent Information - include information on the absent parent.

Absent Parent's Children Information - include information on the child or children of the absent parent receiving Medicaid.

DOM-TPL 411
Revised 12-01-01

DIVISION OF MEDICAID

Estate Recovery Form

TO: **Third Party Liability (TPL) Unit**

FROM: _____, **Medicaid Specialist**

_____ **Regional Office**

RECIPIENT'S NAME _____

MEDICAID ID NUMBER _____

DATE OF DEATH _____ **DATE OF BIRTH** _____

NURSING FACILITY _____

HCBS WAIVER _____

The above named client is now deceased and there is ownership of real and/or personal property which may be considered an estate. The client was age 55 or over when he/she received Medicaid in a nursing facility and there is no legal surviving spouse or dependent child(ren) under age 21 or dependent blind or disabled child(ren) known to the Regional Office.

The case record is attached.

List the assets that were used in calculating the value of the estate. Do not include burial or life insurance, joint bank accounts, life estate property, annuities or promissory notes.

_____

_____

_____

_____

_____

_____

Area Supervisor's Initials

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-TPL-411 - ESTATE RECOVERY FORM

PURPOSE & USE

This form is used to notify the TPL Unit of the death of a Medicaid eligible who was 55 years of age or older when nursing facility services were received and is affected by the estate recovery provision. A form is required whenever the recipient owned or shared ownership in real property or owned personal property totaling $5,000 or more in value.

Do not complete this form if the recipient is exempt from the estate recovery provision, or if there is no real property owned in full or in part and no personal property valued at $5,000 or more at the time of death.

INSTRUCTIONS

Mail the prepared form along with the case record to the TPL Unit.

DOM-TPL 412
Issued 02-01-96

DIVISION OF MEDICAID
NON-REFERRAL ESTATE RECOVERY FORM

TO: Third Party Liability (TPL) Unit

FROM: _____, Medicaid Specialist

_____ Regional Office

RECIPIENT'S NAME _____

MEDICAID ID NUMBER _____

TOTAL ASSETS (including burial contract) $_____

DECEASED SPOUSE'S NAME _____

COUNTY OF RESIDENCE PRIOR TO NF _____

The above named client is now deceased. There is no ownership of real property. There is ownership of personal property; however, the value is less than $5,000. The client was 55 or older when he/she received Medicaid in a nursing facility and there is no legal surviving spouse or dependent child(ren) under age 21 or dependent blind or disabled child(ren) known to Regional Office.

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-TPL-412 - NON-REFERRAL ESTATE RECOVERY FORM

PURPOSE & USE

This form is used to notify the TPL Unit of the death of a Medicaid eligible who was 55 years of age or older when nursing facility services were received, but is not affected by the estate recovery provision. A form is required when there is no ownership of real property, personal property is valued at less than $5,000, there is no surviving legal spouse, no dependent child(ren) under age 21, and no dependent blind or disabled child(ren).

INSTRUCTIONS

Complete an original and one copy. Mail the original to the TPL Unit. Retain the copy in the case record. Do not mail the case record.

DOM - 301
Revised 10-01-96

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the agency/organization listed below to release benefit or other information needed to establish and/or continue eligibility for Medicaid. I also hereby authorize that a photocopy of this authorization be accepted with the same authority as this original. The information disclosed will be used in connection with my claim for Medicaid benefits with the Mississippi Medicaid Agency. This authorization form will be in effect for one (1) year from the date of my signature.

✓ _____ _____

SIGNATURE OF CLIENT OR DESIGNATED REPRESENTATIVE (attach copy of DOM-302 if Representative signs) — DATE

IDENTIFYING INFORMATION OF MEDICAID APPLICATION/RECIPIENT

Name _____ **Medicaid ID#** _____

Social Security No. _____ **Date of Birth** _____

Benefit Claim No. _____

NAME OF AGENCY/ORGANIZATION _____

ADDRESS _____

_____

Please release the following information on the above named Medicaid applicant/recipient.

Entitlement Amount of Benefit _____

Effective Date of Current Entitlement Amount _____

List Any Deductions Currently Withheld _____

List Any Bonus or Additional Payments Paid During Last 12 Months _____

_____

Other:

_____ _____

Signature of Agency Official Completing Form — Date

Please return the completed original to:

DOM-301A
Revised 10-01-00

For Medicaid Use Only
Applicant _____
Social Security Number _____
Medicaid ID Number _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO THE STATE AGENCY MAKING MEDICAID ELIGIBILITY DETERMINATIONS

Information for the medical sources (to be completed by DDS)

Name of Source _____ Address _____

Identifying patient information:

Name and address at time of admission or treatment _____

Birthdate _____

Check One:
☐ In-patient ☐ Out-patient

Admission date(s) _____ Discharge Date _____ Clinic/patient # _____ Other pertinent information (bldg, clinic, etc) _____

Claimant's Authorization (to be completed by Disabled Person or Person Authorized to Act in His/Her Behalf)
GENERAL AND SPECIAL AUTHORIZATION TO RELEASE MEDICAL AND OTHER INFORMATION IN ACCORDANCE WITH THE PROVISIONS OF THE SOCIAL SECURITY ACT; THE PUBLIC HEALTH SERVICE ACT, SECTIONS 523 AND 527; AND TITLE 38 U.S.C. VETERANS BENEFITS, SECTION 4132.

I hereby authorize the above-named source to release or disclose to the state agency making Medicaid eligibility determinations the following information for the period(s) identified above:

1. All medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, acquired immunodeficiency syndrome (AIDS), or test for or infection with human immunodeficiency virus (HIV);
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living;
3. Information about how my impairment(s) affected my ability to work.

I understand that this authorization, except for action already taken, may be voided by me at anytime. If I do not void this authorization, it will automatically end when a final decision is made on my claim. If I am already receiving benefits, the authorization will end when a final decision is made as to whether I can continue to receive benefits.

✍ _____ _____ _____
Signature of applicant (or representative*) * Representative's relationship to applicant Date

_____ _____
Street address (include apartment number if applicable) Telephone number

_____ _____ _____
City State Zip

Witnesses are required ONLY if this statement has been signed by mark "X" above.

_____ _____
1. Signature of Witness 2. Signature of Witness

_____ _____
Address Address

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-301 - AUTHORIZATION TO RELEASE INFORMATION

PURPOSE & USE

This form is used to authorize the release of benefit and other related information from an agency or organization that requires the client's signature prior to providing such information. It is designed to be a two-way form whereby the agency releasing benefit information can respond on the same form originated by the Medicaid agency. In the event the applicant or recipient is unable to sign his/her name, a completed Form DOM-302, Designated Representative Statement must be attached to Form DOM-301 to document that the individual signing the form is duly authorized to sign in the client's behalf. A signed DOM-301 is valid for one (1) year following the date of the authorizing signature.

INSTRUCTIONS

Prepare an original and 2 copies. Mail the original and 1 copy to the agency releasing the benefit information and retain the second copy only until the completed original is returned. The agency completing the form should retain the copy of the completed form.

Signature of Client: The client or designated representative will sign in this space. If the designated representative signs in the client's behalf, a completed DOM-302 must accompany the authorization form.

Date: Enter the date the client or representative signs the form.

The identifying information of the client should be completed by the Medicaid Regional Office along with the name/address of the agency where the form will be sent for benefit information.

The remainder of the form should be completed by the agency/organization releasing the benefit information; however, if the worker is requesting information not specified on the form, the worker must list the needed information in the "Other" section.

The Regional Office name and address must be stamped in the space at the bottom of the form. The worker should also sign his/her name below the Regional Office stamp so that the form can be returned to the appropriate worker when completed and returned.

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-301A - AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PURPOSE & USE

The purpose of this form is to release medical information to the Disability Determination Service (DDS) for the purpose of making a disability or blindness decision. A separate form must be completed for each source (hospital, doctor, etc.) listed on the DOM-323, Disability or Blindness Report.

INSTRUCTIONS

Prepare an original and 1 copy. Mail the original along with the DOM-323 and DOM-325 to DDS. The Regional Office will complete the portion at the top of the form "For Medicaid Use" and the "Claimant's Authorization" portion of the form. The Medicaid Specialist/Supervisor completing the form will fill in the client's identifying information and have the client or representative sign the form in the designated space. Two witness signatures are required if the client signs with a mark.

NOTE: If the applicant is unable to sign Form DOM-301A and the authorized representative signs in the applicant's place, the representative must state on the form the reason the applicant is unable to sign his/her name, e.g., "patient unconscious," "patient senile," etc. A DOM-302, Designated Representative Statement, must accompany all DOM-301A Forms signed by the representative.

Leave the top portion of the form "Information for the Medical Sources" blank for DDS to complete. The Regional Office need only ensure that the client signs the appropriate number of forms for each doctor, hospital, or other medical source listed on the DOM-323, and explain to the client that the form(s) will be submitted to the sources the client listed on DOM-323.

DOM-302
Revised 07-01-84

DESIGNATED REPRESENTATIVE STATEMENT

CLIENT'S DESIGNATION

I hereby designate _____ as my representative in the application/redetermination process of eligibility for Medicaid from the State of Mississippi.

✓_____ Date _____
Client's Signature

I understand that by accepting this designation as representative, I will provide or assist in providing the necessary information to establish the individual's eligibility for Medicaid. I also understand that if I knowingly withhold information or knowingly misrepresent facts about the situation of the individual, I may be prosecuted for perjury and/or fraud.

✓_____ Date _____
Representative's Signature

Address _____

Witness _____ Date _____

STATEMENT OF SELF-DESIGNATION BY REPRESENTATIVE

I hereby declare that I am acting for _____ in providing information to establish the individual's eligibility for Medicaid because he/she is too aged or ill to provide information about his/her situation and to act responsibly for himself/herself. I will provide information to the best of my knowledge concerning the individual's situation. I understand that if I knowingly withhold any information or knowingly misrepresent the facts, I may be prosecuted for perjury and/or fraud. I agree to notify the State Medicaid Agency immediately of any change in the individual's situation of which I become aware.

✓_____ Date _____
Representative's Signature

Address _____

Witness _____ Date _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-302 - DESIGNATED REPRESENTATIVE STATEMENT

PURPOSE & USE

The purpose of this form is to designate in writing someone who is qualified to act in a client's behalf for the purpose of completing and signing all eligibility forms and providing all pertinent information about the client. Refer to Section C for policy governing persons who can file an application or redetermination for a client.

INSTRUCTIONS

Prepare an original and 1 copy. The client can designate a representative by completing the "Client's Designation" portion of the form. If the client is unable to designate someone, the representative can complete the "Statement Self-Designation By Representative" and designate himself/herself without the client's signature if the representative is determined qualified to act in the client's behalf.

Notate on the Record of Contact the date mailed to the client or representative. When the original is returned, file it in the case record. The representative keeps the copy.

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-303 - NOTICE OF DELAY

PURPOSE & USE

This form is used only for applications pending beyond the applicable standard of promptness due to agency delay. The purpose of the form is to explain to the applicant or representative the reason for the agency delay. Agency delay includes all delays attributed to the worker or DDS resulting in an overdue application.

The exception to issuing DOM-303 for an application processing agency delay is in the instance of a transfer of resources. Although an application may become overdue because a transfer is discovered, the Notice of Transfer of Resources form issued to the applicant serves as notice that the transfer issue must be resolved before eligibility is determined.

Refer to Section C for policy governing Standards of Promptness for applications.

INSTRUCTIONS

Prepare an original and 1 copy. Issue the original to the applicant or representative and file the copy in the case record. Enter the applicable due date for the application and an explanation for the delay.

The worker sill sign, date and return address stamp the form.

DOM-303
Revised 11-01-84

NOTICE OF DELAY

_____ Applicant's Name _____

_____ Medicaid ID # _____

_____

At the time the application for Medicaid was filed, we explained that Medicaid is allowed _____ days to complete the application and determine eligibility. This processing period ended on _____; however, your application has not been completed due to agency delay. The reason for the delay is explained below:

_____

_____

_____

_____

_____

_____

_____

_____

You will be notified when a decision has been reached on your application.

Medicaid Specialist _____ Date _____

Regional Office Address/Telephone:

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-305 - NOTICE OF ACTION

PURPOSE & USE

This form is used to notify applicants of the approval of an application and to notify recipients of approval of a redetermination. For institutionalized recipients, this form is used to approve a redetermination provided Medicaid Income remains the same or decreases for the current month. If Medicaid Income increases in the first month of approval of a redetermination, the recipient must be notified via DOM-306, Notice of Adverse Action, and provided 10 days advance notice. For a complete discussion of the use of this form refer to Section C.

THIS FORM IS GENERATED BY MEDS BUT IS AVAILABLE IN HARDCOPY IF NEEDED.

INSTRUCTIONS

Prepare an original and 1copy. The original is mailed to the client or representative and the copy is filed in the case record.

This form is divided into two sections. The portion to be completed depends on the type action to be taken.

THE FOLLOWING ACTION HAS BEEN TAKEN ON YOUR MEDICAID APPLICATION: The top portion is to be completed when approving an application. Check the appropriate block to indicate the action taken.

You have been approved for Retroactive Medicaid...: Check this block if the application involves retroactive approval and specify the month(s) of retroactive eligibility in the space provided. If the applicant is being denied any month(s) of retroactive eligibility, specify in the "Remarks" section. If the retroactive approval involves month(s) of nursing home care, include the amount of Medicaid Income in the space provided.

Note: For 1002 Retro approvals, include the following statement in the Remarks section: "You will not receive a Medicaid card for the month(s) identified above. Please show this notice to all providers of medical services that rendered services in your behalf during the month(s) shown above."

You have been approved for Medicaid beginning: Check this block if the application is being approved and enter the beginning date of eligibility.

If the recipient is in a nursing home/hospital, enter the amount of Medicaid Income and when the client must begin to pay toward the cost of his care in the spaces provided. If income protection is applicable, enter "$0" in the first space for the first month of care and enter the amount of Medicaid Income to begin the next month in the second space provided.

THE FOLLOWING ACTION HAS BEEN TAKEN ON YOUR MEDICAID CASE: The lower section is completed when approving a redetermination in which Medicaid Income remains the same or decreases in at least the first month. This section is also used to notify the client that his/her Medicaid case is being transferred to another Regional Office. Check the appropriate block to indicate the action taken.

The redetermination of your Medicaid case has been approved: Check this block when approving a redetermination where Medicaid Income remains the same. Enter the amount of Medicaid Income, also.

The amount you must pay. . . has been reduced: Check this block when Medicaid Income will be reduced. Enter the effective date of the reduced amount and the amount. Note, it is only necessary for the first month to reflect a decrease in Medicaid Income and not all 4 months that can be shown.

Your case has been transferred. . .: Check this block if the client's case is being transferred to another Regional Office name the new Regional Office. Include at the bottom of the form the address and telephone number of the new Regional Office which will handle the case.

DATE OF MAILING: The Supervisor or Specialist reviewing the case will enter the date of mailing. The date entered must be the date the form is mailed out.

ADDRESS/TELEPHONE NUMBER OF REGIONAL OFFICE: Stamp or write the Regional Office address in the space provided and include the telephone number.

Signature of Medicaid Worker: The worker will sign the form in this space.

DOM-305
Revised 10-01-96

Regional Office _____

NOTICE OF ACTION

_____

_____

_____

Client's Name _____

Medicaid ID # _____

THE FOLLOWING ACTION HAS BEEN TAKEN ON YOUR MEDICAID APPLICATION:

( ) You have been approved for Retroactive Medicaid benefits for the months listed below. If you were in the nursing home/hospital during these months, the money amount listed is the amount you must pay toward the coast of your care.

Month/Year _____ $ _____

Month/Year _____ $ _____

Month/Year _____ $ _____

( ) You have been approved for Medicaid beginning _____. If you are in a nursing home/hospital the amount you must pay toward the cost of care is:

Month/Year _____ $ _____

Month/Year _____ $ _____

HE FOLLOWING ACTION HAS BEEN TAKEN ON YOUR MEDICAID CASE:

( ) The redetermination of your Medicaid case has been approved. You remain eligible for Medicaid benefits. Medicaid Income remains $ _____.

( ) The amount you must pay toward the cost of your nursing home/hospital care has been reduced.

Beginning _____, you will pay $ _____

Beginning _____, you will pay $ _____

( ) Your case has been transferred to the _____ Regional Office. The address of this office is given below.

REASON/REMARKS: _____

IF YOU DISAGREE WITH THE ACTION TAKEN ON YOUR CASE, you may request a fair hearing. Hearing requests must be made in writing within 30 days of the date the worker signed this form. Your written request should be mailed to the Regional Office address shown below. THIS DOES NOT APPLY TO ESTATE RECOVERY PER MISS. CODE ANN. SEC. 43-13-317.

DATE OF MAILING: _____ MEDICAID SPECIALIST: _____

EGIONAL OFFICE ADDRESS/TELEPHONE:

Enclosures:

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-306 - NOTICE OF ADVERSE ACTION

PURPOSE & USE

The purpose of this form is to notify the client of any adverse action taken on an application or active case. Adverse actions include all rejections of applications, case closures, and increases in Medicaid Income. The form explains the client's right to a hearing and the right to continuation of benefits if a hearing is timely requested to appeal an increase in Medicaid Income or termination of benefits.

THIS FORM IS GENERATED BY MEDS BUT IS AVAILABLE IN HARDCOPY IF NEEDED.

INSTRUCTIONS

Prepare an original and 1 copy. The original is mailed to the client along with a hearing pamphlet. The copy is filed in the case record. Refer to Section C for policy governing adverse actions and continuation of benefits.

The DOM-306 is divided into two sections. The correct section to complete depends on the type of action taken.

THE FOLLOWING ACTION HAS BEEN TAKEN ON YOUR MEDICAID APPLICATION: Complete the top portion of DOM-306 for a rejection of an application. In the space provided, enter the reason for the rejection which includes an explanation of the policy supporting the action taken.

THE FOLLOWING ACTION HAS BEEN TAKEN ON YOUR MEDICAID CASE: Complete the lower portion of DOM-306 for either a termination of benefits (closure) or and increase in Medicaid Income, whichever is applicable. The effective date of the termination or increase will be entered in the appropriate space. Refer to Section C for policy which governs the effective dates of either type of action.

The reason for the closure or increase will be clearly stated in the space provided. For closures, include an explanation of the policy which supports the action taken. For an increase in Medicaid Income, include the new amount to be paid and the reason for the increase.

For both terminations and increases in Medicaid Income, complete the continuation of benefits portion of the fair hearing statement. The date to be entered is 10 calendar days from the date of mailing. The Supervisor or Specialist who reviews the case and mails the form should enter the date of mailing and the date which represents the end of the 10-day advance notice period in the space provided.

DATE OF MAILING: Enter the date the form is mailed.

WORKER: The worker will sign here.

ADDRESS/TELEPHONE NUMBER OF REGIONAL OFFICE: The Regional Office address and telephone number must be stamped in the space provided.

DOM-306
Revised 10-01-96

Regional Office _____

NOTICE OF ADVERSE ACTION

_____ Client's Name _____

_____ Medicaid ID # _____

_____

THE FOLLOWING ACTION HAS BEEN TAKEN ON YOUR MEDICAID APPLICATION:

( ) Your request for Medicaid benefits must be denied because _____

_____

_____

IF YOU DISAGREE WITH THE ACTION TAKEN ON YOUR APPLICATION, you have 30 days from the date the worker signs this notice to request a fair hearing. A hearing pamphlet is enclosed which explains hearing procedures.

THE FOLLOWING ACTION HAS BEEN TAKEN ON YOUR MEDICAID CASE:

( ) Your case will close effective _____.

) You remain eligible for Medicaid, however there has been an increase in the amount you must pay toward the cost of your nursing home/hospital care.

Beginning _____, you will pay $ _____

Beginning _____, you will pay $ _____

Beginning _____, you will pay $ _____

REASON: _____

_____

_____

IF YOU DISAGREE WITH THE ACTION TAKEN ON YOUR MEDICAID CASE, you have 30 days from the date the worker signs this notice to request a fair hearing. A hearing pamphlet is enclosed which explains hearing procedure.

If you request a hearing by _____, you can continue to receive Medicaid, or receive it at your current level, during the hearing process. THIS DOES NOT APPLY TO ESTATE RECOVERY PER MISS. CODE ANN. SEC. 43-13-317.

DATE OF MAILING _____ MEDICAID SPECIALIST _____

EGIONAL OFFICE ADDRESS/TELEPHONE

Enclosures: Hearing Pamphlet

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-307 - REQUEST FOR INFORMATION

PURPOSE & USE

The purpose of this form is to inform an applicant or recipient in writing of the information needed in order to complete the application or redetermination process. All requests for information must be put into writing to the client or representative with a copy for the case record.

THIS FORM IS AVAILABLE IN MEDS

INSTRUCTIONS

Prepare an original and 1 copy. Issue the original to the client or representative and retain the copy in a tickler file. If the original is returned with the information, discard the copy and file the original and the information in the case record. If the original is not returned, but the information requested is submitted, file the copy in the case record. If the requested information is not submitted within ten (10) days, file the tickler copy in the case record and prepare DOM-309, Second Request for Information. The DOM-307 original or copy must be retained in the case record to confirm the request for information.

Note: This form is designed to be issued along with DOM-300A, Redetermination Form, to allow the recipient ten (10) days in which to complete the redetermination form and return the needed information. However, if new or additional information is required upon return of the completed DOM-300A, and this information was not included on the DOM-307 issued along with the DOM-300A, it is necessary to send another DOM-307 requesting the information for the first time.

Enter the appropriate identifying information and check the appropriate block to indicate whether the request is for an application or redetermination. Enter the date which is 10 days after the date the form is prepared and mailed in the space provided.

List in the space provided each item needed to determine eligibility.

The worker will sign, date and return address stamp the form.

DOM-307
Revised 10-01-96

REQUEST FOR INFORMATION

_____ Client's Name _____

_____ Medicaid ID # _____

_____

☐ This is to give you in writing the information we must have in order to determine Medicaid eligibility. If you have been in and talked with a worker, this letter will repeat for you the information needed.

☐ Enclosed is a Redetermination Form which must be completed in order to continue Medicaid eligibility for the client named above. Completion of the form is required at least once every year for each client. Listed below is the information needed to complete the redetermination.

Either bring or mail in the information listed below before _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Regional Office Address/Telephone:

_____
Medicaid Specialist

_____
Date

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-309 - SECOND REQUEST FOR INFORMATION

PURPOSE & USE

This form is used as a second request when the information requested via DOM-307 was not provided by the end of the 10-day period specified. The second request informs the client or representative of the information still needed to complete the application or redetermination process.

THIS FORM IS AVAILABLE IN MEDS.

INSTRUCTIONS

Prepare an original and 1 copy. Issue the original to the client or representative and retain the copy in the tickler file. If the original is returned with the information, discard the copy and file the original and the information in the case record. If the original is not returned but the information requested is submitted, file the copy in the case record. If the requested information is not submitted within ten (10) days, file the tickler copy in the case record. The DOM-309 original or copy must be retained in the case record to confirm the second request for information.

In the space provided, enter the information requested via DOM-307, Request for Information, that has not been received.

Check the appropriate block to indicate whether the request involves an application or redetermination in process.

Applications - Enter the applicable standard of promptness of either 45 or 60 days in the space provided. Also enter the date the 45 or 60-day period will end as determined by the date application was filed. In the last space, enter the date which is ten (10) days following the date DOM-309 is mailed.

Redetermination - In the space provided, enter the date which is ten (10) days following the date DOM-309 is mailed.

The worker will sign, date and return address stamp the form.

DOM-309
Revised 11-01-84

SECOND REQUEST FOR INFORMATION

_____ Client's Name _____

_____ Medicaid ID # _____

_____

On _____, you were mailed a request for the following information:

_____

_____

_____

_____

_____

_____

_____

☐ We must have this information to complete the Medicaid application for the above named applicant. The processing time of _____ days that Medicaid is allowed to complete the application and determine eligibility ends on _____. If we do not receive the needed information by _____, appropriate action will be taken to deny the application.

☐ We must have this information to continue Medicaid eligibility for the above named client. As of this date, we have not received this information. If we do not receive the needed information by _____ _____, appropriate action will be taken to close the client's Medicaid Case.

Regional Office Address/Telephone:

Medicaid Specialist _____

Date _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-310 - STATEMENT OF HOUSEHOLD EXPENSES

PURPOSE & USE

This form is used only for individuals in Former SSI Recipients coverage groups who must have SSI policy applied to their case. When such a client has Income-In-Kind and alleges that the cash value of In-Kind Support & Maintenance (ISM) is less than the Presumed Maximum Value (PMV) or alleges that household expenses are shared, the client must complete this form to determine the income to count or the living arrangement in which the client will be placed.

INSTRUCTIONS

Prepare an original to mail or give the client for completion.

DOM-310
Issued 07-01-81

STATEMENT OF HOUSEHOLD EXPENSES

Client's Name _____

Medicaid ID # _____

RETURN BY: _____

PLEASE COMPLETE ITEMS BELOW FOR THE PERSON NAMED ABOVE WHO LIVES IN YOUR HOUSEHOLD.

1. Total number of persons living in this household: _____

2. Rent or mortgage payment for this household: _____

   City and county taxes, if not included above: _____

   House insurance, if not included above: _____

   TOTAL MONTHLY SHELTER EXPENSES: $_____

3. Average monthly expenses for utilities for this household:

   Lights $_____

   Water $_____

   Heating Fuel $_____

   Sewer $_____

   Garbage Collection $_____

   TOTAL $_____

4. Average monthly expenses for food for this household: $_____

5. TOTAL amount person named above pays each month: $_____

WHEN COMPLETE, MAIL TO:

✓_____

Signature of Person Completing the Form

Date _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-311 - REQUEST FOR MEDICAID APPLICATION

PURPOSE & USE

Form DOM-311 is designed to accompany Form DOM-300, Application Form, when a request for an application is made known to the Regional Office or when the Regional Office is made aware that an individual has entered a nursing facility and needs to apply for Medicaid. The form explains that all questions must be answered on DOM-300 and also informs the applicant of the processing time allowed to determine eligibility.

INSTRUCTIONS

Complete an original and 1 copy. Issue the original to the applicant or representative and file the copy in the correspondence file until the application is formally filed. When the application is filed and a case record set up, file the copy in the case record.

Check the appropriate block that applies to whether the application was requested or that the Regional Office is aware that the applicant has entered a nursing facility and needs to apply. If the latter is true, enter the name of the applicant and the name of the nursing facility.

The worker will sign, date and return address stamp the form.

DOM-311
Revised 02-01-99

REQUEST FOR MEDICAID APPLICATION

_____
Date

_____ RE: _____

_____

_____

☐ We have received your request for a Medicaid application. Enclosed is an application form for you to complete. Please answer all questions completely. We may require that you show proof of all income and resources available to the applicant. (Copies are allowed.)

☐ We have received notification that _____ has entered _____ nursing facility. If you are interested in applying for Medicaid to assist in the payment of the nursing home expenses, complete the enclosed application form. Please answer all questions completely. We will require that you show proof of all income and resources available to the applicant.

The application form may be mailed to the Regional Office listed below. If you need assistance with your application, you may call the phone number below. The date the Division of Medicaid receives the application is considered the date that you apply.

The Division of Medicaid is allowed an application processing time of 45 days for all aged (age 65 or over) and blind individuals and 90 days for all applications for disabled individuals. This processing time begins when the Medicaid office receives the signed application.

_____
Medicaid Specialist

Attachments: DOM-300
Application Checklist
Pamphlet

Regional Office Address/Telephone:

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-312 - NOTICE OF POTENTIAL ELIGIBILITY FOR VA BENEFITS

PURPOSE & USE

Form DOM-312 is used to advise Medicaid applicants or recipients of the requirement to apply for initial or increased VA benefits in accordance with the Utilization of Other Benefits provision. Refer to Section D for a policy discussion of this provision.

INSTRUCTIONS

Complete an original and 2 copies. Issue the original to the client or representative, file one copy in the case record and use the remaining copy as the tickler copy set for follow up in 30 days of issuance of the notice.

Check the appropriate block(s) to indicate that the client must apply for VA Improved Pension or VA Aid & Attendance or both. If another benefit is appropriate, enter the type of benefit under "Other."

The worker will sign and date the form.

DOM-312
ISSUED 07-01-93

DATE: _____

NOTICE OF POTENTIAL ELIGIBILITY FOR VA BENEFITS

_____ NAME: _____

_____ ID#: _____

_____ SSN: _____

VA CLAIM # _____

Our records indicate that you may be eligible for VA benefits or for an increase in your current benefit. To be eligible for Medicaid, you must apply for any and all VA benefits you may be entitled to receive even if your Medicaid eligibility is affected by your entitlement for VA benefits.

The benefit that you need to apply for is:

___ VA Improved Pension benefits <u>including</u> Unreimbursed Medical expenses which may increase your pension benefits.

___ VA Aid & Attendance benefits.

___ Other _____

_____

You must file an application with the Veterans Administration within 30 days of the date on this notice <u>and</u> provide this office with proof that you have filed with the VA. You must provide the VA with all information they need to process your application for benefits. This requirement is in accordance with 42 CFR 435.603.

<u>Notify this office when the VA has made a final decision regarding your benefits.</u>

If you have any question about these instructions, please contact the Regional Office listed below.

Medicaid Specialist _____

Regional Office Address/Telephone Number

DOM-317 - EXCHANGE OF INFORMATION BETWEEN NURSING HOME OR HOSPITAL AND MEDICAID REGIONAL OFFICE

PURPOSE & USE

This form is used by the Nursing Home or Hospital and Regional Medicaid Office as an exchange of information form regarding applicants for and recipients of Medicaid. The purpose of this form is:

1. It is initiated by the Nursing Home/Hospital at the time a Medicaid applicant/recipient enters, transfers in or out, is discharged, or expires in the facility.

2. It is completed by the Regional Medicaid Office at the time an applicant has been approved for Medicaid and will notify the facility of the effective date of Medicaid eligibility and the amount of the client's Medicaid Income. It will also be used to notify the Nursing Home/Hospital of any change in Medicaid Income which occurs or if Medicaid is terminated or denied.

THIS FORM IS GENERATED BY MEDS BUT IS AVAILABLE IN HARDCOPY IF NEEDED.

INSTRUCTIONS

The Nursing Home/Hospital originating the form will prepare an original and 2 copies. The original and 1 copy will be mailed to the appropriate Regional Medicaid Office while the second copy is retained by the facility.

The Regional Office will respond on the same forms originated by the Nursing Home or Hospital. The original is returned to the Nursing Home or Hospital and the copy is retained in the client's case record.

If the Regional Office originates the DOM-317 Form, follow the same procedure outlined above for the distribution of the original and copies of the completed form.

The top portion of the form contains identifying information about the Medicaid applicant or recipient and is completed by the office originating the form. The initial DOM-317 is completed by the nursing home or hospital.

NOTICE OF ACTION TAKEN - This portion of the form is completed by the Nursing Home or Hospital at the time the following situations occur:

1. At the time a Medicaid applicant or recipient enters the facility, the Nursing Home/Hospital will check the appropriate block and enter the month, day, and year of entry.

   Check the appropriate block to indicate whether the client or his/her family has been given DOM-300, Application Form, to complete.

2. At the time a client is discharged to another medical facility, check the appropriate block and enter the month, day and year of discharge. Include the name and address of the new facility, if known, in the space provided.

3. If a client is transferred to another medical facility, check the appropriate block and enter the month, day and year of the transfer. Include the name and address of the new facility in the space provided.

4. When a client is discharged to a private living arrangement, check the appropriate block and enter the month, day and year of discharge. Include the client's new address, if known, in the space provided.

5. At the time of the client's death, check the appropriate block and enter the month, day and year of death in the space provided.

6. When a client is discharged from the facility but remains physically in the facility in the Hospice program, enter the date of Hospice enrollment.

The Nursing Home Administrator will sign the form and enter the date the form is completed in the space provided prior to sending the form to the appropriate Medicaid Regional Office.

Page 2 of DOM-317 - To be completed by the Medicaid Regional Office.

MEDICAID ELIGIBILITY STATUS - This portion of the form is completed by the Medicaid Regional Office as follows:

1. Approvals - Check the 1st block when an applicant is approved for long-term care. In the space provided, enter the beginning Medicaid eligibility date.

   In the spaces provided enter the effective date (month, year) and the amount of applicant's Medicaid Income as reflected on the Institutional Budget. The form is designed to show fluctuating income amounts or income protection for first month and the amount of income to be effective in second month, third month, and fourth month, if different.

2. Changes in Medicaid Income - Check the 2nd block to report a change in the client's Medicaid Income as a result of a special or regular review of the client's case. In the space provided enter the effective date (month, year) and the new amount of client's Medicaid Income.

3. Regular Review - No Change in Medicaid Income - Check the 3rd block if at the time of the regular review there is no change in the client's Medicaid Income. Also enter the amount previously reported.

4. Denials - Check the 4th block if an applicant has been denied eligibility.

5. Terminations - Check the 5th block if a client's case is closed. In the space provided enter the month, day and year the closure is effective.

REMARKS: Enter in the space provided any remarks regarding applicant's or recipient's case.

Signature of Medicaid Worker/Date: The Medicaid Specialist or Supervisor will sign and date the form in the space provided.

DOM-317
Revised 01-01-03

EXCHANGE OF INFORMATION BETWEEN NURSING FACILITY OR HOSPITAL AND REGIONAL MEDICAID OFFICE

Name of Nursing Facility/Hospital _____

Provider No. _____

Address _____

City _____ State _____ Zip _____

Client's Name _____

Medicaid ID_____ Social Security No._____

Name of Responsible Relative _____

Address of Relative _____

Client's County of Residence Before Entering Facility _____

Does this client receive SSI? ( ) Yes ( ) No Amount _____

NOTICE OF ACTION TAKEN

( ) Client entered facility (Month, Day, Year) _____

Family or client has been given an application form? ( ) Yes ( ) No

( ) Client has been discharged to another medical facility as of_____ (date).

Name/address of new facility: _____

_____

( ) Client has been transferred to another facility as of _____ (date).

Name/address of new facility: _____

_____

( ) Client has been discharged to hospice care within same facility effective_____(date).

( ) Client has been discharged to a private living arrangement: _____ (date).

( ) Client is deceased. Date of death: _____

_____ _____

SIGNATURE DATE

Client's Name _____

Medicaid ID # _____ Provider # _____

MEDICAID ELIGIBILITY STATUS

( ) Client is eligible for Medicaid effective _____

Effective _____, Medicaid Income $ _____

Effective _____, Medicaid Income $ _____

Effective _____, Medicaid Income $ _____

Effective _____, Medicaid Income $ _____

( ) Client has had a change in Medicaid Income.

Effective _____, Medicaid Income $ _____

Effective _____, Medicaid Income $ _____

Effective _____, Medicaid Income $ _____

Effective _____, Medicaid Income $ _____

( ) Yearly review has been completed, no change in Medicaid Income.

( ) Client has been denied Medicaid benefits.

( ) Client's Medicaid benefits terminate effective _____

The Medicaid Income figures shown represent a total monthly amount. When collecting medicaid Income from a patient for a partial month stay in your facility, the above figure must be prorated according to the number of days of the stay.

REMARKS: _____

_____

_____

_____

_____ _____

Signature Date

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-318 - EXCHANGE OF INFORMATION BETWEEN MEDICAID REGIONAL OFFICE AND VA/DHS/SSA

PURPOSE & USE

This form is used in conjunction with the Spousal Impoverishment income provision whereby an Institutionalized Spouse (IS) allocates monthly income to a Community Spouse (CS). If either spouse receives a VA Pension, SSI Benefits and/or AFDC or Food Stamps, this form is used to communicate with the Jackson VA Regional Office, the Social Security Administration and the Department of Human Services County Offices concerning cash assistance benefits that may be affected due to a CS allocation. The form is to be initiated by the Medicaid Regional Office after the CS allocation has been determined and agreed to by all concerned parties, i.e., the IS, the CS and/or their designated representatives.

If the IS makes money available to the CS, the appropriate agency must be informed. If cash assistance benefits (not Food Stamps) are affected for either spouse, the appropriate agency will complete the bottom portion of DOM-318 and return it to the Medicaid Regional Office with the adjusted benefits information specified.

Approval of a nursing home case is not to be delayed pending return of this form. When the completed form is returned by the VA/SSA or DHS, appropriate corrective action will be necessary to adjust Medicaid Income and/or the CS allocation amount.

MEDICAID ELIGIBILITY FORMS AND INSTRUCTIONS

INSTRUCTIONS

Prepare an original and 2 copies. The original and one copy will be mailed to the appropriate agency as follows:

For VA Purposes - VA requests that the Medicaid Regional Office send this form to the VARO in Jackson (100 W. Capitol, Jackson, MS 39269 ATTN: Adjudication Division). The form should be sent on a one-time basis only after the initial determination of a VA Pensioner's Medicaid Income and CS allocation. After Medicaid reports this income information once to VA, it is the veteran's responsibility to report any subsequent changes to VA.

For SSA Purposes - If a CS is SSI eligible and opts to retain SSI eligibility, the form should be sent to SSA to report the initial amount of the CS allocation and any subsequent changes. If the CS opts to receive an allocation amount that will cause SSI to terminate, the form will be sent only once.

For DHS Purposes - If a CS receives AFDC and opts to retain AFDC eligibility, send the form to report any allocation amount and subsequent changes. If the CS receives food stamps, advise the appropriate county DHS office of the allocation amount and any subsequent changes.

The top portion of the form is to be completed by the Medicaid Regional Office. Enter the IS/CS identifying information and the amount of the IS Medicaid Income (after the CS allocation has been deducted) and the amount of the CS monthly allocation.

The worker will sign and date the form in the space provided.

The appropriate agency (VA, SSA or DHS) will complete the bottom portion of the form after benefits have been adjusted.

DOM-318
ISSUED 03-01-90

EXCHANGE OF INFORMATION BETWEEN MEDICAID RO AND VA/SSA/DHS

TO: _____ FROM:

_____

_____

_____

The income information listed below involves a married couple whereby one spouse is in a nursing home and the other spouse is at home. This is being sent to you because one or both of the individuals named below have been identified as receiving benefits from your agency. If this information has any impact on the amount of cash assistance paid by your agency, please return this form to the Medicaid Regional Office named above after completing the bottom portion of this form.

Name of Spouse in Nursing Home _____

Name of Nursing Home _____

SSN: _____ Benefit Claim No. _____

Amount of Income Payable to Nursing Home $_____ Effective Date _____

Name of Community Spouse _____

SSN: _____ Benefit Claim No. _____

Income Allocated From Nursing Home
Spouse to Community Spouse $ _____ Effective Date _____

Signature of Worker _____ Date _____

TO BE COMPLETED BY VA/SSA/DHS - As a result of the income information shown above, cash assistance will be adjusted as follows:

Name of Spouse _____

Adjusted Benefit $ _____ Effective Date _____

Type of Benefit _____

Signature of Worker _____ Date _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-319 - REPORT OR REFERRAL TO DISTRICT OR BRANCH SOCIAL SECURITY OFFICE

PURPOSE & USE

This form is used to provide notification to the branch or district Social Security offices in the following instances:

- Refer to the Social Security office a person who appears to be potentially eligible for Supplemental Security Income benefits.

- To notify the Social Security office of information which Medicaid has secured which will possibly affect the SSI benefit amount.

THIS FORM IS AVAILABLE IN MEDS.

INSTRUCTIONS

Prepare an original and 1 copy. Mail the original to the appropriate Social Security Office and file the copy in the case record.

Enter the appropriate referral information and sign and date the form.

DOM-319
Revised 04-01-90

REPORT OR REFERRAL TO DISTRICT OR BRANCH SOCIAL SECURITY OFFICE

TO: _____
Social Security Administration

RE: _____
(Name of Client)

FROM: _____
(Social Security Number)

_____
(Medicaid ID Number)

We have secured the following information concerning the above named individual:

1. ( ) The above named person is being referred to you as a possible claimant for SSI benefits. Should this person be determined eligible for benefits, please report to us the beginning month of eligibility. His/her address is _____.

2. ( ) Beneficiary has entered a Title XIX institution as a patient.
   Name of Nursing Home _____
   Date of Entry _____
   Estimated length of stay _____

3. ( ) Beneficiary left a Title XIX institution patient status. His/her new address is _____
   Date of Departure _____

4. ( ) Change of address (moved from private living arrangement to another)
   Old Address _____
   New Address _____

5. ( ) Beneficiary deceased. Date of Death _____

6. ( ) Change in income or resources of beneficiary. Specify _____
   _____

7. ( ) Change in income or resources of spouse. Specify _____
   _____

8. ( ) Beneficiary entered a public institution.
   Name of Institution _____
   Address of Institution _____
   Date of Entry _____

9. ( ) Other, specify _____

REMARKS:

_____ _____
DATE Medicaid Specialist

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-320A - AGREEMENT TO SELL PROPERTY

PURPOSE & USE

This form is to be completed by the client or representative, with the assistance of the Medicaid worker if necessary, prior to application of the reasonable efforts to sell property exclusion. This exclusion and the use of this form is described in detail in Section F, Resources.

INSTRUCTIONS

Prepare an original and one (1) copy. The client or representative will keep the original and the copy will be filed in the case record.

The portion of the form describing the property in question is to be completed by the worker or the client or representative. The appropriate signature of the client or representative must appear on the form before the exclusion is applied. The form must also be dated.

IMPORTANT INFORMATION ABOUT THIS AGREEMENT

Within thirty (30) days of signing this agreement the Medicaid client or designated representative must take action to:

1. List the property in question with a realtor or begin any other appropriate method of sale (advertise via local media, place a "For Sale" sign on the property, conduct open houses or otherwise show the property).

2. Send appropriate proof to the Medicaid Regional Office of the method(s) of sale decided upon.

After initial proof of a sale attempt is submitted, the owner(s) of the property must actively maintain all efforts to sell the property and must not reject any reasonable offer to buy the property. The burden is on the client and other owners(s) to prove to Medicaid's satisfaction that an offer was rejected because it was not reasonable.

AT ANY TIME REASONABLE EFFORTS TO SELL ARE STOPPED OR A REASONABLE OFFER TO BUY IS REFUSED, THE PROPERTY BECOMES A COUNTABLE RESOURCE TO THE MEDICAID CLIENT BEGINNING WITH THE FIRST MONTH AFTER THE EFFORT TO SELL STOPPED OR THE REFUSAL TO SELL OCCURRED.

The Medicaid worker will check every ninety (90) days to determine if reasonable efforts to sell are being maintained. Appropriate proof will be requested as necessary.

DOM-320A
Issued 06-01-88

Client's Name: _____

Medicaid ID # _____

AGREEMENT TO SELL PROPERTY

I understand that the resources owned by the person shown as the Medicaid client exceeds the amount which an eligible individual may have and still qualify for Medicaid. By signing this agreement, I (We) agree to take all necessary steps to sell the real property described below and to actively continue my (our) efforts to do so until the property is sold. I (We) agree to sell the property for the best possible price and to notify Medicaid within five (5) working days after completion of the sale. Failure to comply with the terms of this agreement will result in the termination of Medicaid benefits and a demand for repayment of any Medicaid funds improperly spent.

Address/Location of Property: _____

_____

Name(s) of Owners: _____

_____

Current Market Value of Property: _____

Amount Owed on Property (if any): _____

Client's Ownership Interest: _____

Value of Client's Share: _____

NOTE: The Medicaid client must receive his/her portion of the net proceeds of the sale. Failure to make these funds available will result in a transfer of resources penalty.

✓_____ _____

Signature of Client or Designated Representative Date

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-321 - RESOURCE COMPUTATION WORKSHEET

PURPOSE & USE

The purpose of this form is to record the value of countable resources which will count toward the client's resource limit. This breakdown should agree with the amounts calculated by MEDS. If the client owns resources but any of the resources are excluded, indicate ownership by checking off the type of resource even though excluded.

INSTRUCTIONS

Prepare an original only and file in the case record.

The worker will make a check mark beside each applicable resource named on the form which the client owns. In the space provided in the right hand column the worker will record the value of each resource checked. The value of each resource will be totaled and the appropriate block checked to indicate if the applicable resource limit is that of an individual or couple. The worker will record in the Remarks section whether the client is eligible or ineligible based on resources and record any additional remarks relating to resources owned. Up to 4 months can be shown on one form.

The worker will sign and date the form.

DOM-321
Revised 10-01-96

Case Name: _____

Case Number: _____

RESOURCE COMPUTATION WORKSHEET

If Client owns any resource listed below, check space If countable, enter countable value	_____ (Month)	_____ (Month)	_____ (Month)	_____ (Month)
____ Retirement Funds				
____ Trust Funds				
____ Safe Deposit Box (if countable, enter amt)				
____ Cash on Hand				
____ Checking Account				
____ Savings Account				
____ Certificates of Deposit				
____ Patient Fund Account				
____ Nursing Home Credit				
____ Other Liquid Resources (Stocks, Bonds, Promissory Notes, Etc)				
____ _____				
____ Home Property (Enter EV if not excluded)				
____ Life Estate or Heir Property (Enter EV if not excluded)				
____ EV of Nonexcluded Property (includes mineral rights)				
____ Household Goods & Personal Effects (Enter CMV if in excess of limit)				
____ Automobiles: Excluded ____ Y ____ N If yes, reason: _____ If no, enter CMV or EV				
____ Countable CSV of Life Insurance				
____ Burial Spaces _____ (Enter CMV if not excluded)				
____ Burial Funds _____ (Enter CMV if not excluded)				
____ _____				
TOTAL COUNTABLE RESOURCES ( ) INDIVIDUAL ( ) COUPLE				

REMARKS: _____

_____

Worker: _____ Date: _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

D0M-321A - BURIAL ASSETS EXCLUSION WORKSHEET

PURPOSE & USE

This form is used to document each case record which involves application of the burial asset exclusion with the amount to be excluded and the amount in excess of the exclusion limit which must be counted as a resource, if any. A separate worksheet is required for an eligible individual with an ineligible or eligible spouse since each member of a couple is entitled to a separate computation.

INSTRUCTIONS

Prepare an original only to be filed in each case record affected by the exclusion. Refer to Section F, Resources, for policy governing funds set aside for burial.

Complete this form only for those individuals who would be ineligible due to excess resources if the burial assets exclusion were not applied. Follow the instructions for the amount to enter in each step as outlined on the form. The end resuslt will designate the amount to be excluded as a resource.

The worker will sign and date the form.

DOM-321-A
Revised 11-01-96

CASE NAME:_____

MEDICAID ID #:_____

BURIAL ASSETS EXCLUSION WORKSHEET

Name _____ **Effective Month:** _____

Person Named Above Is: ___ Eligible Individual ___ Eligible Spouse ___ Ineligible Spouse

1. **Does client meet the resource limit without applying the burial assets exclusion?**

   ____ Yes ____ No If YES, STOP. If NO, CONTINUE:

2. **Determine net burial assets exclusion limit:**

   A. _____ Maximum Burial Assets Exclusion Limit (Use $3000 or $1500, whichever is applicable)

   B. - _____ Offset (Subtract total value of all irrevocable burial arrangments and/or the total face values of life insurance policies owned by the individual or spouse on his/her life PROVIDED cash surrender value was excluded in determining countable resources.)

   C. $_____ Net Burial Assets Exclusion Limit

3. **Determine excluded and countable burial assets:**

   A. $_____ Combined Value of Burial Assets (Revocable burial contracts, revocable trusts, or other designated assets ... e.g., bank accounts, etc.)

   B. $_____ Net Burial Exclusion Limit (2. C.)

   C. $_____ Excluded Burial Assets

   -- If 3.A. equals or exceeds 3.B., then 3.B. is the amount of excluded burial assets.

   -- If 3.A. is less than 3.B., then 3.A. is the amount of excluded burial assets.

   D. $_____ Countable Burial Assets

   -- If 3.A. exceeds 3.B. - - - 3.D. is the difference between 3.A. and 3.B. (Include this amount on DOM-321)

   -- If 3.B. exceeds 3.A. - - - 3.D. is -0-

Medicaid Specialist _____ Date _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-321B - DESIGNATION OF BURIAL FUNDS

PURPOSE & USE

This form documents the client's designation of burial funds. It is to be completed by the worker and signed and dated by the client or representative in each instance when the burial fund exclusion is applied. If no portion of a client's burial fund is excluded, there is no need to complete this form.

Funds set aside for burial may be in the form of a bank account, life insurance, revocable burial contract, or some other form of funds, including cash. DOM-321B must be completed regardless of the form in which the funds are held if the burial exclusion is applicable.

INSTRUCTIONS

Prepare an original and 1 copy. The original is retained in the case record and the copy provided to the client or representative.

Enter the identifying information regarding the funds designated for burial. Show the total amount of funds set aside even though only a portion of the funds may actually be excluded.

TO BE COMPLETED BY THE MEDICAID REGIONAL OFFICE: In the spaces provided, enter the amount of the designated funds which can be excluded and the amount which is a countable resource as determined by completion of DOM-321A, Burial Assets Exclusion Worksheet.

SIGNATURE OF CLIENT OR AUTHORIZED REPRESENTATIVE: The client or representative must sign and date the form in order for the designation to be official.

The date must be entered in order to determine whether the exclusion can be applied as of the date the funds were first set aside for burial. Refer to the burial exclusion policy for a discussion of the 30-day time limit for designating funds.

DOM-321-B
Revised 04-01-86

Case Name _____

Medicaid ID # _____

DESIGNATION OF BURIAL FUNDS

Name of Person for Whom Funds Are Intended _____

First Month Funds Were Set Aside for Burial _____

Form in Which Funds Are Held _____

List below the specific identifying information concerning the burial funds:

Account No. or Policy No. _____

Name on Account or Name of Policy Owner: _____

_____

Name of Bank or Life Insurance Company or Funeral Home:

_____

Total Amount of Funds Set Aside for Burial (current balance in bank account or current cash surrender value of life insurance policy or current value of revocable burial contract)

$ _____

TO BE COMPLETED BY THE MEDICAID REGIONAL OFFICE:

Amount of Burial Funds Which Can BE EXCLUDED $ _____

Amount Which Must Be Counted As A RESOURCE $ _____

I understand that the funds or resource named above is designated for burial purposes only. A penalty for misuse will be applied if any excluded burial funds is used for a purpose other than burial. The penalty results in future Medicaid benefits due the client being offset by an amount equal to the amount of the funds misused.

✓_____ _____

SIGNATURE OF CLIENT OR AUTHORIZED REPRESENTATIVE DATE

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-322 - NOTICE OF TRANSFER OF ASSETS (OBRA-93)

PURPOSE & USE

The purpose of this form is to give notice to a nursing home client that a period of ineligibility exists as a result of a transfer of assets on or after August 11, 1993. DOM-322 informs the client/representative that a 10-day period is allowed in which rebuttal evidence may be presented. This form does not replace the advance notice which must be issued if the rebuttal is not successful. Refer to Section F, Resources, for transfer of assets policy from OBRA-93.

THIS FORM IS AVAILABLE IN MEDS.

INSTRUCTIONS

Prepare an original and 2 copies. The original is given or mailed to the client or representative and 1 copy is retained in the case record. The third copy is used as a tickler copy to hold for 10 days.

Enter the appropriate information pertaining to the transfer(s) being charged.

The worker must sign and date the form.

DOM-322
Revised 10-01-93

Regional Office: _____

NOTICE OF TRANSFER OF ASSETS

_____

_____

_____

Case Name: _____

Medicaid ID: _____

A nursing home patient who applies for or receives Medicaid is prohibited from transferring assets at any time during the 36-month period before applying for or receiving medical assistance in a nursing facility. The look-back period for assets placed in a trust is 60 months prior to application for Medicaid. If assets are transferred, a period of ineligibility shall be charged which is equal to the number of months required to deplete the total uncompensated value based on the total value of all transferred asset(s) divided by the average cost of monthly nursing home care to a private pay patient. This period of ineligibility applies to assets transferred on or after August 11, 1993 as specified in the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66).

Listed below is specific information about assets transferred by the Medicaid applicant/recipient named above:

Resource(s) transferred: _____

_____

Uncompensated Value: _____

Period of Ineligibility for Nursing Home Services:

Beginning: _____

Ending: _____

If you wish to give us evidence that the individual intended to dispose of the resource(s) either at current market value or for other valuable consideration or that resource(s) were transferred exclusively for a purpose other than to qualify for Medicaid, you have ten days from the date given below to submit such evidence before final action is taken on the case.

Medicaid Specialist: _____ Date: _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-322A - NOTICE OF TRANSFER OF RESOURCES (MCCA)

PURPOSE & USE

The purpose of this form is to give notice to a nursing home client that a period of ineligibility exists as a result of a transfer of resources on or after July 1, 1988 through August 10, 1993. DOM-322A informs the client/representative that a 10-day period is allowed in which rebuttal evidence may be presented. This form does not replace the advance notice which must be issued if the rebuttal is not successful. Refer to Section F, Resources, for transfer of resources policy from MCCA.

THIS FORM IS AVAILABLE IN MEDS.

INSTRUCTIONS

Prepare an original and 2 copies. The original is given or mailed to the client or representative and 1 copy is retained in the case record. The third copy is used as a tickler copy to hold for 10 days. Prepare a separate form for transfers that occur in separate months, i.e., only transfers occurring in the same month are combined.

Enter the appropriate information pertaining to the transfer being charged.

The worker must sign and date the form.

DOM-322A
ISSUED 01-01-89

Regional Office: _____

NOTICE OF TRANSFER OF RESOURCES

_____ Case Name: _____

_____ Case No.: _____

_____

A nursing home patient who applies for or receives Medicaid is prohibited from transferring resources at any time during the 30-month period before applying for or receiving medical assistance in a nursing facility. If resources are transferred, a period of ineligibility shall be charged which is equal to the lesser of 1.) 30 months, or 2.) the number of months required to deplete the total uncompensated value based on the value of the transferred resource divided by the average cost of monthly nursing home care to a private pay patient. This period of ineligibility applies to resources transferred on or after July 1, 1988 as specified in the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360).

Listed below is specific information about resources transferred by the Medicaid applicant/recipient named above:

Resource(s) transferred: _____

Uncompensated Value: _____

Period of Ineligibility for Nursing Home Services:

Beginning: _____

Ending: _____

If you wish to give us evidence that the individual intended to dispose of the resource(s) either at current market value or for other valuable consideration or that resource(s) were transferred exclusively for a purpose other than to qualify for Medicaid, you have 10 days from the date given below to submit such evidence before final action is taken on the case.

Worker: _____ Date: _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-323 - DISABILITY OR BLINDNESS REPORT

PURPOSE & USE

This form is used to record the applicant's condition and medical background when the applicant is under age 65 and is disabled and/or blind. If the applicant's disability is to be determined by DDS, this form must be completed by the applicant, representative or Specialist based on the applicant's response to the questions on the form. Refer to Section D, Nonfinancial Eligibility, for policy governing DDS decisions.

If the applicant is a child, complete DOM-323A, Disabled Child Questionnaire, in addition to DOM-323.

INSTRUCTIONS

Prepare an original. DOM-323 along with any prior medical information from the case record will be submitted to DDS in accordance with procedures outlined in the Blindness and Disability policy in Section D.

When the Medicaid Specialist or Supervisor completes the form for the applicant or representative, the CONFIDENTIALITY NOTICE portion of the form will be explained to the applicant. The remainder of the form will be completed based on the applicant or representatives responses to the questions. The information should be as detailed as possible for the benefit of the disability reviewer.

DOM-323
Issued 07-01-81

DISABILITY OR BLINDNESS REPORT

PLEASE PRINT, TYPE OR WRITE CLEARLY AND ANSWER ALL ITEMS TO THE BEST OF YOUR ABILITY. If you are filing on behalf of someone else, enter his or her name and Social Security Number in the space provided and answer all questions about them. COMPLETE ANSWERS WILL AID IN PROCESSING YOUR APPLICATION PROMPTLY.

CONFIDENTIALITY NOTICE: The information requested on this form is authorized by Title XIX of the Social Security Act. The information will be used to further document your request for Medicaid. Information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your eligibility. Information you furnish on the form may be disclosed by the Social Security Administration or the Medicaid Agency to another person or governmental agency only with respect to Social Security and Medicaid programs and only to comply with Federal laws requiring exchange of information between Medicaid and other agencies.

A. NAME OF CLIENT | B. SOCIAL SECURITY NUMBER | C. CASE NUMBER/MEDICAID NUMBER

D. TELEPHONE NUMBER | E. WHAT IS YOUR ILLNESS?

PART I - INFORMATION ABOUT YOUR CONDITION

1. A. When did your illness or injury first bother you? Give month, day and year.

B. When did your illness or injury finally disable you? Give month, day and year.

C. Explain how your condition affects you and keeps you from working?

2. Have you worked since the date shown in item 1A? ☐ Yes ☐ No
If no, go on to Part II

3. If you did work since the date in item 1A did your condition cause you to change --

Your job or job duties?	☐ Yes	☐ No
Your hours of work?	☐ Yes	☐ No
Your attendance?	☐ Yes	☐ No
Anything else about your work?	☐ Yes	☐ No

(If you answered NO to all of these, go to Part III)

4. If you answered YES to Item 3, explain below what the changes in your work circumstances were, the dates they occurred, and how your condition made these changes necessary:

PART II - INFORMATION ABOUT YOUR MEDICAL RECORDS

5. Have you had any of the following tests in the last year:

Test	Check Appropriate Block or Blocks Yes	No	If "Yes", Show Where Done	When Done
Electrocardiogram	☐	☐		
Chest X-Ray	☐	☐		
Other X-Ray (Name the body part here _____	☐	☐		
Breathing Tests	☐	☐		
Blood Tests	☐	☐		
Other (Specify)	☐	☐		

6. List the name, address and telephone of the doctor who has your latest medical record. If you have no doctor, check here ☐

Name _____ Address _____

Area Code/Telephone No. _____ _____

How often do you see this doctor? _____ Date you last saw this doctor _____

Reason for visits _____

_____

Type of treatment received _____

7. A. Have you seen any other doctor since your illness or injury began? ☐ Yes ☐ No

Name _____ Address _____

Area Code/Telephone No. _____ _____

How often do you see this doctor? _____ Date you last saw this doctor _____

Reason for visits _____

_____

Type of treatment received _____

B. Identify below any other doctor you have seen since your illness or injury began. List the doctor(s) names, addresses, dates and reasons for visits. If additional space is needed, use Part VI or attach another sheet of paper.

8. Have you been hospitalized or treated at a clinic for your illness or injury? ☐ Yes ☐ No If "Yes", show the following:

Name of hospital or clinic _____ Address _____

Patient or clinic number _____ _____

Were you an inpatient? (stayed at least overnight) ☐ Yes ☐ No If "Yes" complete the following:

Date of admission _____ Date of discharge _____

Reason for hospitalization or clinic visits _____

_____

Type of treatment received _____

If you have been in other hospitals or clinics for your illness or injury, list the names, addresses, patient or clinic numbers, dates and reasons for hospitalization or clinic visits in Part VI. Remarks.

9. Have you been seen by other agencies for your injury or illness? (VA, Worker's Compensation, Vocational Rehabilitation, Welfare, etc) ☐ Yes ☐ No If "Yes", show the following:

Name of Agency _____ Address _____

Your Claim Number _____

Dates of visits _____

Type of treatment or examination received _____

If more space is needed, list the other agencies, their addresses, your claim numbers, dates, and treatment received in Part VI.

PART III - INFORMATION ABOUT YOUR ACTIVITIES

10. Has any doctor told you to cut back or limit your activities in any way? ☐ Yes ☐ No If "Yes", give name of doctor and tell what he or she told you about cutting back or limiting your activities: _____

11. Describe your daily activities in the following areas and state what and how often you do it.

Household maintenance (including cooking, cleaning, shopping, and odd jobs around the house as well as any other similar activities):

Recreational activities and hobbies (hunting, fishing, bowling, biking, musical instruments, etc.):

Social contacts (visits with friends, relatives, neighbors):

Other (drive car, motorcycle, ride bus, etc.):

PART IV - INFORMATION ABOUT YOUR EDUCATION

12. What is the highest grade of school that you completed? _____

13. Have you gone to trade or vocational school or had any other type of special training? ☐ Yes ☐ No If "Yes", complete the following:

Type of trade or vocational school or training _____

Approximate dates you attended: _____

How this school or training was used in any work you did. _____

PART V - INFORMATION ABOUT THE WORK YOU DID

14. A. If you did work, what was your usual job in the 15 years before you became disabled. (Normally this will be the kind of work you did for the longest period of time.) Include the type of business, for example, farming, restaurant, etc. _____

B. Describe your duties in this job. (Show how much bending, lifting, walking, writing, or other activities were required. How often did you lift things, and how heavy were they? What kind of special tools or skills were required? What kind of written reports did you complete? How many people did you supervise?) _____

15. A. Did your condition make you stop working? ☐ Yes ☐ No

B. If "Yes", what is the date you stopped working? Give month, day, year

C. If this date is different from the one shown in Item 1B (the date you say you became disabled), explain the reason for the difference: _____

PART VI - REMARKS

Knowing that anyone making a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law, I certify that the above statements are true.

NAME (Signature of Client or person filing on the Client's behalf)

✓ _____ Date _____

PART VII - FOR MEDICAID USE ONLY - DO NOT WRITE BELOW THIS LINE

Name of Client _____ SSN _____

16. A. Does the client need assistance in prosecuting his/her claim? ☐ Yes ☐ No If "Yes" show name, address, relationship, and telephone number of an interested party willing to assist the client.

B. Can the client (or his representative) be readily reached by telephone with no communication problems due to language, speec. or hearing difficulties? ☐ Yes ☐ No If "No" worker should also complete Form DOM-324, Vocational Report.

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-323A - DISABLED CHILD QUESTIONNAIRE

PURPOSE & USE

This form is completed along with DOM-323 for all applicants age 18 and under. This form records pertinent medical and educational information for the child. The form is completed by the parent or representative or the Specialist based on the parent/representative's responses.

INSTRUCTIONS

Prepare an original. Submit DOM-323, 323A and any prior medical information to DDS in accordance with procedures outlined in the Blindness and Disability policy in Section D.

The parent or representative of the child must sign and date the form upon completion.

DOM-323-A
Issued 05-01-92

DISABLED CHILD QUESTIONNAIRE

Child's Name _____ Child's Social Security # _____

Your Name/Relationship to Child _____ Daytime Telephone # _____

1. Does child now or in the past attended any type of preschool and/or daycare?

   Name(s) _____

   Addresses _____

   _____

   Telephone #s _____ Dates Attended _____

2. Does child now or in the past attended school (public or private)?

   Name(s) _____

   Addresses _____

   _____

   Telephone #s _____ Dates Attended _____

   Last Teacher's Name _____

   Is the child in a Special Education Program? __ Yes __ No

   If yes, indicate type of program and number of hours per week

   _____

   PLEASE PROVIDE A COPY OF THE CHILD'S INDIVIDUAL EDUCATION PLAN THAT OUTLINES THE CHILD'S PROBLEMS AND LISTS THE PLANS FOR CORRECTING THEM.

3. Does the child receive any special counseling or tutoring?

   a. In school? __ Yes __ No

   b. Outside school? __ Yes __ No

   Please state type of counseling or tutoring, frequency of visits, name & address & telephone # of counselor/tutor.

4. Does the child or family have a social services or early intervention caseworker? If yes,

Name _____

Address _____

Telephone # _____ File # _____

5. Has the child ever been tested or evaluated by any of the following?

Public/ Community Health/ Social Services Dept. __ Yes __ No

Developmental Evaluation Center __ Yes __ No

Community Mental Health Center __ Yes __ No

Speech and Hearing Center __ Yes __ No

Women, Infants & Children (WIC) Program __ Yes __ No

If yes to any of the above, provide the agency name, address & telephone # below. Also state the type of test or evaluation performed.

6. Does or has the child received physical therapy, occupational therapy, or speech & language therapy outside the home?

__ Yes __ No If yes, state the type and frequency of the treatment and the name, address & telephone # of the therapist.

7. Does or has the child received any special therapy, exercises, or any other services for disability at home? __ Yes __ No If yes, state the type and frequency of the treatment and the

name, address & telephone number of the therapist. Indicate if any medication included.

8. Does or has the child received rehabilitation services? ___ Yes ___ No If yes, describe services received and the name, address & telephone # of the rehabilitation counselor.

9. If the child takes any medication on an ongoing, routine basis, please indicate the following:

Name(s) of medication: _____

Dosage and Amount: _____

Frequency: _____

Prescribed by: _____

Address/ Telephone _____

What are medications for: _____

Side effects _____

Does medication work? _____

10. Has the child ever been involved with the court system? __ Yes __ No THIS INFORMATION IS OPTIONAL.

If yes, please explain involvement: _____

Name of Youth Court or Probation/Parole Officer (include address & telephone #.)

11. Does the child participate in any community or school activities such as choir, athletics, clubs, etc.?
__ Yes __ No If yes, describe involvement, amount of time spent in activity, and level of participation. Provide name, address & telephone # of individual who supervises the activity.

REMARKS

I authorize any person, agency or organization to disclose to the State Agency that may review my claim any medical records or other information about the child's disability.

Signature of person filing on child's behalf

Date

MEDICAID ELIGIBILITY FORMS AND INSTRUCTIONS

DOM-324 - VOCATIONAL REPORT

PURPOSE & USE

This form is a supplement to the DOM-323, Disability and Blindness Report, and is to be completed by the Specialist only when the applicant has a communication problem due to language, speech or hearing difficulties which would make it difficult for the DDS reviewer to contact the applicant in order for DDS to obtain the information. The Specialist will complete the form with the applicant or representative, or the applicant may wish to complete the form on his/her own.

INSTRUCTIONS

Prepare an original and attach the form to DOM-323 to be forwarded to DDS. Refer to policy in Section D for disability and blindness policy.

When the Medicaid Specialist completes the form, the CONFIDENTIALITY NOTICE will be explained to the applicant.

DOM-324
Issued 07-01-81

VOCATIONAL REPORT

This report supplements the Disability or Blindness Report (Form DOM-323) by requesting additional information about your last work experience. PLEASE PRINT, TYPE OR WRITE CLEARLY AND ANSWER ALL ITEMS TO THE BEST OF YOUR ABILITY. If you are filing on behalf of someone else, enter his or her name and social security number in the space provided and answer all questions. COMPLETE ANSWERS WILL AID IN PROCESSING THE CLAIM.

CONFIDENTIALITY NOTICE: The information requested on this form is authorized by Title XIX of the Social Security Act. The information will be used to further document your request for Medicaid. Information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your eligibility. Information you furnish on this form may be disclosed by the Social Security Administration or Medicaid Agency to another person or governmental agency only with respect to Social Security and Medicaid programs and only to comply with Federal laws requiring the exchange of information between Medicaid and other agencies.

Name of Client _____

Social Security Number _____ Telephone Number (Where you can be reached) _____

Part I - INFORMATION ABOUT YOUR WORK HISTORY -List the job or jobs you have had in the last 15 years before you stopped working. (If you have a 6th grade education or less, AND performed only heavy unskilled labor for 35 years or more, list the job or jobs you have had since you began to work. If you need more space, use Part III)

JOB TITLE (Begin with your usual job)	TYPE OF BUSINESS	DATES WORKED (Month, Year) FROM	TO	DAYS PER WEEK	RATE OF PAY (Per hr., day, wk., mo., yr.)
1.					
2.					
4.					
5.					
6.					

Part II - INFORMATION ABOUT YOUR JOB DUTIES - Provide the following information for each of the jobs listed in Part I, starting with your usual job:

Job Title (from Part I) _____

A. In your job did you:
- Use machines, tools or equipment of any kind? ☐ Yes ☐ No
- Use technical knowledge or skills? ☐ Yes ☐ No
- Do any writing, complete reports, or perform similar duties? ☐ Yes ☐ No
- Have supervisory responsibilities? ☐ Yes ☐ No

B. Describe your basic duties (explain what you did and how you did it) below. Also, explain all "Yes" answers by giving a FULL DESCRIPTION of: the types of machines, tools, or equipment you used and the exact operation you performed; the technical knowledge or skills involved; the type of writing you did, and the nature of any reports; and the number of people you supervised and the extent of your supervision:

C. Describe the kind and amount of physical activity this job involved during a typical day in terms of:

Walking (circle the number or hours a day spent walking) 0 1 2 3 4 5 6 7

Standing (circle the number of hours a day spent standing) 0 1 2 3 4 5 6 7

Sitting (circle the number of hours a day spent sitting) 0 1 2 3 4 5 6 7 8

Bending (circle how often a day you had to bend) .....Never Occasionally Frequently Constantly

Reaching (circle how often a day you had to reach) ..... Never Occasionally Frequently Constantly

Lifting and Carrying: Describe below what kind of objects or material was lifted; how much it weighed, how many times a day you lifted this material, and how far you carried it.

IF YOU NEED ADDITIONAL SPACE TO PROVIDE INFORMATION ABOUT OTHER JOBS LISTED IN PART I OF THIS FORM, USE PART III OR ATTACHED ADDITIONAL COPIES OF THIS FORM.

Part III - **REMARKS** - Use this section for any other information you may want to give about your work history, or to provide any other remarks you may want to make to support your disability claim:

Knowing that anyone making a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law, I certify that the above statements are true.

NAME (Name of Client)

✓ _____ Date _____

Signature of Client or Person Filing on the Client's Behalf)

DO NOT WRITE BELOW THIS LINE

Form DOM-324 taken by: ☐ Personal Interview ☐ Telephone ☐ Mail

Form Supplemented: ☐ Yes ☐ No If "Yes", by ☐ Personal Interview ☐ Telephone ☐ Mail

Signature of Interviewer or Reviewer _____ Date _____

Title _____ Office _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-325 - DISABILITY DETERMINATION AND TRANSMITTAL

PURPOSE & USE

This form is used to transmit all medical information and DOM Forms 323, 323A and 324 to the Disability Determination Service (DDS). DDS uses the form to record the disability or blindness decision.

INSTRUCTIONS

Prepare an original and 4 copies. Submit the original and 2 copies to DDS, file one copy in the case file, and the remaining copy will serve as the tickler copy. Set a tickler for 75 days from the day of mailing the file folder to DDS. If the decision has not returned from the DDS within 75 days, the Regional Office will contact the State Office as outlined in the policy in Section D.

The top portion of the form is completed by the Regional Office giving specific information about the applicant. Specify whether retroactive months of eligibility are being requested prior to the month of application.

The worker will sign and date the form and include the Regional Office address and applicant's address.

DOM - 025
ISSUED 02-01-92

Case Name _____

Case Number _____

DISABILITY DETERMINATION AND TRANSMITTAL

TO: DISABILITY DETERMINATION SERVICE

1 DECISION REQUEST:
❑ Initial ❑ Cont. Dis. Inv. ❑ Hearing
❑ RETROACTIVE FOR PERIOD

2. SOCIAL SECURITY NUMBER

3 MEDICAID NO.

4. GRANDFATHER STATUS
❑ Yes ❑ No

5. DATE OF BIRTH

6. PRIOR ACTION BY DDS
❑ No ❑ Yes prior medical

7. APPLICATION DATE

8. CLAIMANT ADDRESS

9. MEDICAID OFFICE ADDRESS

10. REMARKS

11. MEDICAID SPECIALIST / SUPERVISOR

12. DATE

DETERMINATION PURSUANT TO SOCIAL SECURITY ACT, AS AMENDED

13. CLAIMANT DISABLED
❑ DISABILITY BEGAN _____
❑ DISABILITY CEASED _____
❑ DISABILITY CONTINUES

14. DIAGNOSIS

15. RE-EXAM
❑ NONE
❑ _____ (Date)

CLAIMANT NOT DISABLED ❑ SEE SSA-834 FOR EXPLANATION (OR BELOW)

16. RETROACTIVE ELIGIBILITY DECISION:
❑ Not eligible during retroactive period. See above for explanation.
❑ Eligible on disability or blindness during retroactive period beginning _____ (Date) and ending _____ (Date).

17. VOCATIONAL REHABILITATION ACTION
❑ SC. IN ❑ SC. OUT ❑ PREV. REF.

18. DISABILITY EXAMINER - DDS DATE

19. REVIEW PHYSICIAN - DDS DATE

20. REMARKS

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-330 - REQUEST FOR FINANCIAL INFORMATION

PURPOSE & USE

This form is to be used to secure verification from a bank, savings and loan association, or other savings agency, concerning the cash or cash assets of an applicant/recipient. Refer to Section F, Resources, for policy regarding the use of this form.

INSTRUCTIONS

Prepare an original and 1 copy. Mail the original to the bank or give the form to the client/representative to take to the bank for completion. Retain the copy in the tickler file. When the original is returned, discard the copy and file the original in the case record.

Enter the client's identifying information on the top part of the form.

Signature of Client: The client or designated representative will sign here. If the designated representative is signing for the client, submit a copy of DOM-302 along with this form.

Signature of Medicaid Worker: The worker will sign in this space.

Date: Enter the date the form is completed.

The bank will complete the lower portion of the form and page 2 and sign in the space provided.

DOM-330
Revised 10-01-96

REQUEST FOR FINANCIAL INFORMATION

Client's Name: _____

Spouse: _____

Address: _____

_____

Client's SSN: _____

Account #: _____

I hereby authorize you to disclose any information concerning my financial accounts to the Mississippi Medicaid Agency for the purpose of determining my Medicaid eligibility.

✓ _____ _____

Signature of Client or Person Authorized to Act for Client — Date

PLEASE NOTE: The Mississippi Medicaid Agency will not be held liable for any charges incurred for researching financial records.

_____ _____

Medicaid Specialist — Date

THE FOLLOWING IS TO BE COMPLETED BY A BANK OFFICIAL

1. Does client's name appear or has it appeared on a checking account (individually or jointly) within the last 3 years? ☐YES ☐NO (If yes, complete Page 2.)

2. Does client's name appear or has it appeared on a savings account (individually or jointly) within the last 3 years? ☐YES ☐NO (If yes, complete Page 2.)

3. Does client own or has client owned (individually or jointly) any Certificates of Deposit or Savings Certificates within the past 3 years? ☐YES ☐NO (If yes, complete Page 2.)

4. Does client rent a safe deposit box? ☐YES ☐NO

_____ _____

Signature of Bank Official Completing This Form — Date

RETURN TO:

TO BE COMPLETED IF "YES" IS CHECKED ON THE REVERSE SIDE

I. CHECKING ACCOUNT NUMBER _____ Individual ( ) Joint ( )

How is account listed? _____

Is this an interest bearing account? ☐ YES ☐ NO

Please provide account balance and interest earned as of the 1st of month:

MONTH	INTEREST	BALANCE
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____

NOTE: If account is closed, give date of closure: _____

Balance at time of closure: _____

Person who authorized closure: _____

II. SAVINGS ACCOUNT NUMBER _____ Individual ( ) Joint ( )

How is account listed? _____

Interest Rate _____% Paid: Semi-Annually ( ) Quarterly ( ) Monthly ( )

Please provide account balance and interest earned as of the 1st of the month:

MONTH	INTEREST	BALANCE
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____

NOTE: If account is closed, give date of closure: _____

Balance at time of closure: _____

Person who authorized closure: _____

III. CERTIFICATES OF DEPOSIT AND SAVINGS CERTIFICATES

Name(s) on Account _____

Amount of Certificate _____ Maturity or Redemption Date_____

CD # _____ Amount/Frequency of Interest _____

NOTE: If Certificate has been redeemed, give name of person who authorized redemption:

_____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-331 - REQUEST FOR INFORMATION CONCERNING INSURANCE

PURPOSE AND USE

This form is used to obtain information concerning any insurance policies a client may have. This does not pertain to Medicare insurance. This form also is a release from the client authorizing the Division of Medicaid to obtain this information for the purpose of determining the client's Medicaid eligibility.

INSTRUCTIONS

Prepare the original and 1 copy and obtain the client or representative's signature. Once signed, retain the copy in the tickler file and mail the original to the appropriate insurance company. When the original is returned, discard the tickler copy and file the original in the case record.

Note in the Record of Contact the dates the forms were mailed and returned by the client and the appropriate insurance company.

Signature of Client or Representative: The client or representative will sign in this space.

The insurance company will complete the middle section of the form requesting insurance information.

The worker will sign, date and return address stamp the form.

DOM-331
REVISED 11-01-88

Case No.: _____

REQUEST FOR INFORMATION CONCERNING INSURANCE

_____ RE: _____

_____ DATE OF BIRTH: _____

_____ SOCIAL SECURITY NO.: _____

Dear Sir:

I hereby authorize you to disclose any information concerning my insurance policy(ies) with your company to the Division of Medicaid for the purpose of determining my Medicaid eligibility.

_____ _____

DATE SIGNATURE OF CLIENT OR REPRESENTATIVE

We have been advised that this person has a policy(ies) with your company. In order for us to determine his/her eligibility, please complete the following items. When completed, please return this form to the address shown below. Your cooperation with this request is greatly appreciated.

NAME OF INSURED _____

POLICY NUMBER(S) _____

OWNER OF POLICY(IES) _____

TYPE OF POLICY(IES) _____

FACE VALUE OF EACH POLICY _____

CASH SURRENDER VALUE (CURRENT) OF EACH _____

AMOUNT OF LOANS AGAINST EACH _____

_____ _____

SIGNATURE OF INSURANCE OFFICIAL DATE

Regional Office Address/Telephone

Medicaid Worker _____

Date _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-333 - REQUEST FOR WORKERS' COMPENSATION COMMISSION DATA

PURPOSE & USE

This form is used to verify Workers' Compensation benefits as a result of an on the job injury. If a possibility of workers' compensation benefits exists, this form is completed by the Specialist and submitted to the State Office Eligibility Division along with a signed/dated DOM-301, Authorization to Release Information, signed by the client.

All inquiries must come through the State Office so that an Eligibility Division staff member can take it to the Workers' Compensation Commission for completion. The Workers' Compensation Commission will not fill individual written requests from Regional Offices.

INSTRUCTIONS

Prepare an original and 1 copy. Mail the original to the State Office Eligibility Division and retain the copy in the record until the original is returned. Include all identifying information on the client, including a workers' compensation claim number, if known.

Part II will be completed and returned by the State Office after verifying the information at the Workers' Compensation Commission.

DOM-333
Revised 01-01-91

REQUEST FOR WORKERS' COMPENSATION COMMISSION DATA

TO: Medicaid State Office, Eligibility Division

FROM: _____ Regional Office

We have received an application/redetermination form for Medicaid from the following person. On this form, he/she stated that a claim was filed with Workers' Compensation. Please check with the Mississippi Workers' Compensation Commission to acquire the information in Part II. We have enclosed a release signed by the applicant/recipient to authorize the Workers' Compensation Commission to release this information to an authorize representative of Mississippi Medicaid.

_____ _____
Date Medicaid Specialist

PART I

Name of Applicant/Recipient: _____

Address: _____

Social Security Number: _____ Medicaid ID Number: _____

MWCC Claim Number: _____

Employer at Time of Accident: _____

Address of Employer: _____

Date of Injury: _____

PART II

Weekly Benefit Rate _____ Maximum Number of Weeks Payable _____

Date of Initial Payment _____ Medicaid Payments _____

Date and Amount of Lump Sum Payment, if applicable _____

Amount of lump sum payment that goes towards: Doctor's bills, $ _____;

Lawyers fees, $ _____; Hospital bills, $ _____; Other, $ _____; $ _____.

No Claim _____

Claim in Process _____

Claim Disallowed _____

_____
Area Supervisor

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-334 - REQUEST FOR INFORMATION REGARDING UNEMPLOYMENT COMPENSATION

PURPOSE & USE

Medicaid routinely matches client's Social Security Numbers with the Employment Security Commission to determine if wages and/or Unemployment benefits are payable. However, if needed, DOM-334 can be used to secure this information from Employment Security.

INSTRUCTIONS

Prepare an original and 1 copy of the form and forward the original to the appropriate Unemployment Claims Center of the Mississippi State Employment Security Commission serving the region. File the copy in a tickler file until the original is returned, then discard the copy and place the original in the case folder.

Enter the client's identifying information on the top part of the form. The worker will sign and date the form and return address stamp the form.

The Employment Security Commission will complete the remainder of the form.

DOM-334
Revised 01-01-91

REQUEST FOR INFORMATION REGARDING UNEMPLOYMENT COMPENSATION

TO: RE: Name _____

S.S. No. _____

I authorize your agency to release to the Mississippi Medicaid Regional Office named above any information concerning my eligibility for and/or receipt of unemployment benefits.

_____ _____
(Signature of Claimant) (Date)

The following information is required for our use in determining the above-named individual's eligibility for medical assistance. This information will not be disclosed to any organization or person outside this agency, except in accordance with regulations or instructions of the Mississippi Employment Security Commission.

_____ _____
(Signature of Medicaid Specialist) (Date)

Please answer the appropriate item(s) including all unemployment insurance programs:

A. _____ If otherwise eligible, the above-named individual may receive benefits during his benefit year beginning _____ and ending _____.

1. $ _____ Weekly benefit amount
2. $ _____ Maximum unemployment benefits payable during the benefit year.
3. $ _____ Unemployment benefits have been paid to date during the benefit year, according to our records.
4. _____ Date most recent unemployment claim was filed.

B. _____ Benefits not being received.

1. _____ No record of claim.
2. _____ Disqualified for a period beginning _____ and ending _____.

BY: _____
Mississippi Employment Security Commission

REMARKS: _____

When complete, please mail to the above stamped Regional Office.

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-335 - REQUEST FOR VERIFICATION FOR WAGES

PURPOSE & USE

This form is used to verify the earnings of an applicant/recipient or spouse whose income must be deemed. It can be adapted for use by parents whose income must be deemed to an eligible child. The signature of the "employee" whose earnings must be verified is required on the form prior to sending it to the employer.

INSTRUCTIONS

Prepare the original and 1 copy and obtain the appropriate signature authorizing release of the information. Mail the original to the employer and file the copy in a tickler file. When the original is returned, discard the copy and file the original in the case record.

Complete the top portion of the form giving identifying client information. The worker will sign, date and return date stamp the form.

The employer should complete the remainder of the form.

DOM-335
REVISED 11-01-88

Case No.: _____

REQUEST FOR VERIFICATION OF WAGES

_____ RE: _____

_____ DATE OF BIRTH: _____

_____ SOCIAL SECURITY NO.: _____

I hereby authorize you to disclose any information concerning my wages to the Division of Medicaid for the purpose of determining my Medicaid eligibility.

_____ _____
DATE SIGNATURE OF CLIENT, SPOUSE OR REPRESENTATIVE

The individual named above is requesting Medicaid benefits. In order for us to determine eligibility, **please provide wage information for the following time period:**

_____

When completed, please return this form to the address shown below. Your cooperation with this request is greatly appreciated.

HOW OFTEN PAID?

_____ weekly _____ every 15 days _____ other (specify)

_____ bi-weekly _____ monthly _____

RATE OF PAY AS OF _____ $_____
DATE AMOUNT

NUMBER OF HOURS WORKED EACH WEEK? _____

DATE EMPLOYMENT BEGAN? _____ ENDED: _____

DATE OF NEXT SCHEDULED RAISE: _____ DATE OF LAST RAISE: _____

REMARKS: _____

_____

EMPLOYER SIGNATURE: _____ DATE: _____

Return to:

Medicaid Worker: _____

Date: _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DQM-336 - INSTITUTIONAL BUDGET

PURPOSE & USE

This form is used to determine eligibility and continuing eligibility for all institutional clients. If the individual applying for long term care Medicaid is eligible based on income, this form is used to determine the SSI coverage group and the fulfillment of the 30-consecutive day requirement for those ineligible for Medicaid at home; and to determine the monthly maintenance needs allowance for a community spouse and other dependent family members; and to document the allowance of any non-covered medical expenses; and finally to determine the Medicaid Income due from the client to pay towards the cost of his/her care.

Refer to Section I, Institutionalization, for policy regarding institutional budgeting.

THIS FORM IS GENERATED BY MEDS BUT IS AVAILABLE IN HARDCOPY IF NEEDED.

INSTRUCTIONS

Prepare an original only for the case record.

STEP 1. ELIGIBILITY BASED ON INCOME

Specify the month or months of the eligibility computation.

1.a. Enter the appropriate Federal maximum of an individual applying for Medicaid.

1.b. Enter the total income of the individual as defined in policy on institutional budgeting.

1.c. If the amount entered in 1.b. in any column is equal to or more than the Federal maximum, the individual or couple is ineligible for Medicaid for that month. Do not complete the remainder of the form if ineligible in all columns. If a deficit results, complete the remaining applicable steps.

STEP 2. COVERAGE GROUP DETERMINATION & 30-CONSECUTIVE DAY REQUIREMENT

Use this section to determine the individual coverage group in the institution based on countable income of the individual against the appropriate SSI FBR. Countable income is determined from preparation of an at-home budget or by showing income less all appropriate SSI exclusions.

If an applicant is ineligible for Medicaid (not just SSI) at home, complete the 30-consecutive day requirement portion (Step 2.b.) which documents date of admission and the 31st day.

Note: The exception to fulfillment of the 30-consecutive day requirement is death in the institution or placing the individual in an at-home MAO coverage group if the institutional stay is less than 31 days.

STEP 3. MONTHLY MAINTENANCE NEEDS ALLOWANCE FOR SPOUSE AND DEPENDENTS

This step is completed if there is a community spouse only or a spouse and other dependent family members who live with the spouse.

3.a. Determine the CS allowance by comparing CS income to the Maximum allowance (specified in Institutional Budgeting policy) for a CS. The CS allowance as determined by this computation may be reduced in Step 4, Medicaid Income Computation, if the IS has income less than the CS allowance.

3.b. Compute up to 3 other dependent family member's allowance amounts in Step 3. Enter the name of the dependent for each computation. Determine each dependent's allowance by using the Family maximum (specified in Institutional Budgeting policy) less each dependent's own income. The difference is then divided by 1/3 to arrive at each dependent's allocation amount. Add together each dependent's allowance as shown in the "1/3 Remainder" space and show the total in Step 4.e.

STEP 4. MEDICAID INCOME COMPUTATION

This portion is used to determine the amount the client must pay toward the cost of his/her care. The form is designed to show the computation of four (4) separate months, if needed, to reflect fluctuations in Medicaid Income.

4.a. Specify the month(s) of the Medicaid Income Computation.

4.b. Show the eligible individual's total income.

4.c. Subtract the appropriate PNA of the individual.

4.d. Subtract the CS monthly allowance which may be equal to the 4.c. Subtotal if the CS allowance computed in Step 3.a. is greater than the remaining income shown in 4.c.

4.e. Subtract the total other Family Members' Allowance if income remains after deducting the CS allowance.

4.f. Subtract the recipient's health insurance premium amount if applicable.

4.g. Subtract any other non-covered medical expenses allowed as per Institutional Budgeting policy.

Enter the total amount of Medicaid Income to be paid by the recipient for each month computed.

COMPUTATIONS: Use this space to document the computation of gross income from Step 1 and the income computations for Step 4, such as the computations for averaged income and the amount of health insurance premium(s) claimed by the client as a deduction. Specify the type of computations shown on the form. For health insurance premiums, specify the method of payment (monthly, quarterly, etc.).

The worker will sign and date the form.

DOM-336
Revised 10-01-96

Case Name: _____

Medicaid ID Number: _____

INSTITUTIONAL BUDGET

STEP 1. ELIGIBILITY BASED ON INCOME

	(Month)	(Month)	(Month)
a. Institutional Income Limit			
b. Income of Individual			
c. If Difference Results, Continue			

STEP 2. COVERAGE GROUP DETERMINATION & 30-CONSECUTIVE DAY REQUIREMENT

a. Determine applicant's SSI Coverage Group

SSI FBR _____

Countable Income _____

Difference _____

If eligible, Coverage Group is 30
If ineligible, Coverage Group is 20

b. Complete only for applicants who are ineligible for Medicaid at-home.

Date of Admission _____

Enter 31st Day _____

Did Applicant Meet 30-Consecutive Day Requirement? Yes _____ No _____

STEP 3. MONTHLY MAINTENANCE NEEDS ALLOWANCE FOR SPOUSE AND DEPENDENTS

a. Community Spouse (CS)

Maximum Allowance _____

Less CS Income - _____

CS Allowance _____

b. Other Dependent Family Members

(1) Name _____

Family Maximum _____

Less Income - _____

Difference _____

1/3 Remainder _____

2. Name _____

Family Maximum _____

Less Income - _____

Difference _____

1/3 Remainder _____

3. Name _____

Family Maximum _____

Less Income - _____

Difference _____

1/3 Remainder _____

If more than 3 Other Dependent Family Members - show computation on Page 2

STEP 4. MEDICAID INCOME COMPUTATION

a. Specify Month(s) of Computation:	(Month)	(Month)	(Month)	(Month)
b. Eligible's Total Income	$	$	$	$
c. Less Personal Needs Allowance	-	-	-	-
Subtotal	$	$	$	$
d. Less CS Monthly Allowance	-	-	-	-
Subtotal	$	$	$	$
e. Less Other Family Members' Allowances (Show total amount)	-	-	-	-
Subtotal	$	$	$	$
f. Less Health Insurance Premium(s)	-	-	-	-
Subtotal	$	$	$	$
g. Less Non-Covered Medical Expenses	-	-	-	-
Subtotal	$	$	$	$
TOTAL MEDICAID INCOME	$	$	$	$

COMPUTATIONS:

Medicaid Specialist _____ Date _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-337 - ELIGIBLE INDIVIDUAL/ELIGIBLE COUPLE & SPOUSE TO SPOUSE DEEMING WORKSHEET

PURPOSE & USE

This form is used to determine income eligibility for individuals or couples who live at-home. Refer to Section H, Budgeting for At-Home Eligibility, for policy regarding at-home eligibility.

THIS FORM IS GENERATED BY MEDS BUT IS AVAILABLE IN HARDCOPY IF NEEDED.

INSTRUCTIONS

Prepare an original only for the case record.

STEP 1. INDIVIDUAL OR ELIGIBLE COUPLE CALCULATION

This portion is used to determine the eligible individual/couple eligibility using the income of the eligible only or the combined income of an eligible couple.

1.a. If the eligible receives VA Aid & Attendance, use this space to subtract the portion designated as Aid & Attendance from the VA payment. Specify in the space provided the type of VA payment received by the eligible, such as pension, compensation, etc.

1.b. If the eligible receives a VA benefit which includes a dependent(s) allocation, use this space to deduct the allocation from the eligible's benefit, if appropriate. If 1.a. is completed, deduct the dependent's allocation from the 1.a. total. Specify the type benefit received by the eligible in the space provided.

1.c. List the type(s) and amount(s) of all unearned income received by the eligible. DO NOT LIST ANY INCOME BASED ON NEED RECEIVED BY THE ELIGIBLE, as this type of income is added in 1.f. Bring down the amount of the VA payment to be used in budgeting (1.a. or 1.b. total) provided the VA payment is not based on need. If the VA payment is based on need, the 1.a. or 1.b. total is added in 1.f.

1.d. Subtract any appropriate SSI/SSA disregard totals, if applicable. Show the computation of the disregarded amount(s) in the space provided in the lower right corner of page 1.

Note: Do not mix budgeting procedures, i.e., only COL applicants are eligible for COL disregards. Do not allow SSI disregards when budgeting for Poverty Level or QMB applicants.

1.e. Subtract the general exclusion from the 1.c. or 1.d. total.

1.f. Add any income based on need received by the eligible to the 1.e., subtotal and specify the type of payment (such as VA pension) that the income represents.

1.g. Enter the total countable unearned income.

1.h. List all type(s) and gross amount(s) of earned income, if applicable.

1.i. Enter the total gross earned income.

1.j. Enter the total countable earned income after all deductions have been applied.

1.k. Enter the totals from 1.g. and 1.j. and add together to arrive at the total countable income.

1.l. Enter the appropriate SSI FBR or Federal Poverty Level (FPL) for an individual or couple and subtract the total countable income taken from the 1.k., total.

If the total is equal to or exceeds the applicable FBR or if the total exceeds the appropriate FPL, the individual or couple is not Medicaid eligible. Do not continue. If a deficit results, the client is eligible based on his/her income and Steps 2 and 3 must be completed if an individual has an ineligible spouse.

STEP 2 - INELIGIBLE SPOUSE CALCULATION

This portion is completed if the eligible has an ineligible spouse at home.

2.a. Enter the ineligible spouse's total unearned income. Do not consider any income based on need received by the ineligible spouse or any income used to budget the income based on need. It may be necessary to contact the agency (such as Human Services, VA) to determine what income is used to budget the ineligible spouse's payment.

Subtract Allocation for Ineligible Child(ren) - If there is a dependent child (under age 18 or under 21 and a student) in the household, complete the allocation portion by entering each child's name in the space provided, an allocation for each child from the SSI Payment Table, and subtracting each child's own income to arrive at the total allocation for each child. Add all total allocations and subtract the total allocation from the ineligible spouse's unearned income. This equals the remaining unearned income.

2.b. Enter the ineligible spouse's earned income. If any unused child's allocation remains from 2.a., subtract the remainder from the earned income to arrive at the remaining earned income.

2.c. Add remaining unearned income total from 2.a. to the amount in 2.b.

2.d. Total Income After Allocations - The sum of 2.a. and 2.b. equal the income after allocating. If this total is less than the difference between the couple and individual SSI FBR or less than the difference between the couple and individual Poverty Levels (whichever is appropriate for the type of budgeting involved) then no deeming applies. Do not complete Step 3 as the eligible individual is eligible.

STEP 3 - COMBINED INCOMES AFTER ALLOCATING

This portion is completed if the eligible has an ineligible spouse at home.

3.a. Enter the eligible's unearned income taken from the Step 1.d. Subtotal in the first space.

Enter the ineligible spouse's remaining unearned income from Step 2.a. in the 2nd space and add this amount to the eligible's unearned income.

Subtract the $20 General Exclusion

Add any income based on need received by the eligible (not any received by the ineligible). This figure is taken from Step 1.f.

This procedure equals the couple's countable unearned income.

3.b. Enter the eligible's gross earned income and add this amount to any remaining earned income from Step 2.b. belonging to the ineligible spouse. Apply the applicable deductions to earned income to arrive at the couple's countable earned income.

3.c. Add together the totals from Step 3.a. and 3.b. to arrive at the total countable income.

3.d. Enter the couple FBR or FPL and subtract the total countable income from the FBR or FPL. If the couple's income is equal to or exceeds the SSI FBR or if income exceeds the FPL, the client is not Medicaid eligible. If a deficit results, the client is eligible based on income.

Instructions for Deeming from Ineligible Spouse to Eligible Individual and Eligible Child

1. Apply the rules of spouse to spouse deeming.

2. If spouse is eligible for Medicaid, there is no income to be deemed to eligible child.

3. If spouse is ineligible (determined in Step 3.d. on this worksheet), deem remaining income to eligible child(ren). Remaining income is that income over the amount needed to reduce the eligible spouse to zero payment. Transfer the countable income from Step 3.d. and the Monthly FBR for a couple, Step 3.d., to the Parent to Child Deeming Worksheet, Form 338, under "Additional Computation Space." Subtract these amounts to obtain the amount of income deemed to the child(ren). Enter this amount in Step 2 of Parent to Child Deeming Worksheet as unearned income and proceed with the remaining steps in Step 2 to determine child(ren)'s eligibility.

DOM-337
Revised 10-01-89

Regional Office _____

ELIGIBLE INDIVIDUAL/ELIGIBLE COUPLE & SPOUSE TO SPOUSE DEEMING WORKSHEET

Case Name _____ Case No. _____

INDIVIDUAL OR ELIGIBLE COUPLE CALCULATION

STEP 1.

UNEARNED INCOME COMPUTATION

a. If applicable, subtract portion of VA that is Aid & Attendance

VA _____ _____
(specify type of VA)
less Aid & Attendance - _____

TOTAL . . . . . _____

b. If applicable, subtract portion of VA that is dependent's allocation (Use 1a total, if applicable)

VA _____ _____
(specify type of VA)
less dependent's allo. - _____

TOTAL . . . . . _____

c. List below the type(s) and amount(s) of all unearned income. Include VA total from 1a or 1b, whichever applies (Total VA is included in either 1c or 1f, depending on the type of VA.)

_____ _____
_____ + _____
_____ + _____
Sub Total _____

d. Subtract HR-1 and/or COL Disregard(s) - _____
Sub Total _____

e. Subtract General Exclusion - 20.00
Sub Total _____

f Add Income Based on Need rec'd by the Eligible
Specify _____ + _____

g COUNTABLE UNEARNED INCOME _____

EARNED INCOME COMPUTATION

h. (List type(s) and gross amount(s)

_____ _____
_____ + _____
_____ + _____

i. GROSS EARNED . . . . . _____
Subtract Portion of $20 Not Used in Step 1e. - _____
Sub Total _____
Subtract Work Exclusion - 65.00
_____ / 2)
Sub Total _____
Subtract ½ Remainder - _____
Sub Total _____
Other Deductions
Specify _____ - _____

j. COUNTABLE EARNED INCOME _____

k. COUNTABLE UNEARNED (1g) _____
COUNTABLE EARNED (1j) + _____
TOTAL COUNTABLE INCOME _____

l. Appropriate FBR or FPL (Individual or Couple) _____
less TOTAL COUNTABLE INCOME (1k) - _____
_____
IF "0" OR SURPLUS, NOT ELIGIBLE--DO NOT CONTINUE

Worker Signature _____ Date _____

INELIGIBLE SPOUSE CALCULATION

STEP 2

a. Ineligible Spouse's Unearned Income (Do not include income based on need rec'd by spouse or any income used to budget this income) $ _____

Subtract Allocation for Ineligible Child(ren)

Child's Name _____

Allocation _____

Subtract Child's Own Income - - - - _____

Total Allocation + + + = - _____

REMAINING UNEARNED INCOME _____

b. Ineligible Spouse's Earned Income . . . . . _____

Subtract Remaining Child's Allocation Not Offset in 2a. - _____

REMAINING EARNED INCOME _____

c. Add Remaining Unearned Income Total from 2a. . . . . + _____

d. TOTAL INCOME AFTER ALLOCATIONS . . . . . _____

- IF LESS THAN THE DIFFERENCE BETWEEN THE COUPLE AND INDIVIDUAL FPL OR THE COUPLE AND INDIVIDUAL SSI FBR (WHICHEVER IS APPROPRIATE) - NO DEEMING APPLIES, DO NOT CONTINUE.

COMBINED INCOMES AFTER ALLOCATING

STEP 3

a. Eligible's Unearned From Step 1d. Sub Total _____

Ineligible's REMAINING UNEARNED INCOME (2a.) + _____

Sub Total _____

Subtract General Exclusion - 20.00

Sub Total _____

Add Eligible's Income Based on Need (Step 1f) + _____

COUNTABLE UNEARNED INCOME _____

b. GROSS EARNED (Step 1i) _____

Ineligible's REMAINING EARNED INCOME (Step 2b) + _____

Sub Total _____

Subtract Portion of $20 Not Used in 3a. - _____

Sub Total _____

Subtract Work Expense - 65.00

2) _____ Sub Total _____

Subtract ½ Remainder - _____

COUNTABLE EARNED INCOME _____

c. Countable Unearned (3a.) _____

Countable Earned (3b.) + _____

Total Countable Income _____

d. FBR or FPL for Couple _____

Subtract Total Countable Income (3c.) - _____

IF "0" OR SURPLUS, NOT ELIGIBLE _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-338 - PARENT TO CHILD DEEMING WORKSHEET

PURPOSE & USE

This form is used to determine income eligibility for a disabled child when parent to child deeming is involved. Refer to Section H, Budgeting for At-Home Eligibility, for policy regarding parent to child deeming.

THIS FORM IS GENERATED BY MEDS BUT IS AVAILABLE IN HARDCOPY IF NEEDED.

INSTRUCTIONS

Prepare an original only for the case record when needed.

STEP 1

1.a. Enter parent's combined gross unearned income. Do not include any income based on need received by the parent(s).

1.b. Subtract the living allowances for each ineligible child by entering the allocation amount from the chart of Need Standards in the Appendix for each ineligible child. Subtract each child's own income from the allocation. The remaining amount equals each child's total allocation. The total allocations are added together and subtracted from the parent(s) unearned income to arrive at the remaining earned income of the parent(s).

1.c. Enter the parent's combined gross earned income. Subtract any unused allocation for the ineligible children from Step 1.b. If there is no unearned income from 1.a., subtract the total allocation computed in 1.b. from any earned income in 1.c. The result is the remaining earned income.

STEP 2

2.a. Enter remaining unearned income from Step 1.b. Subtract the $20 general exclusion to arrive at countable unearned income.

2.b. Enter remaining earned income from Step 1.c. Subtract any portion of the $20 general exclusion not used in 2.a. Subtract the $65 work exclusion then subtract 1/2 the remainder to arrive at countable earned income.

2.c. Add countable earned income and countable unearned income together then subtract the living allowance for the parent(s). One parent's living allowance is equal to the full FBR for an individual. Two parents get the full FBR for a couple. Do not use the FPL (Federal Poverty Level) as a living allowance regardless of the coverage group of the child applying.

2.d. The result is the amount of income to deem in Step 3.

STEP 3

If there is more than one eligible child the amount of the parent(s) income deemed from Step 2 will be divided equally among the number of eligible children.

3.a. Enter the amount of deemed income from Step 2.

3.b. Enter the child's own unearned income. Add deemed income from 3.a. then subtract the general exclusion to arrive at the countable unearned income.

3.c. Enter the gross earned income belonging to the child and subtract applicable deductions to arrive at the countable earned income.

3.d. Add the countable earned to the countable unearned income.

3.e. Enter the appropriate FBR if the child is applying for SSI Retroactive benefits or as a Former SSI Recipient. If the child is applying as a PLAD or QMB, use the FPL for an individual. Subtract the total from 3.d. If the income equals or exceeds the SSI FBR or if the income exceeds the FPL, the child is not Medicaid eligible. If a deficit results, the child is eligible.

REMARKS/COMPUTATION SPACE: Use this for any necessary remarks or computation of income.

The worker will sign and date the form.

DOM-338
Revised 01-01-93

Regional Office _____

PARENT TO CHILD DEEMING WORKSHEET

CASE NAME _____ MEDICAID ID# _____

Step 1

a. Parents Unearned Income (Do not include income based on need received by either parent or any income used to budget this income.) _____

b. Subtract Allocation for Ineligible Child(ren):

Child's Name _____

Allocation _____

Subtract Child's Own Income _____ - - - -

Total Allocation _____ + + + + = -_____

REMAINING UNEARNED INCOME _____

c. Parents Earned Income (Total Gross) _____

Subtract Unused Portion of Allocation for Ineligible Children From Step 1b. -_____

REMAINING EARNED INCOME _____

Step 2

a. Remaining Unearned Income (1b) _____

Subtract General Exclusion - 20.00

COUNTABLE UNEARNED ..... _____

b. Remaining Earned Income (1c) _____

Subtract Portion of $20 not used above -_____

Sub-Total _____

Subtract Work Exclusion - 65.00

2) Sub-Total -_____

Subtract 1/2 Remainder -_____

COUNTABLE EARNED ..... _____

c. Add Countable Unearned +_____

TOTAL COUNTABLE INCOME _____

Subtract Living Allowance for Parent(s):
1 Parent = Full FBR Individual
2 Parents = FBR for Couple -_____

d. Amount of Deemed Income _____

_____	÷	_____	=	_____
AMOUNT OF DEEMED INCOME	÷	NUMBER OF ELIGIBLE CHILDREN	=	DEEMED INCOME PER CHILI

STEP 3

a.	Amount of Deemed Income to be Deemed to Child	_____
b.	Add Child's Own unearned Income	+ _____
	Sub-Total	_____
	Subtract General Exclusion	- 20.00
	COUNTABLE UNEARNED INCOME	_____
c.	Add Child's Own Earned Income	+ _____
	Sub-Total	_____
	Subtract Portion of $20 General Exclusion Not Used in 3b.	- _____
	Sub-Total	_____
	Subtract Work Exclusion	- 65.00
	Sub-Total	_____
	Subtract 1/2 Remainder	- _____
	COUNTABLE EARNED INCOME	_____
d.	COUNTABLE UNEARNED (Total from 3b)	_____
	ADD COUNTABLE EARNED (Total from 3c)	+ _____
	TOTAL COUNTABLE INCOME	_____
e.	Appropriate FBR or FPL	_____
	Subtract Total Countable Income	- _____
	RESULT	_____

REMARKS/COMPUTATION SPACE

Medicaid Specialist _____ Date _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-339 - STATEMENT REGARDING PAYMENT OF HEALTH INSURANCE PREMIUMS & NON-COVERED MEDICAL EXPENSES

PURPOSE & USE

This form is used to verify payment of an allowable health insurance premium and non-covered medical expenses billed to a nursing home client in a given quarter. The form must be completed by the client or designated representative for both health insurance and non-covered medical expenses deductions. In addition, if non-covered medical expenses are claimed, the provider of the service must complete the appropriate section of the form. Refer to Section I, Institutionalization, for policy regarding these deductions.

INSTRUCTIONS

All new nursing home approvals must be provided with a Form DOM-339 to be returned at the end of the assigned quarter. Recipients who participate in claiming non-covered medical expenses will be provided with a new Form DOM-339 whenever a completed form is submitted to the Regional Office. DOM-339 Forms that are not completed by the proper authority (Designated Representative, Physician or Hospital) will not be accepted as sufficient verification and the expense(s) will not be allowed as a deduction.

The worker will complete the top portion of the form to specify the months of the quarter to be reported on the form by placing the name of each of the 3 months in the assigned quarter at the top of each column on page 2.

The worker will complete the bottom portion of the form to specify the date the form is due. The Regional Office name and address must also be stamped in the space provided.

DOM-339
Revised 10-01-96

Case Name _____

Medicaid ID #_____

STATEMENT REGARDING PAYMENT OF HEALTH INSURANCE PREMIUMS AND NON-COVERED MEDICAL EXPENSES

Medicaid will allow certain non-covered medical expenses and one health insurance premium to be deducted from the income a nursing home client must pay toward the cost of care (Medicaid Income). Expenses are computed on a quarterly basis. An allowable expense billed in one quarter will not be allowed as a deduction until the next quarter. For example, expenses billed in October will be deducted from Medicaid Income due for January.

Health Insurance Premium Verification

Medicaid can allow an income deduction for one health insurance premium paid by a nursing home client. If the client named above pays for health insurance (other than Medicare), name the policy to be allowed as a deduction.

_____

How often is the premium paid? _____

Is the client's money used to pay for this health insurance premium? ☐ YES ☐ NO

YOU MUST SEND IN PROOF OF PAYMENT BY THE CLIENT AND THE PREMIUM NOTICE FOR A PREMIUM BILLED IN ORDER FOR THE PREMIUM TO BE ALLOWED. If paid monthly or bi-monthly, submit proof of only one payment.

✓_____ _____

SIGNATURE OF CLIENT OR DESIGNATED REPRESENTATIVE DATE

COMPLETED FORM DUE BY _____

Mail to the Regional Office address stamped below:

Non-Covered Medical Expenses

Medicaid can allow income deductions for medical services in excess of the Medicaid service limit for physician visits and/or hospital admissions. Before the expense can be allowed, it must be verified by the provider and all other third party payments must have been paid (such as Medicare and other insurance) so that the client's liability can be clearly identified.

If the client has been billed for physician and/or hospital expenses, is the client's money used to pay for these expenses? ☐ Yes ☐ No

✓ _____ _____

SIGNATURE OF CLIENT OR DESIGNATED REPRESENTATIVE DATE

	MONTH	MONTH	MONTH
PHYSICIAN EXPENSES -- THIS PORTION MUST BE COMPLETED BY THE PHYSICIAN'S OFFICE BILLING THE EXPENSE -- There should be no physician charges for a recipient who has Medicare as there are no physician limits on Medicaid/Medicare recipients. Include only charges in excess of the annual service limit. Name of Physician _____ Physician Charges Billed to Recipient . . . . . . Physician's Signature _____ Date _____	$_____	$_____	$_____
HOSPITAL EXPENSES -- THIS PORTION MUST BE COMPLETED BY THE HOSPITAL BUSINESS OFFICE. Include only those charges in excess of the annual service limit that are not covered by Medicare or other insurance. Name of Hospital _____ Hospital Charges Billed to Recipient . . . . . . Business Official's Signature _____ Date _____	$_____	$_____	$_____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-350 - REQUEST FOR LOCAL HEARING

PURPOSE & USE

The purpose of this form is to allow a client or representative to make a written request for a local hearing. Refer to Section J, Hearings, for policy regarding local hearings.

INSTRUCTIONS

This form will be completed when the client requests a local hearing via a form rather than a letter. The completion of this form is not mandatory; however, the hearing request must be made in writing. Prepare an original and 1 copy. File the original in the case record for use in scheduling the hearing. The copy belongs to the client.

The client or representative will complete and sign the form except for the Regional Office section.

The worker will enter in the space provided the following: The date the hearing request was received in writing; the date the notice to the client, either DOM-305 or 306, was mailed to the client; and, check whether or not continuation of benefits applies. Refer to Section J, Hearings.

DOM-350
Revised 04-01-82

Regional Office _____

Case Name _____

Medicaid ID # _____

REQUEST FOR LOCAL HEARING

I wish to request a local hearing for the following reason (s):

_____

Date

✓ _____

Signature of Client or Representative

_____

Mailing Address

_____

FOR REGIONAL OFFICE USE ONLY

Date Local Hearing Request Received in Writing _____

Date Notice to Client Mailed _____

Continuation of Benefits ☐ Yes ☐ No

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-351 : NOTICE OF DECISION ON LOCAL HEARING

PURPOSE & USE

This form is used to notify the client of the decision rendered as a result of the local hearing. This form may also be used by the client to request a State-level hearing if he/she disagrees with an adverse local-level hearing.

Prepare an original and 1 copy. The original is mailed to the client or representative and the copy is filed in the case record. Refer to Section J, Hearings.

INSTRUCTIONS

In the space provided, enter the date the local hearing was held and the decision reached by the Regional Office staff member who conducted the hearing. The decision must include a policy statement which supports the decision, i.e., the policy pertaining to the hearing issue must be explained.

In addition, the effective date of any further action to be taken as a result of the hearing will be specified. For example, if benefits are to be reinstated, the effective date of reinstatement must be shown. If benefits have been continued pending the hearing and the hearing decision is adverse, the effective date of any reduction or termination of benefits will be shown.

Date of Mailing: Enter the date the form is mailed to the client.

Signature of Local Hearing Officer: The person who conducted the local hearing will sign here.

Mailing Address of Regional Office: Stamp the Regional Office address in this space.

A hearing pamphlet will be enclosed on all adverse hearing decisions.

DOM-351
Revised 04-01-82

Regional Office _____

NOTICE OF DECISION ON LOCAL HEARING

TO _____

_____

_____

Case Name _____

Medicaid ID # _____

This is to notify you of the decision reached as a result of the local hearing held _____

_____. The decision is as follows:

If you disagree with this decision and wish to request a State hearing, we must receive your written request within 15 days from the date of mailing shown below. In order to request a State hearing you may complete the bottom portion of this form and mail it into the Regional Office at the address shown below. If we do not hear from you within 15 days from the date of mailing this form, we will know that you understand the reason for this decision on your local hearing.

_____ _____

Date of Mailing Signature of Local Hearing Officer

Mailing Address of Regional Office:

COMPLETE THIS SECTION IF YOU WISH TO REQUEST A STATE HEARING

I wish to request a State Hearing because I disagree with the decision reached on my local hearing.

_____ _____

Date Signature of Client or Representative

Enclosure: Hearing Pamphlet

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-352 - REQUEST FOR STATE HEARING

PURPOSE & USE

This form is used to allow the client/representative to make a written request for a State hearing. If a local-level hearing has already been held on the same issue, the client may request a State hearing by completing the bottom portion of DOM-351 or by completing DOM-352. Either method is acceptable.

The completion of this form is not mandatory; however, all hearing requests must be made in writing. If the client prefers, the request may be put in a letter to the Regional of State Office. Refer to Section J, Hearings.

INSTRUCTIONS

Complete an original and 2 copies. The original will be forwarded to the Eligibility Division in the State Office. One copy is part of the case record kept in the Regional Office, and the other copy is the client's.

The client or representative will complete and sign the form except for the Regional or State Office section.

FOR REGIONAL OR STATE OFFICE USE ONLY

The Regional Office will complete this section if the hearing request is filed with the Regional Office. If the request is mailed directly to the State Office. the hearing official will complete this portion by contacting the Regional Office.

1. Check whether or not a local hearing has been held.

2. Enter the date DOM-306 was mailed to the client; or, if a local hearing has been held, enter the date DOM-351 was mailed to client.

3. Check whether or not continuation of benefits is applicable.

DOM-352
Revised 10-01-96

Regional Office _____

Case Name _____

Medicaid ID # _____

REQUEST FOR STATE HEARING

TO: **Division of Medicaid, Office of the Governor**
Eligibility Division
239 North Lamar Street, Suite 801
Jackson, Mississippi 39201-1399

I wish to request a State hearing before a State hearing officer for the following reason(s):

_____

_____

_____

_____

_____

_____

_____

Date: _____ ✓ _____

SIGNATURE OF CLIENT OR REPRESENTATIVE

_____

MAILING ADDRESS

_____

FOR REGIONAL OR STATE OFFICE USE ONLY

Has Local Hearing been held? ☐ Yes ☐ No

Date DOM-306 or DOM-351, if Local Hearing held, was mailed: _____

Continuation of Benefits apply: ☐ Yes ☐ No

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-354 - IMPROPER PAYMENT REPORT

PURPOSE & USE

This form is used by the Regional Office to report cases involving improper Medicaid payments due to Agency or client error. The form is submitted to the Medicaid Eligibility Division in the State Office. Refer to Section I, Improper Medicaid Benefits.

INSTRUCTIONS

Prepare an original and 1 copy. Exception: Prepare an original and 2 copies when the report is for a Medicaid eligible couple or two separate cases in the same family. The copy remains in the case record and the original is routed to the Medicaid Eligibility Division. The form should be typewritten when possible. If typing is not possible, please be sure the handwriting is legible. Each section of the form should be completed or notated as not applicable (NA). Extra sheets of paper may be used when there is not enough room on the form to fully explain.

Regional Office: Enter the Regional Office name.

1. Aged & Disabled Medicaid: Enter the name of the recipient, Medicaid ID number, and address. For an eligible couple, enter the name of the spouse also. Enter the name and address of the designated representative, if applicable.

2. Improper Payment Information: Enter the reason for the Improper Payment (check the applicable block) and the source of the information, such as IEVS hit, SVES, BENDEX, SDX, bank clearance, etc. Explain how this information was verified by independent verification. Enter the date of the last redetermination (or application or last contact with the client or representative as appropriate). In the space provided, summarize the events/cause of the improper payment. Include pertinent dates, such as the date(s) the changes occurred that caused the improper payment.

3. Period of Time Covered by Improper Payment: Enter the beginning date (month/day/year) that the improper payment began. This is the date the change could have been effected had the change been reported timely or acted upon promptly. Also enter the ending date (month/day/year) of the improper payment.

   Enter the client's coverage group for each improper payment period of time. In the space provided, enter the amount of Medicaid Income used and the amount Medicaid Income should have been (correct amount). Enter the coverage group in which eligibility remains for each improper payment period (if appropriate).

4. Action by Regional Office: Enter the effective date of closure via MEDS or the effective date of the corrective action via MEDS, whichever is applicable.

5. Resources Available for Recovery: Enter the client's income source(s) and amount(s) and list any and all resources available to the client.

   Worker Signature/Date: The worker completing the form will sign and date here.

   Supervisor Signature: The Medicaid Specialist Supervisor will sign here after reviewing the form.

   Date: Enter the date the form is signed by the Supervisor.

DOM-354
Revised 09-01-95

Regional Office_____

IMPROPER PAYMENT REPORT

1. AGED & DISABLED MEDICAID

Recipient's Name_____ ID#_____

Address_____

Designated Representative's Name & Address_____

_____

2. IMPROPER PAYMENT INFORMATION

Reason for Improper Payment: ( ) Suspected Fraud
( ) Agency Error
( ) Client Error

Source of Information:

_____

Verification of Information:

_____

Date of Last Redetermination (or Application) or Date Information Was Last Reported

_____

Summarize the Events/Cause of Improper Payment (include date(s) changes occurred)

_____

_____

_____

_____

_____

_____

3. PERIOD OF TIME COVERED BY IMPROPER PAYMENT

The begin date of the improper payment is the date action could have been taken if the information had been promptly reported or acted upon:

Begin Date MM/DD/YY	End Date MM/DD/YY	Cov. Group in which ineligibility occurs	Medicaid Income Used	Correct Medicaid Income	Cov. Group in which eligibility remains
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	

4. ACTION BY REGIONAL OFFICE

Effective date of case closure or correction: _____

_____

5. RESOURCES AVAILABLE FOR RECOVERY

_____

_____

_____

_____

WORKER'S SIGNATURE _____ DATE _____

SUPERVISOR'S SIGNATURE _____ DATE _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-367 - RECORD OF CONTACT

PURPOSE & USE

The Record of Contact is used to record the events that occur during the application process and during the remainder of the time the case remains active. All telephone contacts concerning the client and correspondence or forms issued to the client are recorded on DOM-367. Any action taken by the worker on the case is also recorded on the form.

INSTRUCTIONS

The Record of Contact is completed by the worker or supervisor handling the case and is filed in the case record. Only the original is required and when both sides are full, begin entries on a new form. Disposal of an application should be notated in red ink for easy reference.

Revised 11-01-84

Medicaid ID #________________

RECORD OF CONTACT

.e	Person/Source Contacted	Purpose/Results of Contact	Init.

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DIVISION OF MEDICAID REGIONAL OFFICES

BRANDON REGIONAL OFFICE (M25)
3035 Greenfield Road
Pearl, MS 39208
601-825-0477 - Lisa Smith, Supervisor

BROOKHAVEN REGIONAL OFFICE (M21)
1372 Johnny Johnson Drive
Brookhaven, MS 39601-3317
601-835-2020 - Sarah Underwood, Supervisor

CANTON REGIONAL OFFICE (M29)
616 E. Peace Street
Canton, MS 39046
601-859-3230 - Jerlin Parks, Supervisor

CLARKSDALE REGIONAL OFFICE (M13)
528 S. Choctaw Street
Clarksdale, MS 38614
662-627-1493 - Geneva Cotton, Supervisor

CLEVELAND REGIONAL OFFICE (M15)
201 E. Sunflower, Suite 10
Cleveland, MS 38732-7753
662-843-7753 - Ivey Anderson, Supervisor

COLUMBIA REGIONAL OFFICE (M24)
1111 Hwy 98 ByPass
Suite B
Columbia, MS 39429 -3701
601-731-2271 - Sonji Pittman, Supervisor

COLUMBUS REGIONAL OFFICE (M02)
2207 5th Street North
Columbus, MS 39705
662-329-2190 - Jane Niles, Supervisor

CORINTH REGIONAL OFFICE (M12)
2619 S. Harper Road
Corinth, MS 38834-9399
662-286-8091 - (vacant) Supervisor

GREENVILLE REGIONAL OFFICE (M04)
585 Tennessee Gas Road
Greenville, MS 38701-8160
662-332-9370 - Tonia Williams, Supervisor

GREENWOOD REGIONAL OFFICE (M03)
805 W. Park Avenue, Suite 6
Greenwood, MS 38930-2832
662-455-1053 - Deborah Woods, Supervisor

GRENADA REGIONAL OFFICE (M14)
1109 Sunwood Drive
Grenada, MS 38901
662-226-4406 - Mary McIntyre, Supervisor

GULFPORT REGIONAL OFFICE (M09)
101 Hardy Court Shopping Center
Gulfport, MS 39507-2528
228-863-3328 - Kendra Landry, Supervisor

HATTIESBURG REGIONAL OFFICE (M08)
132 Mayfair Blvd.
Hattiesburg, MS 39402-1463
601-264-5386 - Barbara Lofton, Supervisor

HOLLY SPRINGS REGIONAL OFFICE (M11)
695 Salem Avenue
Holly Springs, MS 38635-2109
662-252-3439 - Elise Cornwell, Supervisor

JACKSON REGIONAL OFFICE (M06)
1695 High Street, Suite A
Jackson, MS 39202
601-961-4361 - Kim Crapps, Supervisor

KOSCIUSKO REGIONAL OFFICE (M17)
334 Hwy 12 West
Kosciusko, MS 39090
662-289-4477 - Phyllis Peden, Supervisor

LAUREL REGIONAL OFFICE (M22)
1100 Hillcrest Drive
Laurel, MS 39440-4731
601-425-3175 - Horace Hayes, Supervisor

McCOMB REGIONAL OFFICE (M23)
301 Apache Drive
McComb, MS 39648-6309
601-249-2071 - Virginia Crimiel, Supervisor

MERIDIAN REGIONAL OFFICE (M05)
3848 Old Hwy 45 N.
Meridian, MS 39301
601-483-9944 - Bob McHann, Supervisor

NATCHEZ REGIONAL OFFICE (M20)
103 State Street
Natchez, MS 39120
601-445-4971 - Sissy Allen, Supervisor

NEW ALBANY REGIONAL OFFICE (M27)
1510 Munsford Drive
New Albany, MS 38652
662-534-0441 - Ann Simmons, Supervisor

NEWTON REGIONAL OFFICE (M19)
9423 Eastside Drive Ext.
Newton, MS 39345-2622
601-635-5205 - Allen Muse, Supervisor

PASCAGOULA REGIONAL OFFICE (M10)
4119 Amonett Street
Pascagoula, MS 39567-4413
228-762-9591 - Gary Cross, Supervisor

PHILADELPHIA REGIONAL OFFICE (M18)
1122 E. Main Street, Eastgate Plaza, Suite 15
Philadelphia, MS 39350-2300
601-656-3131 - Robert Burton, Supervisor

PICAYUNE REGIONAL OFFICE (M30)
1845 Cooper Road
Picayune, MS 39466
601-798-0831 - Chris Freeland, Supervisor

SENATOBIA REGIONAL OFFICE (M26)
2776 Hwy 51 South
Senatobia , MS 38668
662-562-0147 - Truly Payne, Supervisor

STARKVILLE REGIONAL OFFICE (M16)
313 Industrial Park Drive
Starkville, MS 39759
662-323-3688 - Cathy Crow, Supervisor

TUPELO REGIONAL OFFICE (M01)
1742 McCullough Blvd.
Tupelo, MS 38801-7101
662-844-5304 - Claire Tutor, Supervisor

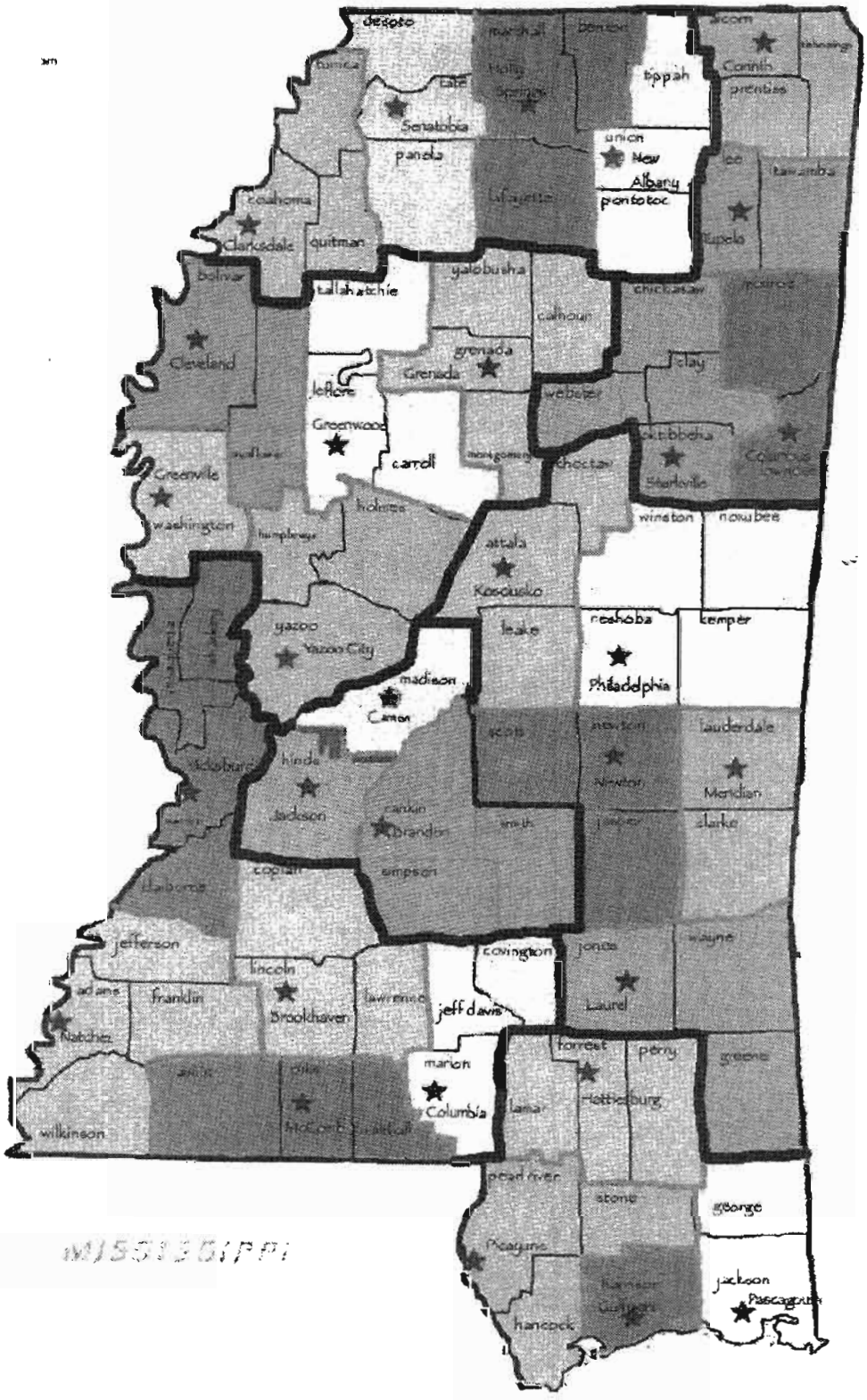
VICKSBURG REGIONAL OFFICE (M07)
2734 Washington Street
Vicksburg, MS 39180-4656
601-638-6137 - Dorothy Jones, Supervisor

YAZOO CITY REGIONAL OFFICE (M28)
110 North Jerry Clower Blvd., Suite A
Yazoo City, MS 39194
662-746-2309 - Barbara Watson, Supervisor

REGIONAL OFFICE FAX NUMBERS

REGIONAL OFFICES	FAX NUMBERS
BRANDON REGIONAL OFFICE	1-601-825-2184
BROOKHAVEN REGIONAL OFFICE	1-601-833-5429
CANTON REGIONAL OFFICE	1-601-859-9526
CLARKSDALE REGIONAL OFFICE	1-662-627-5460
CLEVELAND REGIONAL OFFICE	1-662-843-4609
COLUMBIA REGIONAL OFFICE	1-601-736-7924
COLUMBUS REGIONAL OFFICE	1-662-329-8581
CORINTH REGIONAL OFFICE	1-662-287-9763
GREENVILLE REGIONAL OFFICE	1-662-334-4577
GREENWOOD REGIONAL OFFICE	1-662-459-9754
GRENADA REGIONAL OFFICE	1-662-226-8821
GULFPORT REGIONAL OFFICE	1-228-868-0121
HATTIESBURG REGIONAL OFFICE	1-601-261-1244
HOLLY SPRINGS REGIONAL OFFICE	1-662-252-6843
JACKSON REGIONAL OFFICE	1-601-961-4412
KOSCIUSKO REGIONAL OFFICE	1-662-289-9420
LAUREL REGIONAL OFFICE	1-601-425-9441
MCCOMB REGIONAL OFFICE	1-601-249-4629
MERIDIAN REGIONAL OFFICE	1-601-486-2988
NATCHEZ REGIONAL OFFICE	1-601-442-0571
NEW ALBANY REGIONAL OFFICE	1-662-534-7196
NEWTON REGIONAL OFFICE	1-601-635-5213
PASCAGOULA REGIONAL OFFICE	1-228-762-7309
PHILADELPHIA REGIONAL OFFICE	1-601-656-7950
PICAYUNE REGIONAL OFFICE	1-601-798-6753
SENATOBIA REGIONAL OFFICE	662-562-7897
STARKVILLE REGIONAL OFFICE	1-662-324-1872
TUPELO REGIONAL OFFICE	1-662-840-9941
VICKSBURG REGIONAL OFFICE	1-601-638-7186
YAZOO CITY REGIONAL OFFICE	1-662-746-2645

Regional Office Boundaries



Division Director Regions

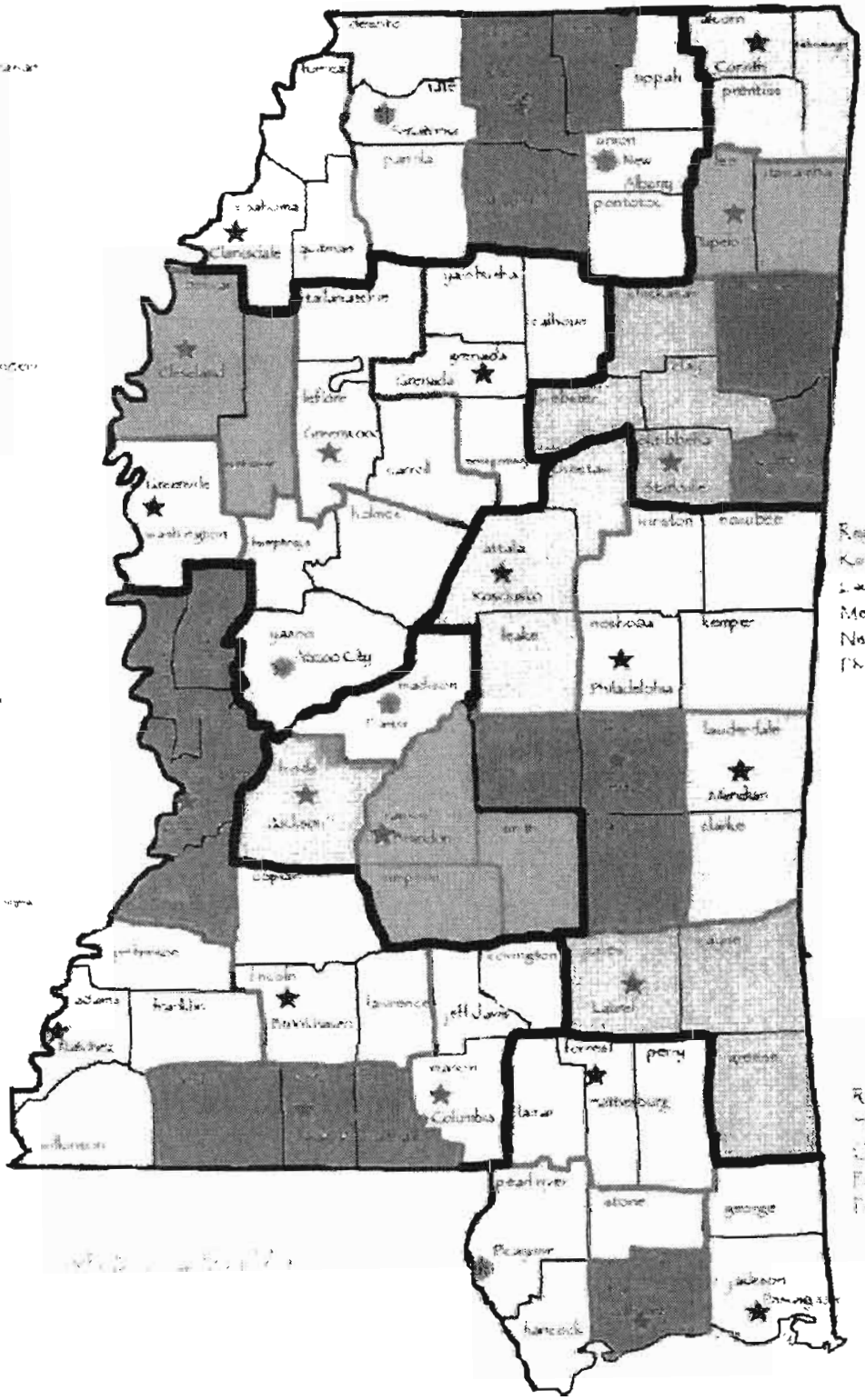


CHART OF NEED STANDARDS AND RESOURCE LIMITS

INSTITUTIONAL INCOME LIMITS		07-01-81	07-01-82	07-01-83	01-01-84	01-01-85
Federal Maximum (Gross Income)	Individual	794.10	852.90	912.90	942.00	975.00
	Couple	1588.20	1705.80	1825.80	1884.00	1950.00
State Maximum (Countable Income)	Individual	NA	NA	852.90	852.90	NA
	Couple	NA	NA	1705.80	1705.80	NA
MEDICARE PREMIUMS						
Part A		NA	NA	NA	NA	NA
Part B		11.00	12.20	12.20	14.60	15.50
SSI FEDERAL BENEFIT RATES						
SSI Individual FBR	Own Household (LA-A)	264.70	284.30	304.30	314.00	325.00
	Household of Another (LA-B)	176.47	189.54	202.87	209.34	216.67
	Title XIX Facility (LA-D)	25.00	25.00	25.00	25.00	25.00
SSI Couple FBR	Own Household (LA-A)	397.00	426.40	456.40	472.00	488.00
	Household of Another (LA-B)	264.67	284.27	304.27	314.67	325.34
	Title XIX Facility (LA-D)	50.00	50.00	50.00	50.00	50.00
Deeming	Allocation to Each Ineligible Child	132.30	142.10	152.10	158.00	163.00
Presumed Maximum Value (PMV) of Inkind S & M	Individual	108.23	114.76	121.43	124.66	128.33
	Couple	152.33	162.13	172.13	177.33	182.66
SSI RESOURCE LIMITS						
	Individual	1500.00	1500.00	1500.00	1500.00	1600.00
	Couple	2250.00	2250.00	2250.00	2250.00	2400.00
FEDERAL POVERTY LIMITS						
	Individual					
	Couple					
SPOUSAL IMPOVERISHMENT MAXIMUMS						
Federal Resource Maximum						
Community Spouse Monthly Maintenance Needs Allowance						
Other Family Members Needs Allowance						

CHART OF NEED STANDARDS AND RESOURCE LIMITS

INSTITUTIONAL INCOME LIMITS		01-01-86	01-01-87	01-01-88	07-01-88	01-01-89
Federal Maximum (Gross Income)	Individual	1008.00	1020.00	1062.00	NA	1104.00
	Couple	2016.00	2040.00	2124.00	NA	2208.00
State Maximum (Countable Income)	Individual	NA	NA	NA	NA	NA
	Couple	NA	NA	NA	NA	NA

MEDICARE PREMIUMS						
Part A		NA	NA	NA	NA	NA
Part B		15.50	17.90	24.80	NA	31.90

SSI FEDERAL BENEFIT RATES						
SSI Individual FBR	Own Household (LA-A)	336.00	340.00	354.00	NA	368.00
	Household of Another (LA-B)	224.00	226.67	236.00	NA	245.34
	Title XIX Facility (LA-D)	25.00	25.00	25.00	30.00	30.00
SSI Couple FBR	Own Household (LA-A)	504.00	510.00	532.00	NA	553.00
	Household of Another (LA-B)	336.00	340.00	354.67	NA	368.67
	Title XIX Facility (LA-D)	50.00	50.00	50.00	60.00	60.00
Deeming	Allocation to Each Ineligible Child	168.00	170.00	178.00	NA	185.00
resumed Maximum Value (PMV)	Individual	132.00	133.33	138.00	NA	142.66
of Inkind S & M	Couple	188.00	190.00	197.33	NA	204.33

SSI RESOURCE LIMITS						
	Individual	1700.00	1800.00	1900.00	NA	2000.00
	Couple	2550.00	2700.00	2850.00	NA	3000.00

FEDERAL POVERTY LIMITS						
	Individual					
	Couple					

SPOUSAL IMPOVERISHMENT MAXIMUMS					
Federal Resource Maximum					
Community Spouse Monthly Maintenance Needs Allowance					
Other Family Members Needs Allowance					

CHART OF NEED STANDARDS AND RESOURCE LIMITS

INSTITUTIONAL INCOME LIMITS		07-01-89	01-01-90	03-01-90	01-01-91	03-01-91
Federal Maximum	Individual	NA	1158.00	NA	1221.00	
(Gross Income)	Couple	NA	2316.00	NA	NA	
State Maximum	Individual	NA	NA	NA	NA	
(Countable Income)	Couple	NA	NA	NA	NA	
MEDICARE PREMIUMS						
Part A		156.00	175.00	NA	177.00	
Part B		NA	28.60	NA	29.90	
SSI FEDERAL BENEFIT RATES						
SSI Individual FBR	Own Household (LA-A)	NA	386.00	NA	407.00	
	Household of Another (LA-B)	NA	257.34	NA	271.34	
	Title XIX Facility (LA-D)	NA	30.00	NA	30.00	
SSI Couple FBR	Own Household (LA-A)	NA	579.00	NA	610.00	
	Household of Another (LA-B)	NA	386.00	NA	406.67	
	Title XIX Facility (LA-D)	NA	60.00	NA	60.00	
Deeming	Allocation to Each Ineligible Child	NA	193.00	NA	203.00	
Presumed Maximum Value	Individual	NA	148.66	NA	155.66	
(PMV) of Inkind S & M	Couple	NA	213.00	NA	223.33	
SSI RESOURCE LIMITS						
	Individual	NA	2000.00	NA	NA	
	Couple	NA	3000.00	NA	NA	
FEDERAL POVERTY LIMITS						
Qualified Medicare	Individual	424.00	449.00	471.00	524.00	552.00
Beneficiaries (QMB)	Couple	569.00	602.00	632.00	702.00	740.00
Poverty Level Aged &	Individual	424.00	449.00	471.00	524.00	552.00
Disabled (PLAD)	Couple	569.00	602.00	632.00	702.00	740.00
Qualified Working	Individual	Effective 07-01-90		1047.00	NA	1104.00
Disabled Individuals (QWDI)	Couple	Effective 07-01-90		1404.00	NA	1480.00

SPOUSAL IMPOVERISHMENT MAXIMUMS	10-01-89	01-01-90	07-01-90	01-01-91	07-01-91
Federal Resource Maximum	60,000	62,580	NA	66,480	
Community Spouse Monthly Maintenance Needs Allowance	1,500	1,565	NA	1,662	
Other Family Members Needs Allowance	815	NA	856	NA	985

CHART OF NEED STANDARDS AND RESOURCE LIMITS

INSTITUTIONAL INCOME LIMITS		01-01-92	03-01-92	01-01-93	03-01-93	01-01-94
Federal Maximum	Individual	1266.00	NA	1302.00	NA	1338.00
(Gross Income)	Couple	NA	NA	NA	NA	NA
State Maximum	Individual	NA	NA	NA	NA	NA
(Countable Income)	Couple	NA	NA	NA	NA	NA
MEDICARE PREMIUMS						
Part A		192.00	NA	221.00		245.00
Part B		31.80	NA	36.60		41.10
SSI FEDERAL BENEFIT RATES						
SSI Individual FBR	Own Household (LA-A)	422.00	NA	434.00		446.00
	Title XIX Facility (LA-D)	30.00	NA	30.00		30.00
SSI Couple FBR	Own Household (LA-A)	633.00	NA	652.00		669.00
	Title XIX Facility (LA-D)	60.00	NA	60.00		60.00
Deeming	Allocation to Each Ineligible Child	211.00	NA	218.00		223.00
Presumed Maximum Value	Individual	140.66	NA	144.66		1438.66
(PMV) of Inkind S & M	Couple	211.00	NA	217.33		223.00
SSI RESOURCE LIMITS						
	Individual	2000.00	NA	2000.00		2000.00
	Couple	3000.00	NA	3000.00		3000.00
FEDERAL POVERTY LIMITS						
Qualified Medicare	Individual	552.00	568.00	NA	581.00	NA
Beneficiaries (QMB)	Couple	740.00	766.00	NA	786.00	NA
Poverty Level Aged &	Individual	552.00	568.00	NA	581.00	NA
Disabled (PLAD)	Couple	740.00	766.00	NA	786.00	NA
Qualified Working	Individual	1104.00	1135.00	NA	1162.00	NA
Disabled Individuals (QWDI)	Couple	1480.00	1532.00	NA	1572.00	NA
Specified Low-Income	Individual					
Medicare Beneficiaries (SLMB)	Couple					

SPOUSAL IMPOVERISHMENT MAXIMUMS	01-01-92	01-01-93	01-01-94
Federal Resource Maximum	68700.00	70740.00	72660.00
Community Spouse Monthly Maintenance Needs Allowance	NA	NA	1817.00
Other Family Members Needs Allowance	NA	NA	985.00

CHART OF NEED STANDARDS AND RESOURCE LIMITS

INSTITUTIONAL INCOME LIMITS		03-01-94	01-01-95	03-01-95	01-01-96
Federal Maximum	Individual	NA	1,374.00	NA	1,410.00
(Gross Income)	Couple	NA	NA	NA	NA
State Maximum	Individual	NA	NA	NA	NA
(Countable Income)	Couple	NA	NA	NA	NA

MEDICARE PREMIUMS				
Part A	NA	261.00	NA	289.00
Part B	NA	46.10	NA	42.50

SSI FEDERAL BENEFIT RATES					
SSI Individual FBR	Own Household (LA-A)	NA	458.00	NA	470.00
	Title XIX Facility (LA-D)	NA	30.00	NA	30.00
SSI Couple FBR	Own Household (LA-A)	NA	687.00	NA	705.00
	Title XIX Facility (LA-D)	NA	60.00	NA	60.00
Deeming	Allocation to Each Ineligible Child	NA	229.00	NA	235.00
Presumed Maximum Value	Individual	NA	156.66	NA	156.66
(PMV) of Inkind S & M	Couple	NA	229.00	NA	235.00

SSI RESOURCE LIMITS					
	Individual	NA	2,000.00	NA	2,000.00
	Couple	NA	3,000.00	NA	3,000.00

FEDERAL POVERTY LIMITS					
Qualified Medicare	Individual	614.00	NA	623.00	NA
Beneficiaries (QMB)	Couple	820.00	NA	836.00	NA
Poverty Level Aged &	Individual	614.00	NA	623.00	NA
Disabled (PLAD)	Couple	820.00	NA	836.00	NA
Qualified Working	Individual	1,227.00	NA	1,245.00	NA
Disabled Individuals (QWDI)	Couple	1,640.00	NA	1,672.00	NA
Specified Low-Income	Individual	675.00	736.00	747.00	NA
Medicare Beneficiaries (SLMB)	Couple	902.00	984.00	1,003.00	NA

SPOUSAL IMPOVERISHMENT MAXIMUMS	03-01-94	01-01-95	03-01-95	01-01-96
Federal Resource Maximum	NA	74,820.00	NA	76,740.00
Community Spouse Monthly Maintenance Needs Allowance	NA	1,870.50	NA	1,918.50
Other Family Members Needs Allowance	NA	985.00	NA	985.00

CHART OF NEED STANDARDS AND RESOURCE LIMITS

INSTITUTIONAL INCOME LIMITS		03-01-96	01-01-97	03-01-97	01-01-98
Federal Maximum	Individual (Gross Income)	NA	$1,452.00	NA	$1,482.00
MEDICARE PREMIUMS					
Part A		NA	$311.00	NA	$309.00
Part B		NA	$ 43.80	NA	$ 43.80
QI-2 Benefit Amount					$ 1.07
SSI FEDERAL BENEFIT RATES					
SSI Individual FBR	Own Household (LA-A)	NA	$484.00	NA	$494.00
	Title XIX Facility (LA-D)	NA	$ 30.00	NA	$ 30.00
SSI Couple FBR	Own Household (LA-A)	NA	$726.00	NA	$741.00
	Title XIX Facility (LA-D)	NA	$ 60.00	NA	$ 60.00
Deeming	Allocation to Each Ineligible Child	NA	$242.00	NA	$247.00
Presumed Maximum Value (PMV)	Individual	NA	$161.33	NA	$164.66
SSI RESOURCE LIMITS	Individual	NA	NA	NA	NA
	Couple	NA	NA	NA	NA
FEDERAL POVERTY LIMITS					
Qualified Medicare Beneficiaries (QMB)	Individual	$ 645.00	NA	$658.00	NA
	Couple	$ 864.00	NA	$885.00	NA
Poverty Level Aged & Disabled (PLAD)	Individual	$ 645.00	NA	$658.00	NA
	Couple	$ 864.00	NA	$885.00	NA
Specified Low-Income Medicare Beneficiaries (SLMB)	Individual	$ 774.00	NA	$ 789.00	$ 789.00
	Couple	$1,036.00	NA	$1,061.00	$1,061.00
Qualifying Individual QI-1 Group	Individual				$ 888.00
	Couple				$1,194.00
Qualifying Individual QI-2 Group	Individual				$1,151.00
	Couple				$1,548.00
Qualified Working Disabled Individuals (QWDI)	Individual	$1,290.00	NA	$1,315.00	NA
	Couple	$1,727.00	NA	$1,769.00	NA

SPOUSAL IMPOVERISHMENT MAXIMUMS	03-01-96	01-01-97	03-01-97	01-01-98
Federal Resource Maximum	NA	$ 79,020.00	NA	$80,760.00
Community Spouse Monthly Maintenance Needs Allowance	NA	$ 1,975.50	NA	$ 2,019.00
Other Family Members Needs Allowance	NA	$ 985.00	NA	$ 985.00

CHART OF NEED STANDARDS AND RESOURCE LIMITS

INSTITUTIONAL INCOME LIMITS		03-01-98	01-01-99	03-01-99	07-01-99
Federal Maximum	Individual (Gross Income)	$1,482.00	$1,500.00	NA	NA

MEDICARE PREMIUMS					
Part A		$ 309.00	$309.00	NA	NA
Part B		$ 43.80	$ 45.50	NA	NA
QI-2 Benefit Amount		NA	$ 2.23	NA	NA

SSI FEDERAL BENEFIT RATES					
SSI Individual FBR	Own Household (LA-A)	$ 494.00	$500.00	NA	NA
	Title XIX Facility (LA-D)	$ 30.00	$ 30.00	NA	NA
SSI Couple FBR	Own Household (LA-A)	$ 741.00	$751.00	NA	NA
	Title XIX Facility (LA-D)	$ 60.00	$ 60.00	NA	NA
Deeming	Allocation to Each Ineligible Child	$ 247.00	$251.00	NA	NA
Presumed Maximum Value (PMV)	Individual	$ 164.66	$ 166.66	NA	NA
	Couple		$ 250.33	NA	NA
SSI RESOURCE LIMITS	Individual	$2000.00	$2000.00	NA	NA
	Couple	$3000.00	$3000.00	NA	NA
Liberalized Resource Limits	Individual				$3000.00
	Couple				$4000.00

FEDERAL POVERTY LIMITS					
Qualified Medicare Beneficiaries (QMB)	Individual	$ 671.00	N/A	$ 687	NA
	Couple	$ 905.00	N/A	$ 922	NA
Poverty Level Aged & Disabled (PLAD)	Individual	$ 671.00	N/A	$ 687	NA
	Couple	$ 905.00	N/A	$ 922	NA
Specified Low-Income Medicare Beneficiaries (SLMB)	Individual	$ 805.00	N/A	$ 824	NA
	Couple	$1,085.00	N/A	$1,106	NA
Qualifying Individual QI-1 Group	Individual	$ 906.00	N/A	$ 927	NA
	Couple	$1,221.00	N/A	$1,245	NA
Qualifying Individual QI-2 Group	Individual	$1,174.00	N/A	$1,202	NA
	Couple	$1,583.00	N/A	$1,613	NA
Qualified Working Disabled Individuals (QWDI)	Individual	$1,342.00	N/A	$1,374	NA
	Couple	$1,809.00	N/A	$1,844	NA
Working Disabled (WD)	Individual	N/A	N/A	N/A	$1,717.00
	Couple	N/A	N/A	N/A	$2,305.00

SPOUSAL IMPOVERISHMENT MAXIMUMS	03-01-98	01-01-99	03-01-99	07-01-99
Federal Resource Maximum	$80,760.00	$81,960.00	NA	NA
Community Spouse Monthly Maintenance Needs Allowance	$ 2,019.00	$ 2,049.00	NA	NA
Other Family Members Needs Allowance	$ 985.00	$ 985.00	NA	NA

CHART OF NEED STANDARDS AND RESOURCE LIMITS

INSTITUTIONAL INCOME LIMITS		01-01-2000	05-01-00	07-01-00	01-01-01
Federal Maximum	Individual (Gross Income)	$1,536.00	NA	NA	$1,590.00
Earned Income Disregard				$212.00	$ 221.00

MEDICARE PREMIUMS					
Part A		$301.00	NA	NA	$300.00
Part B		$ 45.50	NA	NA	$ 50.00
QI-2 Benefit Amount		$ 2.87	NA	NA	$ 3.09

SSI FEDERAL BENEFIT RATES					
SSI Individual FBR	Own Household (LA-A)	$512.00	NA	NA	$530.00
	Title XIX Facility (LA-D)	$ 30.00	NA	NA	$ 30.00
SSI Couple FBR	Own Household (LA-A)	$769.00	NA	NA	$796.00
Deeming	Allocation to Each Ineligible Child	$257.00	NA	NA	$ 266.00
Presumed Maximum Value (PMV)	Individual	$170.66	NA	NA	$ 176.66
	Couple	$256.33	NA	NA	$ 265.33
SSI RESOURCE LIMITS	Individual	$2,000.00	NA	NA	$2,000.00
	Couple	$3,000.00	NA	NA	$3,000.00
Liberalized Resource Limits	Individual	$3,000.00	NA	$4000.00	NA
	Couple	$4,000.00	NA	$6000.00	NA

FEDERAL POVERTY LIMITS					
Qualified Medicare Beneficiaries (QMB)	Individual	NA	$ 696.00	NA	NA
	Couple	NA	$ 938.00	NA	NA
Poverty Level Aged & Disabled (PLAD)	Individual	NA	$ 696.00	$ 940.00	NA
	Couple	NA	$ 938.00	$1266.00	NA
Specified Low-Income Medicare Beneficiaries (SLMB)	Individual	NA	$ 835.00	NA	NA
	Couple	NA	$1,125.00	NA	NA
Qualifying Individual QI-1 Group	Individual	NA	$ 940.00	NA	NA
	Couple	NA	$1,266.00	NA	NA
Qualifying Individual QI-2 Group	Individual	NA	$1,218.00	NA	NA
	Couple	NA	$1,641.00	NA	NA
Qualified Working Disabled Individuals (QWDI)	Individual	NA	$1,392.00	NA	NA
	Couple	NA	$1,875.00	NA	NA
Working Disabled (WD)	Individual	NA	$3,545.00	NA	NA
	Couple	NA	$4,753.00	NA	NA

SPOUSAL IMPOVERISHMENT MAXIMUMS	01-01-2000	05-01-00	07-01-00	01-01-01
Federal Resource Maximum	$84,120.00	NA	NA	$87,000.00
Community Spouse Monthly Maintenance Needs Allowance	$ 2,103.00	NA	NA	$ 2,175.00
Other Family Members Needs Allowance	$ 985.00	NA	NA	$ 985.00

CHART OF NEED STANDARDS AND RESOURCE LIMITS

INSTITUTIONAL INCOME LIMITS		03/01/01	01/01/02	03/01/02	01/01/03
Federal Maximum	Individual (Gross Income)	NA	$1,635.00	NA	$1,656.00
Earned Income Disregard		NA	$228.50	NA	$232.00

MEDICARE PREMIUMS					
Part A		NA	$319.00	NA	$316.00
Part B		NA	$54.00	NA	$58.70
QI-2 Benefit Amount		NA	$3.91	NA	NA

SSI FEDERAL BENEFIT RATES					
SSI Individual FBR	Own Household (LA-A)	NA	$545.00	NA	$552.00
	Title XIX Facility (LA-D)		$30.00	NA	$30.00
SSI Couple FBR	Own Household (LA-A)	NA	$817.00	NA	$829.00
Deeming	Allocation to Each Ineligible Child	NA	$272.00	NA	$277.00
Presumed Maximum Value (PMV	Individual	NA	$181.60	NA	$204.00
	Couple	NA	$272.33	NA	$296.33
SSI RESOURCE LIMITS	Individual	NA	$2,000.00	NA	$2,000.00
	Couple	NA	$3,000.00	NA	$3,000.00
Liberalized Resource Limits	Individual	NA	$4,000.00	NA	$4,000.00
	Couple	NA	$6,000.00	NA	$6,000.00

FEDERAL POVERTY LIMITS					
Qualified Medicare Beneficiaries (QMB)	Individual	$716.00	NA	$739.00	NA
	Couple	$968.00	NA	$995.00	NA
Poverty Level Aged & Disabled (PLAD)	Individual	$ 967.00	NA	$997.00	NA
	Couple	$1,307.00	NA	$1,344.00	NA
Specified Low-Income Medicare Beneficiaries (SLMB)	Individual	$ 859.00	NA	$886.00	NA
	Couple	$1,161.00	NA	$1,194.00	NA
Qualifying Individual QI-1 Group	Individual	$ 967.00	NA	$997.00	NA
	Couple	$1,307.00	NA	$1,344.00	NA
Qualifying Individual QI-2 Group	Individual	$1,253.00	NA	$1,293.00	NA
	Couple	$1,694.00	NA	$1,742.00	NA
Qualified Working Disabled Individuals (QWDI)	Individual	$1,432.00	NA	$1,477.00	NA
	Couple	$1,935.00	NA	$1,990.00	NA
Working Disabled (WD)	Individual	$3,645.00	NA	$3,757.00	NA
	Couple	$4,903.00	NA	$5,041.00	NA

SPOUSAL IMPOVERISHMENT MAXIMUMS	03/01/01	01/01/02	03/01/02	01/01/03
Federal Resource Maximum	NA	$89,280.00	NA	$90,660.00
Community Spouse Monthly Maintenance Needs Allowance	NA	$2,232.00	NA	$2,266.50
Other Family Members Needs Allowance	NA	$985.00	NA	$985.00

CHART OF NEED STANDARDS AND RESOURCE LIMITS

INSTITUTIONAL INCOME LIMITS		03/01/03	01/01/04	03/01/04	01/01/05
Federal Maximum	Individual (Gross Income)	NA	$1,692.00	NA	$1,737.00
Earned Income Disregard		NA	$238.00	NA	$245.00

MEDICARE PREMIUMS					
Part A		NA	$343.00	NA	$375.00
Part B		NA	$66.60	NA	$78.20
QI-2 Benefit Amount		NA	NA	NA	NA

SSI FEDERAL BENEFIT RATES					
SSI Individual FBR	Own Household (LA-A)	NA	$564.00	NA	$579.00
	Title XIX Facility (LA-D)		$30.00		$30.00
SSI Couple FBR	Own Household (LA-A)	NA	$846.00	NA	$869.00
Deeming	Allocation to Each Ineligible Child	NA	$282.00	NA	$289.50
Presumed Maximum Value (PMV)	Individual	NA	$208.00	NA	$213.00
	Couple	NA	$302.00	NA	$309.67
SSI RESOURCE LIMITS	Individual	NA	$2,000.00	NA	$2,000.00
	Couple	NA	$3,000.00	NA	$3,000.00
Liberalized Resource Limits	Individual	NA	$4,000.00	NA	$4,000.00
	Couple	NA	$6,000.00	NA	$6,000.00

FEDERAL POVERTY LIMITS					
Qualified Medicare Beneficiaries (QMB)	Individual	$749.00	NA	$776.00	NA
	Couple	$1,010.00	NA	$1,041.00	NA
Poverty Level Aged & Disabled (PLAD)	Individual	$1,010.00	NA	$1,048.00	NA
	Couple	$1,364.00	NA	$1,406.00	NA
Specified Low-Income Medicare Beneficiaries (SLMB)	Individual	$898.00	NA	$931.00	NA
	Couple	$1,212.00	NA	$1,249.00	NA
Qualifying Individual QI-1 Group	Individual	$1,010.00	NA	$1,048.00	NA
	Couple	$1,364.00	NA	$1,406.00	NA
Qualified Working Disabled Individuals (QWDI)	Individual	$1,497.00	NA	$1,552.00	NA
	Couple	$2,020.00	NA	$2,082.00	NA
Working Disabled (WD)	Individual	$3,807.00	NA	$3,945.00	NA
	Couple	$5,115.00	NA	$5,271.00	NA

SPOUSAL IMPOVERISHMENT MAXIMUMS	03/01/03	01/01/04	03/01/04	01/01/05
Federal Resource Maximum	NA	$92,760.00	NA	$95,100.00
Community Spouse Monthly Maintenance Needs Allowance	NA	$2,319.00	NA	$2,377.50
Other Family Members Needs Allowance	NA	$985.00	NA	$985.00

CHART OF NEED STANDARDS AND RESOURCE LIMITS

INSTITUTIONAL INCOME LIMITS		03/01/05	01/01/06	03/01/06	01/01/07
Federal Maximum	Individual (Gross Income)	NA	$1,809.00	NA	$1,869.00
Earned Income Disregard		NA	$257.00	NA	$267.00

MEDICARE PREMIUMS				
Part A	NA	$393.00	NA	$410.00
Part B	NA	$88.50	NA	$93.50
QI-2 Benefit Amount	NA	NA	NA	NA

SSI FEDERAL BENEFIT RATES					
SSI Individual FBR	Own Household (LA-A)	NA	$603.00	NA	$623.00
	Title XIX Facility (LA-D)		$30.00	NA	$30.00
SSI Couple FBR	Own Household (LA-A)	NA	$904.00	NA	$934.00
Deeming	Allocation to Each Ineligible Child	NA	$301.50	NA	$311.50
Presumed Maximum Value (PMV)	Individual	NA	$221.00	NA	$227.66
	Couple	NA	$321.33	NA	$331.33
SSI RESOURCE LIMITS	Individual	NA	$2,000.00	NA	$2,000.00
	Couple	NA	$3,000.00	NA	$3,000.00
Liberalized Resource Limits	Individual	NA	$4,000.00	NA	$4,000.00
	Couple	NA	$6,000.00	NA	$6,000.00

FEDERAL POVERTY LIMITS					
Qualified Medicare Beneficiaries (QMB)	Individual	$798.00	NA	$817.00	NA
	Couple	$1,070.00	NA	$1,100.00	NA
Healthier MS Waiver	Individual	$1,077.00	NA	$1,103.00	NA
	Couple	$1,444.00	NA	$1,485.00	NA
Specified Low-Income Medicare Beneficiaries (SLMB)	Individual	$957.00	NA	$980.00	NA
	Couple	$1,283.00	NA	$1,320.00	NA
Qualifying Individual QI-1 Group	Individual	$1,077.00	NA	$1,103.00	NA
	Couple	$1,444.00	NA	$1,485.00	NA
Qualified Working Disabled Individuals (QWDI)	Individual	$1,595.00	NA	$1,633.00	NA
	Couple	$2,139.00	NA	$2,200.00	NA
Working Disabled (WD)	Individual	$4,053.00	NA	$4,149.00	NA
	Couple	$5,411.00	NA	$5,565.00	NA

SPOUSAL IMPOVERISHMENT MAXIMUMS	03/01/05	01/01/06	03/01/06	01/01/07
Federal Resource Maximum	NA	$99,540.00	NA	$101,640.00
Community Spouse Monthly Maintenance Needs Allowance	NA	$2,488.50	NA	$2,541.00
Other Family Members Needs Allowance	NA	$985.00	NA	$1,650.00

CHART OF NEED STANDARDS AND RESOURCE LIMITS

INSTITUTIONAL INCOME LIMITS					
Federal Maximum	Individual (Gross Income)	NA	$1,911.00	NA	
Earned Income Disregard		NA	$274.00	NA	

MEDICARE PREMIUMS				
Part A	NA	$423.00	NA	
Part B	NA	$96.40	NA	
QI-2 Benefit Amount	NA		NA	

SSI FEDERAL BENEFIT RATES					
SSI Individual FBR	Own Household (LA-A)	NA	$637.00	NA	
	Title XIX Facility (LA-D)	NA	$30.00	NA	
SSI Couple FBR	Own Household (LA-A)	NA	$956.00	NA	
Deeming	Allocation to Each Ineligible Child	NA	$318.50	NA NA	
Presumed Maximum Value (PMV)	Individual	NA	$232.33	NA	
	Couple	NA	$338.66	NA	
SSI RESOURCE LIMITS	Individual	NA	$2,000.00	NA	
	Couple	NA	$3,000.00	NA	
Liberalized Resource Limits	Individual	NA	$4,000.00	NA	
	Couple	NA	$6,000.00	NA	

FEDERAL POVERTY LIMITS					
Qualified Medicare Beneficiaries (QMB)	Individual	$851.00	NA	$867.00	
	Couple	$1,141.00	NA	$1,167.00	
Healthier MS Waiver	Individual	$1,149.00	NA	$1,170.00	
	Couple	$1,541.00	NA	$1,575.00	
Specified Low-Income Medicare Beneficiaries (SLMB)	Individual	$1,021.00	NA	$1,040.00	
	Couple	$1,369.00	NA	$1,400.00	
Qualifying Individual QI-1 Group	Individual	$1,149.00	NA	$1,170.00	
	Couple	$1,541.00	NA	$1,575.00	
Qualified Working Disabled Individuals (QWDI)	Individual	$1,702.00	NA	$1,734.00	
	Couple	$2,282.00	NA	$2,334.00	
Working Disabled (WD)	Individual	$4,321.00	NA	$4,399.00	
	Couple	$5,771.00	NA	$5,899.00	

SPOUSAL IMPOVERISHMENT MAXIMUMS				
Federal Resource Maximum	NA	$104,400.00	NA	
Community Spouse Monthly Maintenance Needs Allowance	NA	$2,610.00	NA	
Other Family Members Needs Allowance	NA	$1,711.25	NA	

	SSI RETRO	COL	DAC	OBRA'87	OBRA'90
CATEGORY	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
PROGRAM CODES	01,02,04	01,02,04	02,04	02,04	02,04
AGE	65 or >	65 or >	Must be 18	No Medicare Must be 60-64	No Medicare 50-59
BLINDNESS	Yes	Yes	Yes	Yes	Yes
DISABILITY	Yes	Yes	Yes	Yes	Yes
CITIZENSHIP	Yes	Yes	Yes	Yes	Yes
RESIDENCE	Yes	Yes	Yes	Yes	Yes
UTIL. OF BENE.	Yes	Yes	Yes	Yes	Yes
SSN	Yes	Yes	Yes	Yes	Yes
ASSIGN. RIGHTS	Yes	Yes	Yes	Yes	Yes
PHYSICIAN CERT.	No	No	No	No	No
INCOME	SSI Limits	COL Disregards	DAC & COL Disregards	OBRA + COL Disregards	
Individual	$637.00	$637.00	$637.00	$637.00	
Couple	$956.00	$956.00	$956.00	$956.00	
RESOURCES	SSI Limits				
Individual	$2000.00				
Couple	$3000.00				
SPOUSAL IMPOVERISHMENT	N/A				
TRANS. PENALTY	N/A				
30-CONSEC. DAY REQUIREMENT	N/A				
EFFECTIVE DATE-RETROACTIVE ELIGIBILITY	07-01-81 3 mos. prior to SSI appl.	07-01-81 Retro applies	07-01-87 Retro applies	07-01-88 Retro applies	01-01-91 Retro applies
SERVICES	Full	Full	Full	Full	Full

	MAO AT-HOME						
	QMB	HEALTHIER MS WAIVER	QWDI	WD	BREAST & CERVICAL	SLMB	QI-1
CATEGORY	Mandatory	Optional	Mandatory	Optional	Optional	Mandatory	Mandatory
PROGRAM CODES	31,32,34	45	90	25	27	51	54
AGE	N/A Must Have	N/A Must Not Have	Must be <65	N/A	Must be <65	Must have	Must have
BLINDNESS	Part-A	Part-A	N/A--Must	N/A	N/A	Part-A	Part-A
DISABILITY	Medicare	Medicare	have Mcare	Yes	N/A	Medicare	Medicare
CITIZENSHIP	Yes	Yes	Yes	Yes	Yes	Yes	Yes
RESIDENCE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
UTIL. OF BENE.	Yes	Yes	Yes	No	N/A	Yes	Yes
SSN	Yes	Yes	Yes	Yes	Yes	Yes	Yes
ASSIGN. RIGHTS	Yes	Yes	Yes	Yes	N/A	Yes	Yes
PHYSICIAN CERT.	No	No	No	No	No	No Card	No
INCOME	100% FPL	135% FPL	200% FPL	250% FPL	250% FPL	1.20 FPL	135% FPL
Individual	$867.00	$1,170.00	$1,734.00	$2,167.00	$2,167.00	$1,040.00	$1,170.00
Couple	$1,167.00	$1,575.00	$2,334.00	$2,917.00	$2,917.00	$1,400.00	$1,575.00
RESOURCES	Liberal	Liberal	SSI	Liberal	Liberal	Liberal	Liberal
Individual	N/A	$4,000.00	N/A	$24,000	N/A	N/A	N/A
Couple	N/A	$6,000.00	N/A	$26,000	N/A	N/A	N/A
SPOUSAL IMPOVERISHMENT	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TRANS. PENALTY	N/A	N/A	N/A	N/A	N/A	N/A	N/A
30-CONSEC. DAY REQUIREMENT	N/A	N/A	N/A	N/A	N/A	N/A	N/A
EFFECTIVE DATE--RETROACTIVE ELIGIBILITY	07-01-89 No retro	10-01-04 Retro applies	07-01-90 Retro applies	07-01-99 Retro applies	07-01-01 Retro applies but not prior to 07-01	01-01-93 Retro applies	01-01-98 Retro applies
SERVICES	Medicare cost-sharing	Full with certain limitations	Medicare Part-A Premium No Card	Full	Full	Medicare Part-B Premium No Card	Medicare Part-B Premium No card

	MAO LONG-TERM CARE AT HOME					
CATEGORY	HCBS Handicapped Waiver	HCBS Traumatic Brain Injury	HCBS Assisted Living Waiver	HCBS Elderly/Disable Waiver	HCBS MR/DD Waiver	Disabled Child At-Home
PROGRAM CODES	Optional 24	Optional 24	Optional 10,11,12	Optional 21,22	Optional 21,22	Optional 89
AGE	No age limit	No age limit	No age limit	No age limit	No age limit	Must be 18 or <
BLINDNESS	N/A	N/A	N/A	N/A	N/A	Yes
DISABILITY	Yes	Yes	Yes if <65	Yes if <65	Yes if <65	Yes
CITIZENSHIP	Yes	Yes	Yes	Yes	Yes	Yes
RESIDENCE	Yes	Yes	Yes	Yes	Yes	Yes
UTIL. OF BENE.	Yes	Yes	Yes	Yes	Yes	Yes
SSN	Yes	Yes	Yes	Yes	Yes	Yes
ASSIGN. RIGHTS	Yes	Yes	Yes	Yes	Yes	Yes
PHYSICIAN CERT.	Yes	Yes	Yes	Yes	Yes	Yes
INCOME	NH Limit 300%	NH Limit 300%	NH Limit 300%	NH Limit 300%	NH Limit 300%	NH Limit 300%
Individual	$1,911.00	$1,911.00	$1,911.00	$1,911.00	$1,911.00	$1,911.00
Couple	N/A	N/A	N/A	N/A	N/A	N/A
RESOURCES	Liberalized	Liberalized	Liberalized	Liberalized	Liberalized	SSI
Individual	$4,000.00	$4,000.00	$4,000.00	$4,000.00	$4,000.00	$2,000.00
Couple	NA	NA	N/A	N/A	N/A	N/A
SPOUSAL IMPOVERISHMENT	SI rules apply even if living at-home					N/A
TRANS. PENALTY	Yes	Yes	Yes	Yes	Yes	N/A
30-CONSEC. DAY REQUIREMENT	N/A	N/A	N/A	N/A	NA	N/A
EFFECTIVE DATE--RETROACTIVE ELIGIBILITY	01/01/94 Retro applies but not prior to 01/94	07/01/01 Retro applies but not prior to 07/01	10/01/00 Retro applies but not prior to 10/00	07/01/00 Retro applies but not prior to 07/00	07/01/00 Retro applies but not prior to 07/00	07/01/89 Retro applies
SERVICES	Full Services + Waiver Services	Full Services + Waiver Services	Full Services + Waiver Services	Full Services + Waiver Services	Full services + Waiver Services	Full

	LONG-TERM CARE	
	SSI At-Home	Under 300%
	Nursing Home Swing Bed/Hosp	Nursing Home Swing Bed/Hosp
CATEGORY	Optional	Optional
PROGRAM CODES	01,02,04	01,02,04
AGE	65 or >	65 or >
BLINDNESS	Yes	Yes
DISABILITY	Yes	Yes
CITIZENSHIP	Yes	Yes
RESIDENCE	Yes	Yes
UTIL. OF BENE.	Yes	Yes
SSN	Yes	Yes
ASSIGN. RIGHTS	Yes	Yes
PHYSICIAN CERT.	NH only	NH only
INCOME	300% of SSI Individual Amount	
Individual	$1,911.00	
Couple	N/A	
RESOURCES	Liberalized Resource Policies	
Individual	$4,000.00	
Couple	N/A	
SPOUSAL IMPOVERISHMENT	Applies to all LTC clients with a CS Resource Limit $101,640.00 Monthly Needs Allowance - $2,541.00	
TRANS. PENALTY	Applies to NH/SB	
30-CONSEC. DAY REQUIREMENT	Applies to all Long-Term Care clients	
EFFECTIVE DATE--RETROACTIVE ELIGIBILITY	Nursing Home--07-01-81--retro applies Swing Bed -- 07-01-84 -- retro applies	
SERVICES	Full services including Vendor Payment for Nursing Facility care	

2008 FEDERAL POVERTY LEVEL* (FPL)
ALL STATES (EXCEPT ALASKA, HAWAII) AND D.C.

Program Code 91 - Children Under Age 19

FAMILY	100% FPL	
AFDC – RELATED	ANNUAL	MONTHLY
1	10,400.00	867.00
2	14,000.00	1,167.00
3	17,600.00	1,467.00
4	21,200.00	1,767.00
5	24,800.00	2,067.00
6	28,400.00	2,367.00
7	32,000.00	2,667.00
8	35,600.00	2,967.00

Program Code 87- Children Under 6

133% FPL	
ANNUAL	MONTHLY
13,832.00	1,153.00
18,620.00	1,552.00
23,408.00	1,951.00
28,196.00	2,350.00
32,984.00	2,749.00
37,772.00	3,148.00
42,560.00	3,547.00
47,348.00	3,946.00

Program Code 88-PW & Children to Age 1

185% FPL	
ANNUAL	MONTHLY
19,240.00	1,604.00
25,900.00	2,159.00
32,560.00	2,714.00
39,220.00	3,269.00
45,880.00	3,824.00
52,540.00	4,379.00
59,200.00	4,934.00
65,860.00	5,489.00

QMB

FAMILY SIZE	100% FPL	
SSI - RELATED	ANNUAL	MONTHLY
INDIVIDUAL	10,400.00	867.00
COUPLE	14,000.00	1,167.00

SLMB

120% FPL	
ANNUAL	MONTHL
12,480.00	1,040.00
16,800.00	1,400.00

QI-1/HEALTHIER MS WAIVER

135% FPL	
ANNUAL	MONTHLY
14,040.00	1,170.00
18,900.00	1,575.00

QWDI

FAMILY SIZE	200% FPL	
SSI-RELATED	ANNUAL	MONTHLY
INDIVIDUAL	20,800.00	1,734.00
COUPLE	28,000.00	2,334.00

WORKING DISABLED

250% FPL	
ANNUAL	MONTHLY
26,000.00	2,167.00
35,000.00	2,917.00

*Published in the Federal Register.

TABLE OF AFDC REQUIREMENTS FOR USE IN ALLOCATING NURSING HOME RECIPIENTS INCOME TO DEPENDENTS AT HOME

NUMBER OF PERSONS	REQUIREMENTS
1	218
2	293
3	368
4	443
5	518
6	593
7	668
8	743
9	818
10	893
11	968
12	1043
13	1118
14	1193
15	1268
16	1343
17	1418
18	1493
19	1568
20	1643
21	1718
22	1793

If more than 22 are in the budget, add $75 for each person above 22.

UNISEX

LIFE ESTATE AND REMAINDER INTEREST TABLE
(26 CFR 20.2031-7)

AGE	LIFE ESTATE	REMAINDER	AGE	LIFE ESTATE	REMAINDER
0	.97188	.02812	35	.93868	.06132
1	.98988	.01012	36	.93460	.06540
2	.99017	.00983	37	.93026	.06974
3	.99008	.00992	38	.92567	.07433
4	.98981	.01019	39	.92083	.07917
5	.98938	.01062	40	.91571	.08429
6	.98884	.01116	41	.91030	.08970
7	.98822	.01178	42	.90457	.09543
8	.98748	.01252	43	.89855	.10145
9	.98663	.01337	44	.89221	.10779
10	.98565	.01435	45	.88558	.11442
11	.98453	.01547	46	.87863	.12137
12	.98329	.01671	47	.87137	.12863
13	.98198	.01802	48	.86374	.13626
14	.98066	.01934	49	.85578	.14422
15	.97937	.02063	50	.84743	.15257
16	.97815	.02185	51	.83674	.16126
17	.97700	.02300	52	.82969	.17031
18	.97590	.02410	53	.82028	.17972
19	.97480	.02520	54	.81054	.18946
20	.97365	.02635	55	.80046	.19954
21	.97245	.02755	56	.79006	.20994
22	.97120	.02880	57	.77931	.22069
23	.96986	.03014	58	.76822	.23178
24	.96841	.03159	59	.75675	.24325
25	.96678	.03322	60	.74491	.25509
26	.96495	.03505	61	.73267	.26733
27	.96290	.03710	62	.72002	.27998
28	.96062	.03938	63	.70696	.29304
29	.95813	.04187	64	.69352	.30648
30	.95543	.04457	65	.67970	.32030
31	.95254	.04746	66	.66551	.33449
32	.94942	.05058	67	.65098	.34902
33	.94608	.05392	68	.63610	.36390
34	.94250	.05750	69	.62086	.37914

UNISEX

LIFE ESTATE AND REMAINDER INTEREST TABLE
(26 CFR 20.2031-7)

LIFE ESTATE AND REMAINDER INTEREST TABLE (Cont.)

AGE	LIFE ESTATE	REMAINDER	AGE	LIFE ESTATE	REMAINDER
70	.60522	.39478	90	.28221	.71779
71	.58914	.41086	91	.26955	.73045
72	.57261	.42739	92	.25771	.74229
73	.55571	.44429	93	.24692	.75308
74	.53862	.46138	94	.23728	.76272
75	.52149	.47851	95	.22887	.77113
76	.50441	.49559	96	.22181	.77819
77	.48742	.51258	97	.21550	.78450
78	.47049	.52951	98	.21000	.79000
79	.45357	.54643	99	.20486	.79514
80	.43659	.56341	100	.19975	.80025
81	.41967	.58033	101	.19532	.80468
82	.40295	.59705	102	.19054	.80946
83	.38642	.61358	103	.18437	.81563
84	.36998	.63002	104	.17856	.82144
85	.35359	.64641	105	.16962	.83038
86	.33764	.66236	106	.15488	.84512
87	.32262	.67738	107	.13409	.86591
88	.30859	.69141	108	.10068	.89932
89	.29526	.70474	109	.04545	.95455

RAILROAD RETIREMENT BOARD DISTRICT OFFICES ADDRESSES/COUNTIES SERVED

BIRMINGHAM DISTRICT OFFICE

Mr. Michael A. Core, Manager
Medical Forum Building
950 22nd Street, Room 426
Birmingham, AL 35203-1126
Telephone (205) 731-0019

Counties Served

Alcorn	Lauderdale	Newton
Benton	Lee	Noxubee
Clay	Lowndes	Oktibbeha
DeSoto	Marshall	Prentiss
Itawamba	Monroe	Tishomingo
Kemper	Neshoba	Winston

LITTLE ROCK DISTRICT OFFICE

Mrs. Ruby Bland, Manager
1200 Cherry Brook Drive, Suite 500
Little Rock, AR 72211-4113
Telephone (501) 324-5241

Counties Served

Attala	Issaquena	Tate
Bolivar	Lafayette	Tippah
Calhoun	Leflore	Tunica
Carroll	Montgomery	Union
Chickasaw	Panola	Washington
Choctaw	Pontotoc	Webster
Coahoma	Quitman	Yalobusha
Grenada	Sharkey	Yazoo
Holmes	Sunflower	
Humphreys	Tallahatchie	

NEW ORLEANS DISTRICT OFFICE

Ms. Pamela Meyer, Manager
501 Magazine Street, Room 1045
New Orleans, LA 70130-3394
Telephone (504) 589-2597

Counties Served

Adams	Hinds	Pearl River
Amite	Jackson	Perry
Claiborne	Jasper	Pike
Clarke	Jeff Davis	Rankin
Copiah	Jefferson	Scott
Covington	Jones	Simpson
Forrest	Lamar	Smith
Franklin	Lawrence	Stone
George	Leake	Walthall
Greene	Lincoln	Warren
Hancock	Madison	Wayne
Harrison	Marion	Wilkinson

COL COMPUTATION HISTORY

All possible calculations back to 07/77 are provided in the following steps.

(1)	Current title II benefit amount 1.023 (1/2008 title II increase	=	Benefit before 1/2008
(2)	Current title II benefit amount 1.033 (1/2007 title II increase	=	Benefit before 1/2007 COL increase
(3)	Benefit before 1/07 COL increase 1.041 (1/2006 title II increase)	=	Benefit before 1/2006 COL increase
(4)	Benefit before 1/06 COL increase 1.027 (1/2005 title II increase)	=	Benefit before 1/2005 COL increase
(5)	Benefit before 1/05 COL increase 1.021 (1/2004 title II increase)	=	Benefit before 1/2004 COL increase
(6)	Benefit before 1/04 COL increase 1.014 (1/2003 title II increase)	=	Benefit before 1/2003 COL increase
(7)	Benefit before 1/03 COL increase 1.026 (1/2002 title II increase)	=	Benefit before 1/2002 COL increase
(8)	Benefit before 1/02 COL increase 1.035 (1/2001 title II increase)	=	Benefit before 1/2001 COL increase
(9)	Benefit before 1/01 COL increase 1.024 (1/2000 title II increase)	=	Benefit before 1/2000 COL increase
(10)	Benefit before 1/00 COL increase 1.013 (1/99 title II increase)	=	Benefit before 1/99 COL increase
(11)	Benefit before 1/99 COL increase 1.021 (1/98 title II increase)	=	Benefit before 1/98 COL increase
(12)	Benefit before 1/98 COL increase 1.029 (1/97 title II increase)	=	Benefit before 1/97 COL increase
(13)	Benefit before 1/97 COL increase 1.026 (1/96 title II increase)	=	Benefit before 1/96 COL increase

(14) Benefit before 1/96 COL increase / 1.028 (1/95 title II increase) = Benefit before 1/95 COL increase

(15) Benefit before 1/95 COL increase / 1.026 (1/94 title II increase) = Benefit before 1/94 COL increase

(16) Benefit before 1/94 COL increase / 1.030 (1/93 title II increase) = Benefit before 1/93 COL increase

(17) Benefit before 1/93 COL increase / 1.037 (1/92 title II increase) = Benefit before 1/92 COL increase

(18) Benefit before 1/92 COL increase / 1.054 (1/91 title II increase) = Benefit before 1/91 COL increase

(19) Benefit before 1/91 COL increase / 1.047 (1/90 title II increase) = Benefit before 1/90 COL increase

(20) Benefit before 1/90 COL increase / 1.040 (1/89 title II increase) = Benefit before 1/89 COL increase

(21) Benefit before 1/89 COL increase / 1.042 (1/88 title II increase) = Benefit before 1/88 COL increase

(22) Benefit before 1/88 COL increase / 1.013 (1/87 title II increase) = Benefit before 1/87 COL increase

(23) Benefit before 1/87 COL / 1.031 (1/86 title II increase) = Benefit before 1/86 COL increase

(24) Benefit before 1/86 COL / 1.035 (1/85 title II increase) = Benefit before 1/85 COL increase

(25) Benefit before 1/85 COL / 1.035 (1/84 title II increase) = Benefit before 1/84 COL increase

(26) Benefit before 1/84 COL / 1.074 (7/82 title II increase) = Benefit before 7/82 COL increase

(27) Benefit before 7/82 COL / 1.112 (7/81 title II increase) = Benefit before 7/81 COL increase

(28) Benefit before 7/81 COL / 1.143 (7/80 title II increase) = Benefit before 7/80 COL increase

(29) Benefit before 7/80 COL / 1.099 (7/79 title II increase) = Benefit before 7/79 COL increase

(30) Benefit before 7/79 COL = Benefit before 7/78
1.065 (7/78 title II increase) COL increase

(31) Benefit before 7/78 COL = Benefit before 7/77
1.059 (7/77 title II increase) COL increase

SLIDING SCALE FOR WORKING DISABLED PREMIUMS*

MONTHLY COUNTABLE EARNINGS - INDIVIDUAL	PREMIUM PER MONTH	MONTHLY COUNTABLE EARNINGS - COUPLE	PREMIUM PER MONTH
Below $1109	$0	Below $1493	$0
$1109 - $1144.99	$55	$1493-$1541.99	$75
$1145 - $1181.99	$57	$1542-$1591.99	$77
$1182 - $1218.99	$59	$1592-$1641.99	$80
$1219 - $1255.99	$61	$1642-$1691.99	$82
$1256 - $1292.99	$63	$1692-$1740.99	$85
$1293 - $1329.99	$65	$1741-$1790.99	$87
$1330 - $1366.99	$67	$1791-$1840.99	$90
$1367 - $1403.99	$68	$1841-$1890.99	$92
$1404 - $1440.99	$70	$1891-$1939.99	$95
$1441 - $1477.99	$72	$1940-$1989.99	$97
$1478 - $1514.99	$74	$1990-$2039.99	$100
$1515 - $1551.99	$76	$2040-$2089.99	$102
$1552 - $1588.99	$78	$2090-$2138.99	$105
$1589 - $1625.99	$79	$2139-$2188.99	$107
$1626 - $1662.99	$81	$2189-$2238.99	$109
$1663 - $1699.99	$83	$2239-$2288.99	$112
$1700 - $1736.99	$85	$2289-$2337.99	$114
$1737 - $1773.99	$87	$2338-$2387.99	$117
$1774 - $1810.99	$89	$2388-$2437.99	$119
$1811 - $1846	$91	$2438-$2488	$122

Premiums are payable for individuals/couple with countable earned income between 150% - 250% of the poverty level for an individual or couple. The premium amount is 5% of countable earnings.

PLANNING AND DEVELOPMENT DISTRICTS/AREA AGENCIES ON AGING

CENTRAL MS PDD/AAA
PDD Director - F. Clarke Holmes
AAA Director - Bettye Burgess
1170 Lakeland Drive
P. O. Box 4935
Jackson, MS 39296
Phone: 601-981-1511 Fax: 601-981-1515
Counties Served: Copiah, Hinds, Madison, Rankin, Simpson, Warren, Yazoo

EAST CENTRAL PDD/AAA
PDD Director - Bill Richardson
AAA Director - Myrtle Burton
410 Decatur Street
P. O. Box 499
Newton, MS 39345
Phone: 601-683-2007 Fax: 601-683-7873
Counties Served: Clarke, Jasper, Kemper, Lauderdale, Leake, Neshoba, Newton, Scott, Smith

GOLDEN TRIANGLE PDD/AAA
PDD Director: Rudy Johnson
AAA Director: Bobby Gann
P. O. Box 828
Starkville, MS 39760
Phone: 662-324-7860 Fax: 662-324-7328
Counties Served: Choctaw, Clay, Lowndes, Noxubee, Oktibbeha, Webster, Winston

NORTH CENTRAL PDD/AAA
PDD Director: Bob Williamson
AAA Director: Darlena Allen
711B South Applegate
Winona, MS 38967
Phone: 662-283-2675 Fax: 662-283-5875
Counties Served: Attala, Carroll, Holmes, Grenada, Leflore, Montgomery, Yalobusha

NORTH DELTA PDD/AAA
PDD Director: Glenn Brown
AAA Director: Fadlalla Zein
245-C Eureka Street
P. O. Box 1488
Batesville, MS 38606-1496
Phone: 662-561-4100 Fax: 662-561-4112
Counties Served: Coahoma, Desoto, Panola, Quitman, Tallahatchie, Tate
Tunica

NORTHEAST MS PDD/AAA
PDD Director: Don Elder
AAA Director: Linda Huddleston
P. O. Box 600
Booneville, MS 38829
Phone: 662-728-6248 Fax: 662-728-2417
Counties Served: Alcorn, Benton, Marshall, Prentiss, Tippah, Tishomingo

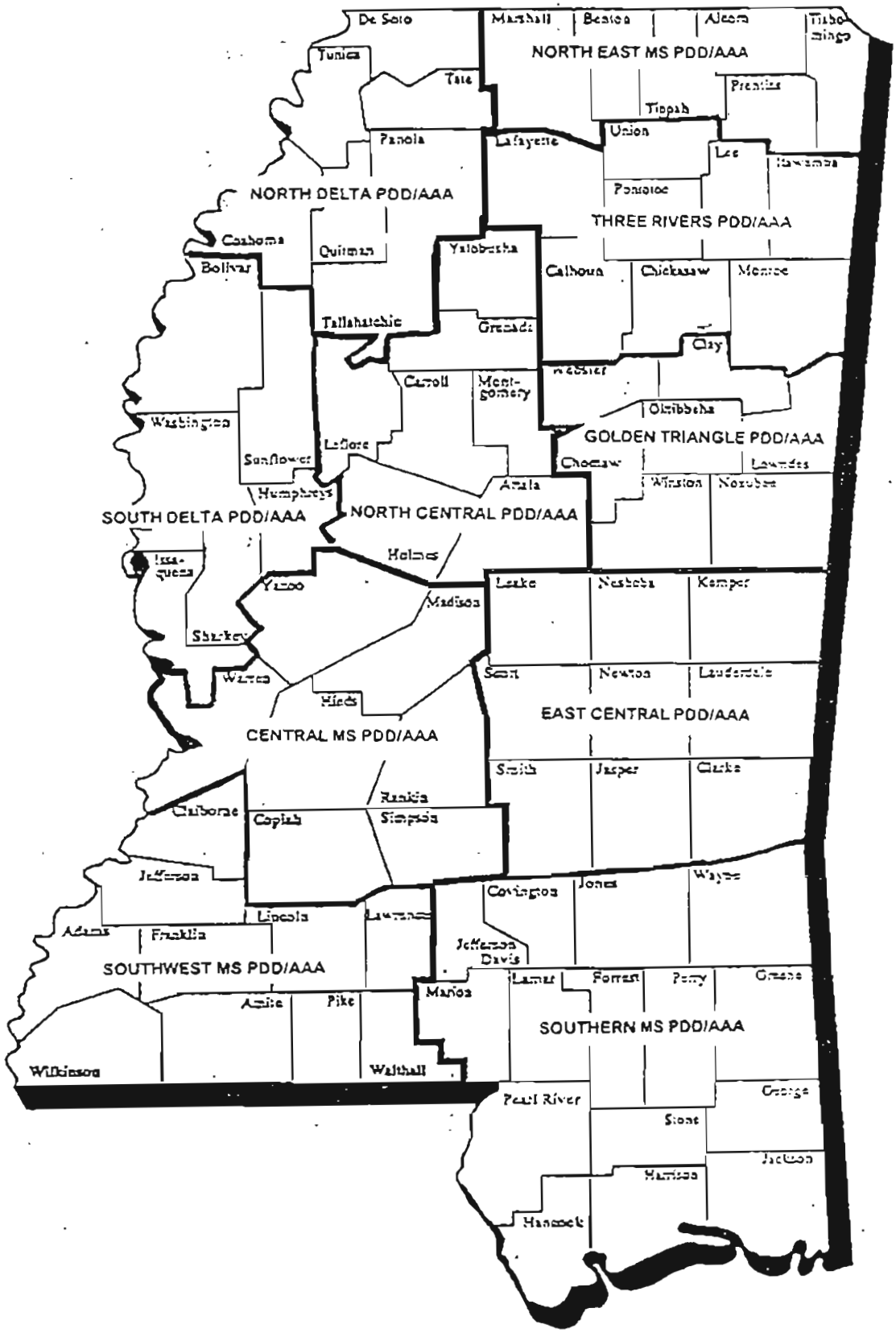
SOUTH DELTA PDD/AAA
PDD Director: William Haney
AAA Director: Sylvia Jackson
124 South Broadway
P. O. Box 1776
Greenville, MS 38702
Phone: 662-378-3831 Fax: 662-378-3834
Counties Served: Bolivar, Humphreys, Issaquena, Sharkey, Sunflower, Washington

SOUTHERN MS PDD/AAA
PDD Director: Leslie Newcomb
AAA Director: Eunice McGlory
2015-A 15th Street
Gulfport, MS 39501
Phone: 228-868-2311 Fax: 228-868-7094
Counties Served: Covington, Forrest, George, Greene, Harrison, Hancock, Jackson, Stone, Wayne, Lamar, Jefferson Davis, Jones, Marion, Pearl River, Perry

SOUTHWEST MS PDD/AAA
PDD Director: Wirt Peterson
AAA Director: David Caulfield
100 South Wall Street
Natchez, MS 39120
Phone: 601-446-6044 Fax: 601-446-6071
Counties Served: Adams, Amite, Claiborne, Franklin, Jefferson, Lawrence, Lincoln, Pike, Walthall, Wilkinson

THREE RIVERS PDD/AAA
PDD Director: Randy Kelley
AAA Director: Buster Turner
75 South Main Street
P. O. Box 690
Pontotoc, MS 38863
Phone: 662-489-2415 Fax: 662-489-6815
Counties Served: Calhoun, Chickasaw, Itawamba, Lafayette, Lee, Monroe, Pontotoc, Union

MS PLANNING & DEVELOPMENT DISTRICTS
AREA AGENCIES ON AGING



MEDICAID'S INDEPENDENT LIVING WAIVER PROGRAM

District 1 - Oxford Office - Counties Served: Benton, Calhoun, Coahoma, DeSoto, Grenada, Lafayette, Marshall, Panola, Quitman,Tallahtachie, Tate, Tunica, Yalobusha

Case Manager: (Currently vacant)
662-234-6080 or 1-800-462-5357

District 2 - Tupelo Office - Counties Served: Alcorn, Chickawaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tippah, Tishamingo, Union

Case Manager: Beth Boyd
662-840-9947

District 3 - Starkville Office - Counties Served: Attala, Choctaw, Clay, Lowndes, Montgomery, Noxubee, Oktibbeha, Webster, Winston

Case Manager: Stacy Ricks
662-324-9646 or 1-877-367-4605

District 4 - Meridian Office - Counties Served: Leake, Neshoba, Kemper, Scott, Newton, Lauderdale, Smith, Jasper, Clarke

Case Manager: Patricia Pryor
601-483-5394

District 5 - Hattiesburg Office - Counties Served: Covington, Wayne, Jones, Lamar, Marion, Forrest, Perry, Jeff Davis, Greene

Case Manager: Theresa Darty
601-544-4860 or 1-800-378-9155

District 6 - Gulfport Office - Counties Served: George, Hancock, Harrison, Jackson, Pearl River, Stone

Case Manager: April Sharp
228-897-7612

District 7 - McComb Office - Counties Served: Adams, Amite, Franklin, Jefferson, Copiah, Lincoln, Pike, Walthall, Wilkinson, Lawrence, Simpson

Case Manager: (Currently vacant)
601-249-4646

District 8 - Jackson Office - Counties Served: Claiborne, Hinds, Madison, Rankin, Warren

Case Manager: Theresa Ricks-White
601-351-1472 or 1-800-378-9156

District 9 - Greenwood Office - Counties Served: Bolivar, Carroll, Holmes, Humphreys, Issaquena, LeFlore, Sharkey, Sunflower, Washington, Yazoo

Case Manager: Johnny Ball
662-455-2706

MEDICAID'S MR/DD WAIVER PROGRAM

BOSWELL REGIONAL CENTER
Post Office Box 128
Sanatorium, MS 39112
Stan Wilkinson, HCBS Director
(601) 867-5000, extension 75246

Counties Served:
Adams,Amite,Claiborne,Copiah,Franklin,Jefferson,Lincoln,Simpson,Wilkinson

Ellisville State School
1101 Hwy 11 South
Ellisville, MS 39437
Dyann Mizell, HCBS Director
Phone: (601) 477-9384, extension 341

Counties Served: Clarke,Covington,Forrest,Greene,Jasper,Jeff
Davis,Jones,Kemper,Lamar,Lauderdale,Lawrence,Lowndes,Marion,Neshoba,Newton,
Noxubee,Perry,Pike,Smith,Walthall,Wayne,Winston

Hudspeth Center
Post Office Box 127-B
Whitfield, MS 39193
Sandra May, HCBS Director
Phone: 664-6172

Counties Served: Attala,Boliver,Carroll,Choctaw,Clay,Hinds,Holmes,Humphreys,Issaquena,
Leake,Leflore,Madison,Montgomery,Oktibbeha,Rankin,Scott,Sharkey,Sunflower,
Warren,Washington,Webster,Yazoo

North MS Regional Center
967 Regional Center Drive
Oxford, MS 38655
Monroe Snider, HCBS Director
Phone: (662) 234-1476, extension 388 or 401

Counties Served: Alcorn,Benton,Calhoun,Chickawaw,Cahoma,DeSoto,Grenada,
Itawamba,Lafayette,Lee,Marshall,Monroe,Panola,Pontotoc,Prentiss,Quitman,
Tallahatchie,Tate,Tippah,Tishamingo,Tunica,Union,Yalobusha

South MS Regional Center
1170 West Railroad
Long Beach, MS 39560
Dr. Lela Weems, HCBS Director
Phone: (228) 867-1234

Counties Served: George,Hancock,Harrison,Jackson,Pearl River,Stone

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
DR. ROBERT L. ROBINSON
EXECUTIVE DIRECTOR

MEDICAID PROGRAM ACTION

Eligibility Transmittal

DATE: April 01, 2008

PROGRAM IDENTIFIER: 435.040108135
Medicaid Regional Offices

SUBJECT: Wholesale Change Increases in Need Standards, RSDI and VA Benefits; Spousal Impoverishment Income and Resource Maximums Increase; Revised SSI Notices, COL Policy, DOM P-2 and P-6, and Appendix.

As of January 1, 2008, the following increases and revisions are effective:

- RSDI, SSI FBR's, VA Pension, Aid & Attendance and Compensation benefits increase by 2.3%
- Nursing Home/Hospital income limit increases to $1,911.00
- Medicare, Part B premium increases to $96.40
- The RSDI & VA increases received by QMB, SLMB, QWDI and QI-1 recipients were not calculated in the 12/07 Wholesale Change process but were increased in the March 2008 Wholesale Change of FPL cases. These increases are always disregarded until the FPL increases.
- The Spousal Impoverishment resource limit increases to $104,400.00 and the monthly needs allowance to $2,610.00

These increases are applicable for all eligibility determinations for the month of January 2008 and forward. Limits in effect prior to 01/2008 must be used for months prior to January.

As of March 1, 2008, the Federal Poverty Levels (FPL) increased as follows:

	Individual	Couple
QMB (100% FPL)	$ 867 month	$1,167 month
SLMB (120% FPL)	$1,040 month	$1,400 month
QI-1 & Healthier MS Waiver (135% FPL)	$1,170 month	$1,575 month
QWDI (200% FPL)	$1,734 month	$2,334 month
WORKING DISABLED (250%)	$2,167 month	$2,917 month

These increases are effective for all eligibility determinations for March 1, 2008, forward.

For any poverty level case approved after WC whose eligibility is retroactive to January or February 2008, use the RSDI and VA amount in effect prior to the 2.3% cost-of-living increase. MEDS will use the FPL in effect prior to the 03/01/08 increase for both months.

Revised SSI Notices, DOM-P6 and Appendix

The SSI notices of denial and termination have been revised to include all changes since January 1, 2008. The appropriate Appendix pages have been revised to include all changes since January 1, 2008. The DOM-P6, at-home pamphlet, has been revised to reflect the 2008 Federal Poverty Levels. The DOM-P2, nursing home pamphlet, has been revised to reflect the changes effective January 1, 2008. The revised pamphlets are located on the DOM website.

VOLUME III REVISIONS

Remove the following pages in Volume III and insert the revised pages.

Remove	Insert
Section B, page 2020, revised 01/01/00	Page 2020
Section B, page 2025/2026, revised 03/01/07	Page 2025/2026
Section B, page 2030/2031, revised 03/01/07	Page 2030/2031
Section B, page 2040/2041, revised 03/01/07	Page 2040/2041
Section B, page 2050/2051, revised 03/01/07	Page 2050/2051
Section B, page 2060, revised 11/01/96	Page 2060
Section B, page 2070, revised 11/01/96	Page 2070
Section B, page 2080, revised 01/01/00	Page 2080
Appendix, page 1, revised 03/01/07	Appendix, page 1
Appendix, page 4L, revised 03/01/07	Appendix, page 4L
Appendix, page 5A, revised 01/01/07	Appendix, page 5A
Appendix, page 5B, revised 03/01/07	Appendix, page 5B
Appendix, page 5C, revised 01/01/07	Appendix, page 5C
Appendix, page 5D, revised 01/01/07	Appendix, page 5D
Appendix, page 6, revised 03/01/07	Appendix, page 6
Appendix, page 10A, revised 01/01/07	Appendix, page 10A
Appendix, page 10B, revised 01/01/07	Appendix, page 10B
Appendix, page 10C, revised 01/01/07	Appendix, page 10C

If you have any questions concerning the material in this transmittal, contact the Bureau of Enrollment.

Robert L. Robinson
Executive Director

RLR:EM:bm

cc: All Holders of Volume III