

**TABLE OF CONTENTS
SECTION A**

GENERAL PROVISIONS

<u>Subject</u>	<u>Page</u>
HISTORY AND LEGAL BASE	
Program Description	1000
Background	1000
SSI Program	1000
Medicaid Program Changes	1001
Children's Health Insurance Program (CHIP)	1003
Division of Medicaid	1003
Current DOM Status	1004
Responsibilities of Division of Medicaid	1005
Safeguarding Confidential Information	1006
NonDiscrimination Requirements	1006
Claims	1006
Hearings	1006

GENERAL PROVISIONS

HISTORY AND LEGAL BASE

PROGRAM DESCRIPTION

Enacted in 1965, Title XIX of the Social Security Act provides authority for States to establish Medicaid programs to provide medical assistance to needy individuals. Title XXI, enacted in 1997, of the Social Security Act authorized the State Children's Health Insurance Program (SCHIP). The programs are jointly financed by the Federal and State governments and administered by States. Within broad Federal guidelines, each State designs its programs of eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made by the State to the providers that furnish services.

BACKGROUND

Enabling legislation for the Medicaid Program in Mississippi was enacted 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 are found in Sections 43-13-101 et. seq. of the Mississippi Code of 1972, Annotated.

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

SSI PROGRAM

The passage of Public Law 92-603 in 1972 amended Title XVI of the Social Security Act and established the new Supplemental Security Income (SSI) program, repealing existing public assistance programs. The new SSI program, known as Section 1634, authorized cash benefits for aged, blind, and disabled individuals, including children under age 18 with disabilities or blindness, provided their disabilities were comparable to adult recipients. State statutes were amended to specify that DPW would no longer determine eligibility for a monthly payment for the adult assistance programs.

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 the states. Mississippi chose a more restrictive criteria and DPW continued to determine eligibility. In the 1980 Session of the State Legislature, Senate Bill 2118 changed the Medicaid eligibility criteria to 1634 status whereby Medicaid would be granted to all SSI recipients in Mississippi using SSI eligibility criteria. During the 1981 Legislative Session, Senate Bill 2478 authorized the Mississippi Medicaid Commission to make its own Medicaid eligibility determination for aged, blind, and disabled individuals.

GENERAL PROVISIONS

HISTORY AND LEGAL BASE

MEDICAID PROGRAM CHANGES

Public Law 97-35 passed in 1981 restricted some Medicaid coverage related to the Aid for Dependent Children (AFDC) program but retained coverage for families with children up to 18 years old and for a qualified pregnant woman with no children if she would be eligible for AFDC if the unborn child was born and living with her, under Section 1931 of the Social Security Act, Title XIX. Medicaid coverage for the needy parent(s) or caretaker relative was added. Refer to Federal Regulations at 42 CFR 435, and so forth.

In 1984 and 1986, Congress enacted legislation that required additional groups of individuals be provided Medicaid benefits. In 1985, 1987, 1988, and 1989, the Mississippi Legislature complied with these federal mandatory requirements (under 42 CFR 435) and provided additional optional coverage by passing legislation to implement new programs covering children and pregnant women.

Under Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Mississippi replaced the AFDC Program with the Temporary Assistance for Needy Families Program (TANF) effective October 1, 1996. TANF is funded under a "block grant" with state matching funds for state-selected programs vs. the pre-reform funding on a percentage federal-state match for the AFDC program. Welfare reform de-linked Medicaid and cash assistance and created the pre-reform Medicaid eligibility group with the same income and resource requirements and methodologies as under the Title IV-A State Plan that was in effect on July 16, 1996. Section 1931 of the Act requires states to cover at least those families with incomes below the Pre-Reform 1996 AFDC income limits, regardless of whether they receive cash assistance.

The following Programs are authorized in the Mississippi Code of 1972, Annotated, in **Section 43-13-115** and authorize Medicaid coverage for the following groups of families and children:

1. Families with children under age eighteen (18) years and qualified pregnant women who qualify for public assistance under Title IV-A and IV-E (foster care) of the federal Social Security Act, including those deemed to be IV-A and low-income families and children under Section 1931 of the Social Security Act. This Program is called **Medical Assistance (MA)**, and also called the "85 Program" because of the year of enactment. [43-13-115(1), (3) and (8)].

GENERAL PROVISIONS

HISTORY AND LEGAL BASE

2. A child born to a woman eligible for and receiving Medicaid under the State Plan on the date of birth shall be deemed to be eligible for Medicaid on the date of birth and will remain eligible for one year so long as the child remains with the mother. [Section 43-13-115 (5)] The child could be covered in the Program 88 or in another category with other children in the family.
3. Children under age six (6) years and pregnant women whose family income does not exceed 133% of the Federal Poverty Level (FPL). This Program is called **Expanded Medicaid (EM)**, also called the “87 Program” because of the year of enactment. [43-13-115 (9)(b)].
4. Children under age one (1) year and pregnant women whose family income does not exceed 185% of the Federal Poverty Level (FPL). This Program is called **Infant Survival (IS)**, also known as the “88 Program” because of the year of enactment. [43-13-115 (9)(c)] There is also a mandatory 60-day (2 full months) extended coverage period for women who were eligible for and receiving Medicaid on the day the pregnancy ends. [42 CFR 435.170 (a)].
5. Children under age nineteen (19) years with family income that does not exceed 100% of the Federal Poverty Level (FPL). This Program is called **Poverty Level (PL)**, also called “91 Program” because of the year of enactment. (The age limit for PL was raised from 18 to 19 years old effective July 1, 1998, as the first phase of CHIP implementation.) [43-13-115 (9)(a)].
6. Women of childbearing age (ages 13-44) whose family income does not exceed 185% FPL may receive family planning services only as covered under Section 43-12-117. [43-13-115 (21)].
7. Section 43-13-115 also provides extensions of Medicaid coverage for persons who were eligible for Medicaid in at least three of the six months preceding the month in which the ineligibility begins for:
 - Up to twelve (12) months for persons who become ineligible for assistance under Title IV-A because of increased income from or hours of employment of the caretaker relative or because of loss of earned income disregards, [43-13-115 (17)], and
 - Up to four (4) months for persons who become ineligible for Title IV-A because of increased child or spousal support. [43-13-115 (18)]

GENERAL PROVISIONS

HISTORY AND LEGAL BASE

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Public Law 105-33 enacted in 1997 established the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act. SCHIP is jointly financed by the Federal and State governments and is administered by the State under the State Plan approved by Department of Health and Human Services. Refer to Federal Regulations at 42 CFR.

The 1998 Session of the Mississippi Legislature amended the Mississippi Code at Section 41, Chapter 86, to establish the **Mississippi Children's Health Insurance Program (CHIP)** Commission to develop the State Plan. The Plan was developed and approved by HHS to provide health care benefits to uninsured, low-income children under age nineteen (19) who are not eligible for any Medicaid Program and whose family income does not exceed 200% of the Federal Poverty Level. CHIP was also designated the "99 Program" because of the year of implementation.

DIVISION OF MEDICAID

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. The Division of Medicaid is the single State Agency designed to administer the Medicaid Program. The Mississippi Department of Human Services (MDHS, formerly known as DPW) continued to determine eligibility for the Medicaid Programs for children and families as authorized under Section 43-13-115 of the Mississippi Code of 1972, Annotated, later adding determination of eligibility for CHIP in 1999 under Section 41-86-15.

GENERAL PROVISIONS

HISTORY AND LEGAL BASE

CURRENT DIVISION OF MEDICAID STATUS

During the 2004 Session of the Mississippi Legislature, House Bill 1434 made significant changes to Section 43-13-115 of the Mississippi Code of 1972. While retaining all Medicaid coverage groups and CHIP (Section 41-86-1 and so forth), **the Division of Medicaid was given the responsibility for determining initial and ongoing Health Benefits eligibility for all children, families, and pregnant women**, except that children under Title IV-E services and other related custody and adoption assistance will have their eligibility certified to the Division of Medicaid by MDHS, Division of Family and Children's Services (FCS).

On January 1, 2005, individuals currently eligible for Mississippi Health Benefits (except for the IV-E-related children) were transferred from MDHS to the Division of Medicaid to handle all HB eligibility functions. Prior to the conversion, all eligible individuals and families were notified of this change and provided information regarding their assignment to a regional Medicaid Office. Outstationed Medicaid eligibility workers continue to provide services in many locations throughout the State. Also, a face to face interview with the HB worker is now required at application and at regular case reviews. The HB beneficiaries must provide verifications of age, family income, and other criteria to support eligibility for benefits. The interview and verification requirements are in effect with the first application or with first regular case review following the conversion of the case to Division of Medicaid.

GENERAL PROVISIONS

HISTORY AND LEGAL BASE

RESPONSIBILITIES OF DIVISION OF MEDICAID

The duties of the Medicaid Agency are set out by enabling State and Federal legislation and the approved State Plan to include:

- To set regulations and standards for the administration of the Medicaid programs
- To receive and expend funds for the program
- To submit a State Plan for Medicaid in accordance with State and 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 and 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 determine eligibility for Mississippi Health Benefits (Medicaid and CHIP) for families, children, and pregnant women
- To redetermine eligibility for Medicaid and Mississippi Health Benefits at the required intervals
- To provide Medicaid Quality Control for Medicaid recipients
- To provide the opportunity for filing appeals and to conduct fair and impartial hearings
- To provide safeguards for preserving the confidentiality of records
- To ensure nondiscrimination in the determination of eligibility and provision of services in accordance with Federal and State regulations for Title XIX and XXI
- To provide information and referral services on Early and Periodic Screening, Diagnosis, and Treatment
- To provide information on family planning services
- To identify third party resources for Health Benefits recipients
- To make referrals to MDHS Division of Child Support to obtain medical support for certain Health Benefits recipients

GENERAL PROVISIONS

HISTORY AND LEGAL BASE

Follow administrative procedures in the Medicaid Eligibility Manual for the Aged, Blind, and Disabled for the following:

- SAFEGUARDING CONFIDENTIAL INFORMATION
- NONDISCRIMINATION REQUIREMENTS
- CLAIMS
- HEARINGS

**TABLE OF CONTENTS
SECTION B**

HEALTH BENEFITS DEFINED

<u>Subject</u>	<u>Page</u>
INTRODUCTION	
Introduction	2000
Responsibility for Eligibility Determinations	2001
Application Processing Timeliness	2001
Eligibility Requirements Common to all HB Categories	2001
POVERTY-LEVEL HB PROGRAMS	
HB Categories Based on FPL Income Tables	2003
Poverty Level - PL/91	2003
Expanded Medicaid - EM/87	2003
Infant Survival - IS/88	2003
Family Planning Services	2004
CHILDREN'S HEALTH INSURANCE PROGRAM – CHIP/99	
Children's Health Insurance Program - CHIP/99	2005
OTHER MEDICAID PROVISIONS	
Other Medicaid Provisions	2007
Deemed Eligible Infants	2007
Pregnant Woman	2008
Retroactive Medicaid Coverage	2009
Postpartum Coverage	2009
MEDICAL ASSISTANCE - MA/85	
Medical Assistance - MA/85	2011
Age	2011
Deprivation	2011
MA Standard Filing Unit Concept	2012
Caretaker Relative/Relationship	2013
Child Support Enforcement Requirements	2014
Special Budgeting Procedures for MA/85 Only	2014
Stepparent Income	2014
\$30 + 1/3 Earned Income Disregard	2014
Extended Medicaid Coverage for MA/85	2015

HEALTH BENEFITS DEFINED

INTRODUCTION

INTRODUCTION

“Mississippi Health Benefits” is the general name used to describe the combination of Medicaid categories and the Children’s Health Insurance Program (CHIP) that provides quality health care benefits for low-income families with children under age nineteen (19) and pregnant women of any age. The Medicaid coverage groups are defined by the age limits of the children and on family income maximums based on the 1996 Pre-Reform AFDC standard of need (See history in Section A) or on a percentage of the Federal Poverty Level (FPL) revised annually. CHIP is designed to provide health care coverage for low-income, uninsured children up to age nineteen with family income that does not exceed 200% FPL. (See Section A for the Federal and State laws and regulations authorizing these coverage groups.)

Only one completed Mississippi Health Benefits Application is needed to request coverage for the family. **All applications for Health Benefits must be tested for Medicaid eligibility first. If the family’s income exceeds the maximum allowed for that age child(ren) in the Medicaid coverage groups and the child is uninsured, the child up to age 19 will be tested for CHIP eligibility.** In some cases, one child may qualify for Medicaid while an older child qualifies for CHIP because of the family’s income level and ages of the child(ren).

Pregnant women may qualify individually or with their children. CHIP does not cover pregnant women except for the teen whose income falls between the 185% and 200% FPL. Women of childbearing age (13-44) also qualify for family planning-only services under Medicaid.

Parents or needy caretakers within the specified degree of relationship may request Medicaid coverage with their children. However, these adults can only be tested and/or be eligible for coverage in the Medical Assistance (MA/85) group covered prior to Welfare Reform in combination with the AFDC money payment (now TANF). Pregnant women who qualify in the MA/85 category will have the full range of Medicaid benefits instead of coverage related only to the pregnancy.

Additional Medicaid benefits are provided by retroactive coverage and in the form of extended coverage periods, including post partum coverage, “deemed” eligible infants, and in MA/85 category only, for periods following ineligibility caused by increased earnings or child and spousal support.

HEALTH BENEFITS DEFINED

INTRODUCTION

Responsibility for Eligibility Determinations

The Division of Medicaid is responsible for determining eligibility for the Health Benefits (HB) categories defined in this section. The Mississippi Department of Human Services (MDHS) will determine eligibility for IV-E foster children, for children under adoption assistance, and for Refugee Medical Assistance (RMA). MDHS also provides child support enforcement services.

Application Processing Timeliness

The Health Benefits application must be processed within a 30 day standard of promptness from the date of receipt by the DOM Regional Office (RO). The applicant is responsible for providing verifications to support the determination of eligibility and for attending and participating in a face to face interview to discuss the application or case review, the HB requirements, and services available, including the EPSDT program and Family Planning.

Eligibility Requirements Common to All HB Categories

All HB categories have common information required to establish initial eligibility and to complete annual case reviews. These include:

- Age of the child (date of birth) - must be verified. The child's birth certificate is the primary document for verification. Document the case fully when it is necessary to use other verifying documents. See Verifications for acceptable documents for age proof.
- SSN for all applicants (except for deemed infants) - must provide the SSN or provide proof of application for SSN
- Household size - Assistance Unit (AU) or Standard Filing Unit (SFU)
- Income of the family (earned, self-employment, and unearned) - must be verified
- Residence in Mississippi / address
- Citizenship (Verify for adults who apply for coverage for themselves)
- Third party insurance - must verify termination of coverage for HB applicant or recipient prior to approval for CHIP
- Pregnancy and due date - must be verified

Note: Verification of certain HB eligibility factors is required. Items not specifically requiring verification may also be verified when the information provided is questionable or conflicting. If the application or review includes conflicting information, the applicant/recipient must be given the opportunity to correct or clarify the factor. Document the case to show the reason for the request for the additional verification and the findings that support or deny eligibility.

HEALTH BENEFITS DEFINED

POVERTY-LEVEL HB PROGRAMS

HB CATEGORIES BASED ON FEDERAL POVERTY LEVEL (FPL) INCOME TABLES

The following Mississippi Health Benefits categories, Medicaid under Title XIX and CHIP under Title XXI, have income eligibility tested against various percentages of the current Federal Poverty Level (FPL). Each category serves children in a specific age group with a maximum qualifying family income limit. The eligible child will remain covered for the twelve (12) month certification period unless he/she meets one of the “early out” reasons or until he/she ages out of all categories.

When the child ages out, he/she remains eligible through the month of his birthday. When this occurs during the 12-month eligibility period, he/she must be tested for eligibility in another HB category, up to age 19, to complete the full eligibility period whenever possible. Uninsured children in MA/85, IS/88 and EM/87 categories may move into 91 or CHIP when they age out. The review due date will remain the same as in the previous category, and a full case review must be conducted at that time.

The FPL categories are listed with a brief description of each followed by the eligibility factors common to all HB categories. Pregnant women may qualify for Medicaid in the MA/85 category, in PL/91 if under age 19, or may qualify only as a pregnant woman in IS/88. The pregnant teen may be tested for CHIP only when all Medicaid categories have been denied.

POVERTY LEVEL - PL/91 - The **Poverty Level** is a Medicaid category that covers children up to age nineteen (19) years whose family income does not exceed 100% of the FPL for their family size. If the child has third party health benefits, the parent/caretaker must assign any benefits from medical coverage to the Division of Medicaid. This category also covers the pregnant teen for full Medicaid benefits if otherwise eligible.

EXPANDED MEDICAID - EM/87 - The **Expanded Medicaid** is a Medicaid category that covers children up to age six (6) years whose family income does not exceed 133% of the FPL for their family size. If the child has third party health benefits, the parent/caretaker must assign any benefits from medical coverage to the Division of Medicaid.

INFANT SURVIVAL - IS/88 - The **Infant Survival** is a Medicaid category that covers children under one (1) year of age and pregnant women whose family income does not exceed 185% of the FPL. If the child has third party health benefits, the parent/caretaker must assign any benefits from medical coverage to the Division of Medicaid. The pregnancy and expected date of confinement/delivery (EDC) are required verifications. The pregnant woman is eligible for covered services related to the pregnancy and for a two-month postpartum coverage period following the end of the pregnancy. The postpartum period ends the last day of the second full month following the month the pregnancy ends.

HEALTH BENEFITS DEFINED

POVERTY-LEVEL HB PROGRAMS

FAMILY PLANNING SERVICES - Women of childbearing age (defined as ages 13 - 44) whose family income does not exceed 185% of the FPL may be eligible for family planning services-only under Mississippi Code of 1972, Section 43-13-117(13). However, any individual eligible under any other full service Medicaid category in 43-13-115 shall receive the benefits to which entitled under that category in addition to family planning services. The woman may qualify with her children or may qualify individually. Eligibility for Family Planning Services for individuals not transitioning from 88 is determined at State office by the DOM's Maternal Child Health Bureau. Women who have been eligible for Medicaid during pregnancy will automatically be eligible for Family Planning Services for two years following the end of the postpartum period. MEDSX automatically updates MMIS to open Family Planning at the end of the postpartum period.

HEALTH BENEFITS DEFINED

CHILDREN'S HEALTH INSURANCE PROGRAM

CHILDREN'S HEALTH INSURANCE PROGRAM - CHIP/99 - CHIP provides health care coverage for uninsured children up to age nineteen (19) in low-income families whose income does not exceed 200% of the FPL. Since children applying for Health Benefits must first be tested for eligibility in Medicaid, the child who tests eligible in a Medicaid program will not be tested for CHIP. CHIP eligibility will be denied to any child under age 19 who is covered by a third party creditable health care plan at the time of application, regardless of who pays for the coverage. Likewise, CHIP eligibility will be terminated when the child becomes covered by third party insurance, becomes eligible for Medicaid, or meets one of the "early out" termination reasons. Also, see explanations on transfers between HB categories.

The benefit start date for CHIP is always a future month. Applications authorized by the 21st of a month should have insurance coverage effective the first day of the following month. Exception: Only infants for whom application is made within 31 days of birth, including the day of birth, may have retroactive coverage back to the date of birth. The infant will be tested first for Medicaid coverage groups, then tested for CHIP if necessary. If found eligible for CHIP, the infant's coverage will go back to the day of birth. This is the exception to all HB eligibility beginning on the first day of a month.

Example: An infant born on December 1st, who does not qualify in any Medicaid category, could have retroactive CHIP coverage if eligible and the application is received no later than December 31.

Example: An application is made on February 10th and approved on February 20th for an infant born on January 15th. If eligible only in CHIP, the start date would be the date of birth.

CHIP eligibility determinations include these factors:

- Children must be tested for Medicaid and fail to qualify solely because of income before being tested for CHIP.
- The child with third party insurance is not eligible for CHIP and will not be tested. If the family reports that the child is no longer covered by third party insurance, verification of the termination must be provided by the family before the child can be tested for CHIP.
- CHIP does not cover pregnant women except for those under age 19 whose countable household income exceeds the 185% FPL for IS/88 category for a pregnant woman, but does not exceed the 200% FPL for CHIP. Pregnancy and due date must be verified to determine eligibility for coverage in all HB categories. If the teen is eligible for CHIP when the pregnancy occurs, eligibility must be tested for Medicaid to cover services related to pregnancy. If the pregnant teen qualifies in IS/88, CHIP eligibility will be terminated. At the end of the two-month postpartum coverage, the teen may return to CHIP for the remainder of the original 12-month CHIP certification period. Test eligibility for mother and child in HB categories as for any other household.

HEALTH BENEFITS DEFINED

CHILDREN'S HEALTH INSURANCE PROGRAM

- The needs of the unborn cannot be counted in the CHIP household size if the teen qualifies for coverage in CHIP.
- There is no “deemed” automatic coverage for an infant born to a CHIP-eligible mother. The child does not qualify as a “deemed eligible” baby because this provision applies only to children born to Medicaid-eligible mothers. However, the parent may apply for HB coverage for the infant and have eligibility tested in any appropriate program. If the income for the AU (mother and child) still exceeds the 185% allowed for IS/88, the infant will be tested for CHIP.
- The deemed eligible infant cannot be placed in CHIP. The deemed infant will be placed in the appropriate Medicaid COE based on the income of the AU even though the mother returns to CHIP after her postpartum period.
- There are no retroactive coverage provisions in CHIP, except for the infant for whom the HB application is made within 31 days of birth (including the day of birth) and who is not eligible in a Medicaid category.

HEALTH BENEFITS DEFINED

OTHER MEDICAID PROVISIONS

OTHER MEDICAID PROVISIONS

The Medicaid categories must also include the following special provisions and/or specific categories of service not covered by CHIP:

DEEMED ELIGIBLE INFANTS - Medicaid eligibility must be granted to infants born to a woman who is eligible for and receiving Medicaid on the date of the child's birth. The infant's deemed status will also apply when the pregnant woman applies after the birth of the child and is found to have been eligible retroactively at the time of birth. The child is deemed to have applied for and been found eligible for Medicaid on the date of birth and will remain eligible for one (1) year, so long as the child remains with the mother. A deemed eligible infant's Medicaid eligibility begins on the child's date of birth even if the birth was not reported timely or the child was not added timely. The hospital or birthing center should fax the Request for Newborn Health Benefits Identification Number to the appropriate RO. A child who dies after its birth is still considered a deemed eligible infant and can be approved and closed simultaneously. A stillborn infant is not considered deemed eligible. A child that is adopted prior to leaving the hospital is not deemed eligible.

The newborn form from the birthing center serves as the application and initial birth documentation. This form contains identifying information about the child and is signed by the mother. A face to face interview is not required prior to authorizing coverage for the child for the deemed eligible year. If the hospital form contains an address that is different from the current address in the system, the address should be changed and the case transferred, if needed after the newborn has been added.

Note: The newborn form is located in the "Inpatient Hospital" provider manual available on the DOM website or the RO may provide the form. A copy is located on the following page.

Follow system instructions for adding the deemed infant into the household. The deemed eligible infant will be exempt from enumeration and child support referral for the first year. The review due date will be set by the system for 12 months. However, a deemed eligible child remains eligible through the month of its first birthday, i.e. the 13th month. Eligibility for the deemed infant may be reviewed with other family members or siblings at the annual case review and a new 12-month certification period established. However, if the other family members are found ineligible at the annual review, do not shorten the deemed infant's eligibility period, unless the infant meets one of the early out reasons.

Note: No "deemed" eligibility period is provided for the infant born to a CHIP-eligible mother. Also, the unborn is not counted in the household size for the pregnant CHIP-eligible teen.

HEALTH BENEFITS DEFINED

OTHER MEDICAID PROVISIONS

PREGNANT WOMAN - The pregnant woman may qualify for Medicaid in the Infant Survival (IS/88) category, in MA/85 or in PL/91 (if under age 19). Refer to the IS/88 description earlier in this section. Only women who are eligible solely due to pregnancy should be placed in the IS/88. If the pregnant woman qualifies for eligibility in the MA/85 or PL/91 categories, she will have the advantage of the full Medicaid services. Verification of the pregnancy and expected due date is required.

A pregnant woman with no children can be placed in MA/85 when it is determined that she would be eligible if the child were born based on eligibility factors such as income, deprivation, child support compliance, etc. If eligible in MA/85, her coverage would not automatically end after the two-month post partum period but would continue after the birth, provided she is otherwise eligible in MA/85. If the pregnant woman is married, her husband's need and income are included in the budgetary process; but he could not be eligible for benefits in MA/85 until after the child is born and a full case review has been completed.

Minors eligible solely due to pregnancy are placed in 88 COE. They must be coded as pregnant minors in MEDSX. However, pregnant minors may be covered in PL/91 as dependent children. The needs and income of the minor, the unborn, her parents, and any siblings included in the application will be considered. Her coverage would not automatically terminate with the postpartum period, but would continue provided the AU continues eligible in that program. The same is true for independent minors who are eligible in 91.

The pregnant woman is covered by Medicaid from the month she is determined eligible through the two-month postpartum period, regardless of any subsequent changes, such as income or marital status. The postpartum coverage period begins with the date the pregnancy ends and concludes at the end of the 2nd month following the end of the pregnancy. The pregnant woman must be informed of the Medicaid coverage end date at the time of approval. The pregnant woman must also be informed that infants born to Medicaid-eligible mothers will be deemed eligible for one year. A case review is not required at the end of the postpartum period.

The application may be filed prior to or after the birth. The pregnant woman may request up to three months of retroactive benefits prior to the application month, provided all eligibility criteria, including the pregnancy, are met for each retroactive month in which there are unpaid medical expenses. Handle requests for coverage following a miscarriage the same as any other request for benefits for a pregnant woman. The pregnancy and end date must be verified and all other eligibility factors must be met for approval. The retroactive months may include postpartum months, depending upon when the application was received. Example: If the application is filed three months after the birth, coverage could be authorized for the month of the birth and the two postpartum months, even though all months fall in the retroactive period.

HEALTH BENEFITS DEFINED

OTHER MEDICAID PROVISIONS

CHIP does not cover services for the pregnant woman except for the eligibility of the teen whose family income falls within the 185% to 200% FPL. When testing CHIP eligibility for the pregnant teen, remember that the AU includes legal parents or the spouse in the household but cannot include the needs of the unborn child.

CHIP children who become pregnant must be assessed for Medicaid eligibility in the IS/88 program. When the RO becomes aware that a CHIP child is pregnant, action must be taken to verify the due date and the child's own income to determine eligibility in IS/88. Pregnancy information will be entered in MEDSX. Do not check the pregnant minor block. The system will determine eligibility for 88, close CHIP and open 88 at the appropriate time. If she is not eligible in IS/88 based on her own (and spouse's) income, she will remain in CHIP through the end of her certification period. The pregnant teen's eligibility for Medicaid will continue through the two-month postpartum period. The baby would be deemed eligible for Medicaid. Afterward, she will return to CHIP for the remainder of the 12-month coverage period. If the 12-month certification period has expired, a full review must be completed to determine the appropriate program for the teen still under age nineteen.

RETROACTIVE MEDICAID COVERAGE - Applicants and recipients may request retroactive Medicaid for unpaid medical expenses for up to three months prior to the initial application/benefit month, provided all eligibility factors are met for the requested month(s), i.e., income, age, household size, pregnancy, etc. Verification of income and pregnancy for retroactive months is required.

CHIP has no retroactive coverage provision, except for infants not eligible for Medicaid for whom application for Health Benefits is made within 31 days of birth, including the birth day. If the child is eligible for CHIP in this case, the benefit start date will be retroactive to the date of birth. Follow system instructions for adding these infants. The review is due the month before the birth month and the child is covered through the birth month.

POSTPARTUM COVERAGE

The Medicaid-eligible pregnant woman is eligible for two more months of coverage after the end of the pregnancy, specifically until the end of the 2nd month following the end of the pregnancy. The review due date is based on the expected date of delivery plus the postpartum period. The woman should report the early end of a pregnancy to prevent a possible claim for overpayment. The hospital or birthing center should report the birth of the child timely to provide documentation of a later than expected delivery date that would allow an extension of the anticipated Medicaid coverage period.

HEALTH BENEFITS DEFINED

OTHER MEDICAID PROVISIONS

Upon notification from the hospital of the birth, the deemed eligible child will be added to the Medicaid case of the mother. The mother's eligibility will be terminated at the end of her two-month postpartum period unless she applies for and is found eligible for continued coverage. Follow MEDSX instructions for adding the child, terminating the postpartum coverage, or changing the eligibility status of the woman.

Note: There is no postpartum period in CHIP.

HEALTH BENEFITS DEFINED
MEDICAL ASSISTANCE-MA/85

MEDICAL ASSISTANCE - MA/85

This Medicaid category covers low income families with children up to age 18. Test for family eligibility in the MA category when the adult caretaker requests Medicaid for him/herself with the children. This is the only Medicaid category that is not based on a Federal Poverty Level (FPL) income scale and that uses both a gross and net income test to determine eligibility.

Under Welfare Reform, Public Law 104-193 in 1996, Medicaid eligibility was delinked from the IV-A money payments for intact families so that very low income families could qualify for Medical Assistance using the AFDC Standard of Need and methodologies in place on July 16, 1996. This allows parent(s) or a needy caretaker who is not pregnant to qualify for Medicaid with their children. The pregnant woman may also qualify in this Medicaid category for the full range of Medicaid services.

In addition to the eligibility factors of need/income, residence, enumeration, citizenship, and assignment of third party medical benefits to DOM that are common to all HB categories, the following criteria apply specifically to the Medical Assistance – MA/85 Program:

Age

The age limit for children is up to age eighteen (18). Coverage may continue through the month in which the child becomes age 18. There is no age limit for parents and needy caretakers. When a child ages out of MA/85 during the certification period, change the category to PL/91 to complete the 12-month certification. Terminate the parent(s) or needy caretaker relative's coverage when the last child in the family turns 18. Note: The age of the child must be verified at application, when a new child is added (except deemed infants), or at the first regular case review conducted by the RO for deemed infants and for all children initially approved by MDHS and transferred to DOM.

Deprivation

The child or children must be deprived of one or both parents because of:

1. Incapacity - determined by the parents' receipt of Social Security or SSI based on disability (Use for two-parent families only.)
2. Death - one or both of the legal parents are deceased
3. Continued absence by reason of
 - Divorce
 - Desertion or non-support of legal parent
 - Paternity not established

HEALTH BENEFITS DEFINED

MEDICAL ASSISTANCE-MA/85

Long term hospital or institutional care
Imprisonment
Court sentence to perform unpaid community service while living at home
Removal of the child from home by court order
Legal adoption by single parent

4. Under/unemployment of the parent (Use for two-parent families only.) Under/employment occurs when the household's income is under the MA/85 Need Standard for the appropriate household size.

MA Standard Filing Unit Concept

The legal parent(s), if in the home, and all technically eligible minor children (under age 18) must be included in the Medicaid household or Standard Filing Unit (SFU). A needy adult caretaker relative (within the specified degree of relationship) other than the legal parent may be included for Medicaid eligibility with the children when there is no legal parent in the home, provided the adult requests to be included and meets all eligibility criteria. See Caretaker Relative definition in Section C.

The needs of the adult must be included in the MA/85 Standard Filing Unit when he/she is:

- The legal parent of at least one child in the budget or of a child who would be in the budget if not receiving SSI (A parent may receive MA/85 Medicaid when the only qualifying child receives SSI.), or
- In families with two legal parents in the home, both parents may be in the SFU when at least one of the parents is incapacitated (receiving SSA disability, not SSI), under/unemployed, or sentenced to work without pay while being allowed to live at home.

Standard Filing Unit (SFU) criteria for MA/85 also includes these factors:

- The family cannot select which children and their income to include or exclude from the MA/85 budget.
- Include the needs of the unborn child(ren) with the pregnant woman in the SFU.
- Unmarried minor parents (under age 18) who reside with their parents must be included in the SFU. However, if the family's income would make the SFU ineligible for Medicaid, test the minor's children with their parent(s) in the home in other HB categories. Recipients and their income are excluded from all HB budget groups.
- When working with blended households, legal parents and their children should be budgeted in separate AU's from grandchildren, nieces and nephews, or other such related or non-related children in the home. (The income of a caretaker other than a legal parent cannot make a child ineligible for coverage.)

HEALTH BENEFITS DEFINED
MEDICAL ASSISTANCE-MA/85

The adult caretaker shall not be eligible for MA/85 even though all other eligibility factors are met when he/she is:

- Serving a TANF Work Program penalty period for failure to satisfactorily participate (applies to two-parent Unemployed Parent [UP] families only),
- Failing without good cause to cooperate with Child Support Enforcement requirements,
- Ineligible on citizenship or alien requirements (Verify citizenship when the adult requests Medicaid coverage. The child's long birth certificate can be used to verify parent's place of birth.),
- Refusing to cooperate with enumeration requirements for self or a child,
- A recipient of SSI Medicaid or Medicaid-only (not SSI related) through the Division of Medicaid. (The case record must be documented to show the adult's Medicaid category. The SSI Medicaid recipient's needs and income are not in the budget; however, the person who receives Medicaid-only through Division of Medicaid will have his/her needs and income included in the budget group to test eligibility for the children.), or
- Not related to the child(ren) within the specified degree.

Example: A non-pregnant mother applies for herself and her two children. She agrees to cooperate with child support. Test the family of 3 for MA/85 first. If they are ineligible on income, deny the mother and test the children in another HB category based on income and age.

Example: A pregnant woman applies for herself and her child. The household includes the disabled (SSA) husband who is the father of the child and unborn. Test the family of 4 for MA/85 first. If ineligible, the father will be denied. Test the mother in IS/88 and the child in PL/91 or other HB category depending upon age and family income.

Example: Grandmother applies for herself with her own 15 year old child and two of her son's children. Neither the son nor the mother of the children is in the home. The applicant has provided proof of relationship to her child and has agreed to cooperate with child support for her child. Two separate budget groups (SFU) are involved in the case. Test the grandmother and her own child as a household of 2 in MA/85. If ineligible, deny the grandmother and test the 15 year-old in a household of 2 in PL/91. If the household of 2 is still ineligible on income, test this child in CHIP. Test the grandchildren and their own income for a household of 2 in the PL/91 category. If the children are ineligible on income, test in other categories based on age and income level. The grandmother cannot be tested with the grandchildren only since her minor child is in the home. The grandmother and her child's income cannot make the grandchildren ineligible or vice versa.

Caretaker Relative/Relationship

Children in MA/85 must reside with their legal parent(s) or, when there is no legal parent in the home, they must live with an adult relative within the specified degree of relationship. The caretaker must be at least 18 years old and must exercise control and supervision over the minor children. The caretaker (head of household) other than the legal parent(s) must be of specific relationship to the children. See Section C for details.

HEALTH BENEFITS DEFINED

MEDICAL ASSISTANCE-MA/85

Child Support Enforcement Requirements

The parent or caretaker relative must cooperate with child support requirements and must assist the State by cooperating with enforcement of the existing support order or in obtaining at least medical support from the absent parent. The parent or caretaker relative will be referred to the MDHS Division of Child Support Enforcement whether or not there is an existing court order for support. Cooperation includes providing information about the absent parent, including name, SSN, current address and place of employment, helping locate the parent and establishing paternity and/or medical support. Medicaid coverage will be denied or terminated for the adults for failure without good cause to cooperate with establishing or enforcing support. The MDHS Division of Child Support Enforcement will determine good cause for failure to cooperate and will determine when a disqualified individual has satisfactorily cooperated and might again be eligible for Medicaid coverage.

If the MA/85 parent or needy caretaker relative refuses at application to cooperate with child support requirements, deny the adult and test the children for eligibility in other HB categories. Inform the caretaker of the services available through the Division of Child Support Enforcement if they wish to participate voluntarily at a later date. If DOM is informed after MA approval that the caretaker has refused without good cause to cooperate, terminate the adult from Medicaid and continue the eligible children through their 12-month certification period. Test the children for other HB categories at the next annual review or when the child ages out.

If the caretaker is willing to cooperate, but no absent parent information is available, enter the deprivation cause and UNKNOWN for the name. The referral will be sent to DHS.

Special Budgeting Procedures for MA/85 Only

The following budget procedures apply **only** to the Medical Assistance category: See Section E, Budgets for more detailed explanation.

- **Stepparent Income:** If the parent requests Medicaid and there is a stepparent in the home, the stepparent's income must be deemed to test parent's eligibility.
- **\$30 + 1/3 Earned Income Disregard:** When the MA/85 case has passed the gross income test, but must be denied or closed on net income that includes earnings, the case must be tested for eligibility allowing the \$30 + 1/3 earnings disregard if the household is entitled to the disregard.

HEALTH BENEFITS DEFINED

MEDICAL ASSISTANCE-MA/85

Extended Medicaid Coverage for MA/85

There are two opportunities available **only** in the MA/85 category for extended Medicaid coverage periods.

1. Families with adults included for Medicaid coverage in the MA/85 category only who have received Medicaid in MA/85 in 3 of the prior 6 months who lose eligibility because of increased earnings or loss of the \$30 + 1/3 disregard are eligible for Extended Medicaid for up to 12 consecutive months.
2. For families with adults included for Medicaid coverage in the MA/85 category only who have received Medicaid in MA/85 in 3 of the prior 6 months, loss of eligibility for Medicaid because of increased child or spousal support entitles the family for up to 4 months Extended Medicaid.

The extended Medicaid period begins the next possible month following the increase in support or earnings or loss of earnings disregards which would have made the MA/85 case ineligible. The income would be excluded in the first prospective month with ineligibility effective for the next month.

Note: Receipt of Medicaid-only as a pregnant woman in another HB category does not meet the requirement for the adult having received Medicaid in at least 3 of the prior 6 months to qualify for the extended Medicaid provisions. The family must have been eligible for Medicaid in MA/85 for the 3 of 6 months prior to losing eligibility because of increased support or earned income or loss of disregards.

Example: At the annual review for 10/2005, the earned income increase that caused ineligibility is verified as beginning in 03/2005. Determine that the family has already used their entitlement for the \$30 + 1/3 earnings disregard or that the income increase exceeded the 185% requirements gross test for MA/85, thereby making the family ineligible for that disregard. The income for 03/2005 would make the first month of Extended Medicaid eligibility 04/2005. The Extended Medicaid would continue for 12 consecutive months, ending 03/31/2006, with a Review Due date for the adults of 03/2006. The children's Review Due date will be 09/2006.

TABLE OF CONTENTS
SECTION C

NONFINANCIAL ELIGIBILITY FACTORS

<u>Subject</u>	<u>Page</u>
GENERAL	
Introduction	3000
Assistance Unit/Standard Filing Unit (Budget Group)	3000
Age	3001
Age Out	3001
Deemed Eligible Infants	3002
Deprivation	3002
Social Security Number Requirement	3003
Residence	3003
Citizenship and Alien Status	3003
Assignment of Third Party Medical Benefits	3004
Retroactive Medicaid	3004
Child Support Enforcement Requirements	3005
Putative Father	3005
Joint Custody	3005
Standard of Need	3005
Emancipation	3006
Minor Parents	3006
Caretaker or Caretaker Relative	3006
Needy Caretaker	3006
Relationship	3007

NONFINANCIAL ELIGIBILITY FACTORS

GENERAL

INTRODUCTION

The Mississippi Health Benefits categories were defined in Section B to give an overview of the categories available with the ages of the children to be covered and the family income maximums allowed. In addition to the income tests for eligibility, there is very specific non-financial information that must be collected and eligibility factors met before proceeding to the actual income test to determine eligibility in any HB category.

The initial application should identify the persons for whom Health Benefits are requested and will set the stage for the collection of information needed to handle this request. Although the children or adults/pregnant women for whom the initial request is made may change as the eligibility investigation develops, the initial request should identify the age of the child(ren), the basic family group/household, and the income available. No later than the face to face interview, the worker will review this information and identify additional data that must be added for the eligibility determination. The applicant must be given a list of the needed items to complete the eligibility decision and a time frame to return the information to ensure timely completion of the application.

The eligibility process begins when the DOM staff receives the completed and signed HB Application. The eligibility determination must be completed within thirty (30) days from the date the application was received by DOM.

Note: Mississippi Health Benefits shall not be granted to individuals who are inmates of a public institution. Also, eligibility in a families and children program cannot be obtained through an HB program if a resident of a long term care facility.

The following factors are associated with the nonfinancial data collection process:

Assistance Unit/Standard Filing Unit (Budget Group)

All individuals who must be included in the budgeting process to determine eligibility for the requested individuals make up the Assistance Unit (AU) or Standard Filing Unit (SFU), terms applied to family units in Federal Poverty Level categories and specifically to MA/85 respectively. See full explanation later in this section and in Section B for the MA/85 category.

NONFINANCIAL ELIGIBILITY FACTORS

GENERAL

Age

Verification of date of birth is required for eligibility. Each HB category has a specific age limit for the children:

- up to age 18 for children with their parents/caretaker in the MA category
- up to age 19 for children in PL/91
- up to age 6 for children in EM/87
- up to age 1 year for children in IS/88 and pregnant women of any age
- up to age 19 for uninsured children in CHIP – The child must be determined ineligible for Medicaid before testing for CHIP.
- “Childbearing age” for women who request family planning services only is 13 - 44 years.

Note: Age must be verified for all children before eligibility can be determined.

The primary verification source for age for school age children is the certified birth certificate. A copy of the certified hospital birth record (footprint certificate prepared and signed by hospital staff) is acceptable verification of age for the preschool child. In the absence of a certified birth certificate or the approved hospital birth record, the age of the preschool child may be verified by submitting the Request for Newborn Health Benefits Identification Number to the hospital where the child was born. The request form must be signed by the parent during the interview and faxed by the RO directly to the hospital. The hospital should complete the form and fax it back to the RO. Assist the family to identify these acceptable sources of verification and document the case to show how age verification was determined.

Age Out

The child may remain eligible in the HB category through the month of their “age out” birthday. Children who age out of one category during a certification period must be tested and moved to another category to complete their 12 month certification period whenever possible. A new HB application is not required to transfer between categories during the certification period.

Children aging out of IS/88 and EM/87 may transfer to CHIP provided they do not have third party coverage.

NONFINANCIAL ELIGIBILITY FACTORS

GENERAL

Children aging out of PL/91 and CHIP at age 19 will no longer be eligible in any HB category and will be terminated the last day of their birth month.

Examples:

1. The MA/85 child turns 18 and can be moved to the PL/91 category for the remainder of his 12-month certification period.
2. A full case review will be necessary for the deemed eligible infant in IS/88 who is turning 1 year old. The infant is now covered by the mother's group health insurance at her workplace. If the child does not qualify in a Medicaid category, terminate his eligibility at the end of his birthday month because he cannot be eligible for CHIP.
3. The uninsured child in EM/87 is turning 6 in March and has 4 more months in her 12-month Certification period. Transfer the child to CHIP effective April 1st.

Note: Follow MEDSX instructions for children aging out.

Deemed Eligible Infants

Medicaid eligibility must be granted/"deemed" to infants born to a woman who is eligible for and receiving Medicaid on the date of the child's birth. The infant's deemed status will also apply when the pregnant woman applies after the birth of the child and is found to have been eligible retroactively at the time of birth. The child is deemed to have applied for and been found eligible for Medicaid on the date of birth and will remain eligible for one (1) year, so long as the child is a member of the mother's household. The deemed infant will be added to Medicaid in the appropriate COE based on income. A child cannot be "deemed" into CHIP. Medicaid eligibility of the mother for the baby to be deemed eligible includes SSI, Foster Care, 9), 88 and 85 COE's. It does not include Emergency Services for undocumented aliens or recipients of Family planning.

Deprivation

Children in the MA/85 category must be deprived of one or both of their parents because of incapacity, death, continued absence or under/unemployment (two parent families). A condition of "deprivation" is not required for children who qualify on need in other categories of Medicaid or CHIP; however, an appropriate deprivation reason is needed for system data entry and reporting. The deprivation code for low-income two-parent families should be underemployed, unless one parent is disabled. Refer to the MA/85 explanation in Section B for detailed deprivation reasons. Accept parent's/caretaker's statement of deprivation status, unless questionable.

NONFINANCIAL ELIGIBILITY FACTORS

GENERAL

Social Security Number Requirement

The Social Security number (SSN) must be provided for all persons for whom the HB application is made. Only those individuals for whom the SSN is provided, or for whom an application for SSN has been verified, may be determined eligible for HB coverage except for the “deemed” eligible infants under one year old born to Medicaid-eligible mothers. The SSN must be provided for these infants before the first annual review can be completed.

Residence

The applicant/recipient must be a resident of the State of Mississippi. A resident is defined as a person/family voluntarily living in Mississippi with the intent to remain here. There is no durational requirement and a permanent mailing address is not required. The application for benefits should be made and will be handled in the RO serving the county in which the applicant resides. Students, including those participating in Job Corps, are considered to be residents of the county in which they reside with their parents or other adult(s) exercising control and supervision. Verification of residence is not required unless questionable.

HB applications should be carefully screened prior to registration to determine the appropriate RO for handling. Refer to Section F for Where to Apply and Accepting Applications.

Refer to application processing instructions for receiving HB applications.

Citizenship and Alien Status

Persons who receive HB must be citizens of the United States or must meet the definition of a qualified alien. However, the unqualified alien parent(s) and their income must be included in the household size to determine eligibility for the children.

Citizenship must be verified for all adults who apply for coverage for themselves. Acceptable verifications include the individual’s own birth certificate, prior receipt of SSI, receipt of Title II benefits on the individual’s own number (A), or the child’s birth certificate which lists the parent’s place of birth.

The policy regarding who can be covered as a qualified alien can be found in detail in the Medicaid Eligibility Manual for Aged, Blind, and Disabled. Please refer to this policy when determining alien status for FCC Programs. Undocumented children will assume the alien status of their parent and will not be eligible for coverage. The unqualified aliens (adult or child) will be in the household size but not be eligible for Medicaid. The pregnant unqualified alien may request eligibility for Medicaid for the day of delivery only and requires special handling by DOM for this determination. The regional office takes the application and forwards to State

NONFINANCIAL ELIGIBILITY FACTORS

GENERAL

Office for processing. The infant may then qualify as a US citizen, but not as a deemed eligible infant. An application will be required.

Assignment of Third Party Medical Benefits

All third party medical benefits (insurance coverage) must be assigned to the Division of Medicaid. The client's signature on the HB application form is a statement of acceptance of this as a condition of eligibility. More detailed information can be found in the Manual for Aged, Blind, and Disabled.

Applicants and recipients must report third party coverage and must provide the name and address of the insurance company and the names of the individuals covered.

CHIP is intended for uninsured children only. Children who are currently included or who are covered during the application month by a third party health insurance program shall **not** be eligible for CHIP. This applies regardless of who pays the premiums. Children may change from a Medicaid coverage group to CHIP without a break in coverage; but there will usually be a break in coverage between the termination of third party insurance and the start date of CHIP because policies usually cover the calendar month. If termination of third party insurance occurs at the end of the application month and all other eligibility factors are met to qualify for CHIP, a new application form will not be required. The application will be approved for the first possible month after normal coverage has ended. Verification of the termination of the third party insurance is required. DOM will also conduct cross matches to identify third party coverage.

Children covered only by the following exceptions to full health insurance (creditable coverage) may be eligible for CHIP: coverage only for accidents, disability income insurance, liability insurance, supplemental policies to liability insurance, workers' compensation insurance, automobile medical payment insurance, credit-only insurance, coverage for onsite medical clinics, or limited-scope dental, vision, or long-term care insurance.

Retroactive Medicaid

Applicants and recipients may request retroactive Medicaid for medical expenses for up to three months prior to the initial application/benefit month, provided all eligibility factors are met for the requested month(s), i.e., income, age, household size, etc.

There is no retroactive coverage in CHIP. CHIP is authorized for a future month except for the infant for whom the application for Health Benefits was made within 31 days of the date of birth.

NONFINANCIAL ELIGIBILITY FACTORS

GENERAL

Child Support Enforcement Requirements

Referral to and cooperation with Child Support Enforcement is not required for CHIP and the Medicaid categories other than MA/85. Referral and cooperation with MDHS Child Support Enforcement is required in the MA/85 category for one or both of the absent parents, when applicable. See the explanation in Section B. Inform parents about child support services available through MDHS to establish paternity and/or seek or enforce financial and medical support. Parents may volunteer to seek medical and/or financial support for children receiving Medicaid in FPL COE's

Putative Father

The term is used to describe the alleged father of a child for whom paternity has not been legally established. Once paternity is established through an admission of paternity through Child Support Enforcement or at the hospital so that his name is on the birth certificate or by court order, he is considered to be a legal parent regardless of marital status.

Joint Custody

When an application is made for a child and the parents share joint physical custody and the child spends an equal amount of time with both, the child must qualify separately in both households. A separate application is not required to gather the information from the parent who is not making application, but financial information about that parent's AU must be verified and provided in order to determine the child is eligible in both households.

If the requested information is not received from the household not making application, the child can only be covered in the applying household. The child can only be covered for the periods (months) in which he/she lives with the parent who made application and whose information was used to determine eligibility. If the child leaves the home of the applicant parent, this would be considered an early-out reason. If the child subsequently returns to the home, a new application must be completed and processed. The DOM staff must ensure the custodial parent understands the child is only eligible when living in his/her home.

If it is determined the child spends more time with one parent than the other, eligibility should be established in that household.

Standard of Need

The child or pregnant woman must not have sufficient income to meet his/her needs according to the Need Standard set for each HB category. Refer to the sections on Income and Budgeting.

NONFINANCIAL ELIGIBILITY FACTORS

GENERAL

Emancipation

In certain situations, the court may grant an order of emancipation or relief of minority to remove the minor from parental care and supervision and to allow the minor to act on his own behalf as an adult. Also, when the child marries, he has in effect emancipated himself from the state of minority and will no longer be considered a minor child unless he is living in the home of his parent apart from the spouse. Request verification and document the case. An independent minor living apart from their parents is also considered to be emancipated.

Minor Parents

An unmarried parent under age 19 with his/her children who resides with his/her parents (the children's grandparents) must be included in the household with his/her parents to determine his/her own eligibility for any Health Benefits category. However, do not deny eligibility for the minor parent's children based on the income of the grandparents. If applicable, deny benefits for the minor parent. Then determine eligibility for the minor parent's children using only the household size and income of the minor parent and his/her children.

If a pregnant minor applies solely on the basis of pregnancy, do not include the parents' needs or income when determining eligibility needs for the pregnant minor parent if the income of her parents would make her ineligible for 85 or 91. Test the pregnant minor, the unborn, and her other children, if applicable in IS/88.

Caretaker or Caretaker Relative

The caretaker relative is the individual in the MA/85 category who is within the specified degree of relationship to the children and who exercises control and supervision over the children. The other HB categories do not require that the caretaker be a relative within the specified degree of relationship. The caretaker or head of household may be a nonrelative. The legal parent must be the caretaker relative/head of household when the legal parent is in the home.

Needy Caretaker

The needy caretaker is applicable to the MA/85 category only and must be the legal parent or a caretaker relative when the parent is not in the home. The needy caretaker must meet the specified degree of relationship to the children and must be determined financially needy by the Standard of Need for that size family in order to qualify to be included for consideration of Medicaid eligibility with the children. Only one needy caretaker may be eligible for Medicaid benefits, even though the grandchildren may live in the home with both grandparents. The family may choose which grandparent will be the eligible, when eligibility is established. It is the responsibility of the family to provide verification of relationship to the children when the adults are requesting coverage for themselves.

NONFINANCIAL ELIGIBILITY FACTORS

GENERAL

Relationship

The case name/head of household will be the name of the person making application for the children. The person may or may not be a relative of the children in the application. Only the MA/85 category requires that the caretaker be related to the child. See MA/85 criteria in Section B. Accept the applicant's statement of relationship to the children except for MA/85. Relationship must be verified for MA/85 that includes the needy caretaker for coverage.

For the Poverty Level Programs, it is not required that the caretaker (head of household) other than the legal parent must be a person in one of the following groups:

1. Any blood relative, including those of half-blood, and including first cousins, nephews, or nieces, and persons of preceding generations as denoted by prefixes of grand, great, or great-great,
2. Stepfather, stepmother, stepbrother, or stepsister,
3. Person who legally adopts a child or his parent as well as the natural and other legally adopted children of such person, and other relatives of the adoptive parents in accordance with State law, and
4. Spouses of any persons named in the above groups even after the marriage is terminated by death or divorce.
5. The natural or biological parent may be included when the child has returned to the home even though the child was legally adopted by another person.

Example: Grandmother adopts a child. The biological mother returns home. The biological mother is not within the specified degree of relationship as the legal mother (grandmother) is in the home.

Example: A grandmother adopts a child. The child later returns to live with the biological mother. In this case, the biological mother is within the specified degree of relationship because the legal mother is not in the home. The grandmother, as the absent legal parent, would be referred to Child Support Enforcement.

If the needy caretaker relative wishes to be included for Medicaid eligibility with the children, it will be the relative's responsibility to provide adequate documents to verify his/her relationship to the children for whom the application is made. Parents may provide the child's birth certificate or other legal documents that show relationship to the child. Another relative would need to provide additional documents to show the relationship to the child's parents and to the child. See section on Verifications.

TABLE OF CONTENTS
SECTION D

INCOME

<u>Subject</u>	<u>Page</u>
BASIC PRINCIPLES	
Definition of Income	4000
Unearned Income	4000
Earned Income	4000
Gross Income	4000
Regular Monthly Income	4001
Verification of Income	4002
Verification Sources	4004
Net Income	4004
Zero Income Households	4004
Establishing Earned Income	4006
Earned Income Defined	4006
Earnings to be Averaged	4007
Other Types of Earned Income	4008
Seasonal Income	4008
Earned Income from Students Under Age 18	4008
Earned Income Tax Credit	4008
TANF Work Program (TWP)	4009
Job Training Partnership Act (JTPA)	4009
Job Corps	4009
National and Community Service Act (AmeriCorps)	4009
Summer Youth Employment and Training Programs (SYETP)	4009
SELF-EMPLOYMENT INCOME	
Self-Employment Income	4010
Exceptions to Annualizing Income	4010
Determining Net Self-Employment	4011
Costs of Producing Self-Employment Income	4012
Allowable Expenses	4012
Calculating Self-Employment Income Without Adequate Records	4013
FARM INCOME	
Farm Income	4015
Determining the Annual Farm Income Cycle	4015
Determining Farm Income	4016
Deductible Expenses for Crops	4016

TABLE OF CONTENTS
SECTION D

INCOME (cont'd)

<u>Subject</u>	<u>Page</u>
UNEARNED INCOME	
Establishing Unearned Income	4018
Social Security	4018
Supplemental Security Income (SSI)	4019
Unemployment Compensation	4019
Trade Adjustment Assistance (TAA)	4019
Trade Readjustment Assistance (TRA)	4019
Worker's Compensation	4019
Severance Pay	4020
Railroad Retirement Benefits	4020
Mississippi Teachers and Public Employees Retirement Benefits	4020
Veterans' Benefits	4020
Military Service Allowances and Allotments	4020
Income from the Mississippi Band of Choctaw Indians	4021
Grants, Loans and Scholarships for Educational Purposes	4021
Support from Absent Parents	4021
Benefits from Insurance Policies	4022
Interest Income and Dividends, Trust Fund Payments	4022
DISREGARDED INCOME	
Income Totally Disregarded	4023

INCOME

BASIC PRINCIPLES

DEFINITION OF INCOME

Income can generally be defined as financial or monetary gain received by the family during a specific period of time, such as weekly, monthly, or annually. It can also be separated into earned and unearned income, depending upon the source from which it is received.

Unearned income usually requires no physical activity by the recipient and is usually in the form of a pension, benefit, compensation, child support, dividends, or contributions from relatives or others, etc.

Earned income is income produced as a result of the individual's performance or profit accruing as compensation or reward for service by the recipient, usually in the form of:

- Wages, salary, or commissions received as an employee of another person or company, or,
- Income or profit which the individual earns by his own efforts, including managerial responsibilities, or through contracts or self-employment when the individual gives substantial services in connection with the enterprise.

GROSS INCOME

All earned and unearned income received by the HB Assistance Unit members, including the children and legal parents in the home, except that income specifically excluded or disregarded by law/regulations or approved State Plan, must be considered as income to the family and used in the income tests for eligibility. (See Income Totally Disregarded later in this Section.) Remember that the MA/85 category has both a gross and net income test for eligibility while other HB categories test eligibility only on net earned and unearned income, which is calculated from the gross income after allowable deductions for the specific Assistance Unit (AU) for whom benefits are requested.

Gross earned income means earned income prior to any deductions for taxes or for any other purposes, except for allowable self-employment expenses. With reference to wages, salaries, or commissions, the term gross earned income means the total amount, without consideration of personal expenses, such as income tax deductions, lunches, and transportation to and from work, and irrespective of expenses, such as the cost of tools, materials, special uniforms, or transportation to call on customers.

All income for each individual included in the Assistance Unit (AU) must be reported at application and annual reviews, and income that is not specifically excluded must be **verified**. The family is responsible for verifying income from all sources except income routinely verified through income cross matches.

INCOME

BASIC PRINCIPLES

If the family needs assistance with verifications, the worker will provide suggestions for alternate documents or methods of verifications. The gross pay from wages and salaries must be used to determine the family income to be tested for the AU. Voluntary and mandatory payroll deductions cannot be excluded. The gross amount of any entitlement benefit will be used without regard to recoupments or other reductions.

REGULAR MONTHLY INCOME

Countable income includes monies from all sources regularly received or anticipated each month. Verification must be requested for the most recent full calendar month. Generally we verify and use income for the month prior to the month of application provided it is their normal ongoing income. If an applicant has already received a full month's income at the time of application, the application month's income can be verified and used. Income may be from many sources and types, including earnings from wages and salaries, tips or other normally recurring sources of earned income, contracts or self-employment, child support, and unearned income. Do not include the 3rd (two-week pay periods) or 5th (weekly pay periods) paycheck as "regular" income. Do not include one-time overtime pay unless the wage earner will continue to receive overtime hours in future months.

Applicants with new wages, not yet paid for an entire month, will be requested to provide verification of the wage rate and anticipated hours so that a full month's earnings may be calculated. If the person is salaried, request verification of the salary amount.

Income received annually or periodically (less than monthly) from the same source must be considered as income and averaged over the period intended to cover, unless specifically addressed or excluded in this section. Yearly payments, such as installment payments from a property sale, land rental and the yearly oil lease income, are averaged over a twelve-month period and the average used as regular monthly income.

Example: The HB family includes two parents and 3 children. They have income from the father's unemployment compensation, mother's weekly wages, the sixteen-year-old's after school job, and annual income from a farm land rental agreement. Verify all income except the teen's wages when the applicant states the child is a student (at least half time) with age being verified under 18. The total monthly income to be tested for the HB assistance unit will include the monthly earnings of the mother (less the work related disregards), father's gross unearned income and the averaged monthly income from the rental payment. The student's income will be disregarded.

Do not consider a nonrecurring lump sum payment as income. Examples of lump sum payments include retroactive payments such as RSDI, sale of an asset (not as self-employment), child support back payments, tax refunds, insurance settlements, loans, etc. However, any portion of the RSDI lump sum that is identified as payment for the current month must be counted as income.

INCOME

BASIC PRINCIPLES

Recurring lump payments such as payments made from a trust fund less often than monthly or the Choctaw Tribal bonus will be considered income to the family and averaged over the period intended to cover.

Reimbursements are disregarded as income to the extent they do not represent a gain. The client's statement regarding a reimbursement will be accepted unless the worker has reason to question that reimbursement exceeds the expenses it covers.

Consider monthly contributions paid directly to the recipient, such as regular cash assistance from family or others, as unearned income.

Also, refer to the special budgeting instructions later in Section E for contractual income and for calculating countable income from self-employment when tax returns are not available.

VERIFICATION OF INCOME

If the individual with earned income is paid weekly, consecutive check stubs (or equivalent documentation) are needed. It is permissible to calculate the amount of a missing check using year to date totals. Use the following time period guidelines for obtaining verifications of income when changes are not expected in the application/review month or the next month:

- An application is received on February 10th. Income for the calendar month of January should be verified to determine eligibility.
- A review for December is completed on November 5th. Income from October should be used to determine eligibility.

Use the following time period guidelines for obtaining verifications of income when changes are not expected in the application/review month or the next month:

- Application received February 27th. Client is expected to begin a new job on March 1. Anticipated income for March should be verified.
- A review for December is completed on November 5th. The client lost his job on October 15th and has been denied unemployment benefits. Since income received in October is from a terminated source, it will not be used to determine eligibility for the next review period. However, potential sources of income the household will have in meeting their needs should be explored.

Income that will be excluded must also be reported by the family but will not require verification.

INCOME

BASIC PRINCIPLES

Refusal of the applicant to provide sources, amounts, and verification of income and/or to cooperate in verification of income will cause the HB application/case to be denied or closed.

Do not request verification of income for a household member whose income will not be used to determine eligibility for the individuals requesting Health Benefits, such as a stepparent whose spouse is not requesting coverage in 85 or 88, siblings who are excluded from the HB request, or non-needy caretakers who are not legal parents of the HB assistance unit children.

Since there are no resource tests related to Health Benefits categories, requests for bank statements or other resource documentations should be limited to those situations that require verification by showing direct deposits for a source of unearned income, such as dividends and interest income, or other income when no other verification is available, etc. Do not use direct deposit amounts to verify earned income from employers since these amounts would not be the gross income.

Earned income must be verified for each person that will be included in the assistance unit, including children and legal parents or needy caretaker relatives. When a stepparent is living in the MA/85 household, the income of the stepparent must be verified because it will be used to determine the eligibility of the legal parent in the home. Income of the stepparent also must be verified when he/she has requested coverage for himself or his own children. The income of the student under age 18 years must be reported but does not require verification since it will be disregarded. If the child does not meet the student earnings disregard criteria, earnings are countable and must be verified.

Verification of earned income should include the name and address of the employer, the frequency of payment, the day of the week or the date of the month that the payment is regularly received, the hours worked, gross income and deductions, etc. Verification can be accomplished by check stubs, other statement from the employer, completion of the income verification form by the employer, etc.

Unearned income must be reported and verified. Income which can be verified by electronic cross matches must be reported by the applicant and verified by the available match.

Note: Verifications must be requested by the DOM worker if not provided at the HB interview. Failure or refusal by the individual to provide all required income verifications will cause the case to be denied or closed.

INCOME

BASIC PRINCIPLES

VERIFICATION SOURCES

Verification sources for income may include viewing or copies of:

- Checks, check stubs, print-outs, award notices, etc.
- Direct deposit records for certain unearned income
- Written statements from employers
- Copies of contracts for school employees and others working on contract,
- Tax returns for self-employment records, farm income records
- Rent or lease agreements
- Support checks, court orders for child/spousal support, absent parent statements, DHS Child Support furnished verification, etc.
- Electronic data matches, etc.

Note: Remember that gross income must be verified first; then appropriate disregards can be made. Verifications may require a combination of documents.

NET INCOME

Net income which must be tested against the Need Standard for each HB category includes both earned and unearned income after certain deductions are allowed from gross earnings. Calculate the net income by deducting the allowable earned income disregards from the gross earned income of the AU and by allowing the up to \$50 disregard for child support when the family receives this type income.

Note: MA/85 is the only category that requires both a gross and net income test for eligibility determination. MA/85 also includes certain earnings disregards and related extended benefits not allowed in the other HB categories.

ZERO INCOME HOUSEHOLDS

There are households who may correctly report no income. The lack of income for the family must be carefully documented during the face to face interview and information requested as needed. There is a difference between the household that reports no (zero) income and the AU or SFU that has no countable income. It is reasonable to accept that some households have no countable income, such as:

- The application is made by a nonrelative for children, and the children have no income
- The application is made by a relative other than parents for children
- The application is made for a pregnant minor whose parent's income will not count
- There is other noncountable income in the house, i.e., SSI, TANF, Education Income, etc.

INCOME

BASIC PRINCIPLES

There are several possible sources of income for children that should be explored including child support, contributions, RDSI from deceased or disabled parents, part time jobs for teens, etc. Document the findings for the case.

Other households that include parents and children may also report zero income. When this occurs at application or review, the worker must explore sources of support to reasonably explain how the family is managing without income. Often a crisis has occurred recently that resulted in the current lack of income. Other circumstances may be long-standing and need more detailed documentation.

Crisis situations may include:

- Loss of job or lay off,
- Loss of income because of serious illness of the primary wage earner,
- Separation or divorce of the parents, etc.

Document the circumstances with dates and explore the family's plan for future months. The worker may find that the family is living on savings or other financial investments. This will not be considered income unless it falls under the definition of regular income, such as payments from an investment, insurance, annuities, trust fund payments, etc. When the person has lost his/her job, look for potential income sources from Unemployment Benefits, Workers' Compensation, salary protection insurance, etc. When the person is ill, look for sick pay or disability coverage related to the job, etc., that would be counted as earned income.

Ongoing situations involving no income may include:

- Living with relatives who are providing in-kind support with shelter and food,
- In-kind contributions from relatives or friends outside the home who provide lodging or pay the rent and utilities directly; verification is requested
- Irregular cash contributions from friends/relatives, churches, etc.,

Note: Cash contributions made on a regular basis from the same source must be considered income. In-kind contributions (funds are not given to family) are not counted as income.

Lack of income must be documented and the family must be able to reasonably explain their present and future living arrangements. Determine if the family is receiving or has applied for Food Stamps or TANF, has the person applied for RSDI or SSI, Workers' Compensation, Unemployment, or other benefits.

If the family fails to respond or cannot reasonably explain their lack of income, the application must be denied or continued eligibility terminated at review. Evaluate the family's responses when provided. If the response is vague or unrealistic or the situation has continued for an extended period without adequate explanation, deny or close the case. If the explanations appear reasonable, approve or continue benefits. The case record must be documented in all instances of allowing eligibility with zero or very low income.

INCOME

BASIC PRINCIPLES

ESTABLISHING EARNED INCOME

The family must verify earned income at each application and regular review for each family member, adult and child, who will be included in a HB budget group/household budget group to test for eligibility. The legal parent's income (except SSI and any other income of the SSI recipient) must be included with the child(ren)'s income in the tests for eligibility. Hourly wages and salaries are the most common sources of earned income.

Earned income shall include at least the following:

1. All gross wages and salaries (before withholding) for services performed as an employee are earned income. This includes wages withheld at the employee's request, advances on income, and other taxable income received on a regular basis such as annual bonuses, profit sharing, and commissions.
 - Earnings may include tips for services performed. Food and beverage establishments may pay wait staff a small hourly rate and permit the employee to receive tips as the bulk of his/her income. The amount of tips reported by the employee plus base hourly pay should be counted as income.
 - Advances on wages are payments made in exchange for services or labor to be performed and count as earned income vs. a loan which requires repayment of the principle, usually plus interest.
 - Wages and salaries and /or vacation pay received after employment ends (such as, the last paycheck rather than severance pay) is counted as earned income when it is received in more than one installment. Severance pay would usually be unearned income and, unless received in ongoing installments, would not be considered normal recurring income.
 - Payment for sick leave provided by the employer is considered earned income if the employee is expected to return to work when recovered and is still considered an employee by his employer. Usually this is a continuation of salary with normal payroll deductions. Disability or sick pay from a source other than the employer, such as from an insurance company, is unearned income even when the employee plans to return to work.
 - Money that is diverted from an employee's gross earnings through a cafeteria plan to pay certain expenses, such as child care or medical expenses, is counted as earned income.
2. Training allowances from vocational and rehabilitative programs recognized by Federal, State or local governments, such as the Work Incentive Program, to the extent the pay is not a reimbursement, are considered earnings. Exception: Training allowances received through programs authorized by JTPA are excluded.
3. Earnings include payments to individuals participating in the on-the-job training programs under Section 204(5), Title II, of JTPA, including monies paid by JTPA and the employer.

INCOME

BASIC PRINCIPLES

4. Basic Allowance for Housing (BAH) and Basic Allowance for Subsistence (BAS) for military personnel are treated as earned income when received in lieu of free housing and/or food. The BAH is one monthly payment. (Any gain or benefit that is not in the form of money payable directly to the AU, such as free meals or housing furnished to military personnel living on base, is considered as in-kind benefit and excluded as income.)

The following types of earned income must be averaged or prorated:

1. Contractual Income - Income from contractual work must be considered as being received in each month covered by the contract, regardless of the number of months in which the income is actually received. The contract amount will be divided by 12 to calculate the months income. The contract may be written or implied. For example: school employees may be paid for 9 months but their income must be averaged over a 12-month period to obtain monthly income.
2. Self-employment - For self-employment income, use the most current year's tax return. If the tax return for the current year is not yet available, it is permissible to use the most recent return until the current year return can be obtained. Do not allow depreciation. Obtain the net earnings for the self-employment enterprise and add back any amount shown as depreciation. Annualize this amount to obtain the monthly income amount to begin the budgeting process. The income, after allowable exclusions, from a self-employment enterprise is considered earned income. Deduct appropriate \$90 earnings disregards and child care deductions from annualized earned income. Refer to the "Self-Employment" income instructions later in this section for a detailed discussion of self-employment.
 - Payments received for a roomer or boarder, except foster care placements, shall be considered as a self-employment enterprise, regardless of the number of hours spent weekly in providing service.
 - Ownership of rental property shall be considered a self-employment enterprise. However, the income derived, less the cost of doing business, from rental property shall be considered earned income only if the household member is actively engaged in the management of the property at least an average of 20 hours per week. Otherwise, the income is considered unearned and the earned income deductions cannot be allowed.
 - Payments made to day care providers under the Child and Adult Care Food Program of the National School Lunch Act shall be considered gross income from which costs of doing business may be subtracted. Included in the cost of doing business are the food expenses incurred by the providers to feed children under their care.
3. Certain types of income received as a commission will be annualized when the income is received less often than monthly. A W-2 or commission report for the prior years will be used to determine the monthly amount to be anticipated as normal recurring of income for the current review period. An example would be a car salesman who does not receive commissions on a monthly basis.

INCOME

BASIC PRINCIPLES

Note: Unearned income sources may also require averaging or prorating. Ongoing income from a source that is received less than monthly, such as annual or periodic income from oil leases or rental of farmland or other property, must be averaged or prorated over the period of time intended to cover. The total unearned income will be verified and the amount divided by months covered. The averaged/prorated amount will be counted as monthly income for the family along with other earned and unearned income to test for eligibility.

OTHER TYPES OF EARNED INCOME

Seasonal Income

If income received on a seasonal basis can be determined as self-employment, handle accordingly. If not, determine the income for the current season (or the off season) using the most current month's normal income. If ineligible, the household may apply at any time.

Earned Income from Students Under Age 18

Disregard all of the monthly earned income of each child who is under eighteen (18) years old if the child is a full-time student or is a part-time student who is not a full-time employee. A student is a child who is attending a school, college, or university or a course of vocational or technical training designed to fit him or her for gainful employment and includes participation in the Job Corps program under the Job Training Partnership Act (JTPA).

The student's earned income exclusion shall continue to apply up to age 18 during temporary interruptions in school attendance due to semester breaks, provided the child's enrollment will resume following the break.

If the child's earnings or amount of work performed cannot be differentiated from that of other members of the HB budget group, the total earnings of the group shall be prorated equally among the working members and the child's prorata share excluded. This may occur especially with families working as a group on chicken or dairy farms when the single wage agreement includes an assortment of duties to be performed by multiple family members.

The household must report the student's income even though it will be excluded.

Earned Income Tax Credit

The Earned Income Tax Credit (EITC) is a refundable tax credit for families and dependent children. EITC payments may be received either monthly (as advance payments through the employer), annually (as a refund from IRS), or both. The family should report this source of income, but EITC payments are totally disregarded as income in the determination of HB eligibility. The worker should make low-income families aware of this tax credit if they are not already taking advantage of this benefit.

INCOME

BASIC PRINCIPLES

TANF Work Program (TWP)

Disregard supportive service payments made for the TANF Work Program (TWP) training activities as income. The TWP participant may receive supportive services related to the job training, but payments are made only as reimbursements for child care and/or transportation, or payments for the supportive services are paid directly to the service provider. When the TWP participant moves into unsubsidized employment, the earnings will be counted as regular earned income subject to appropriate disregards and extended benefits if eligible in MA.

Job Training Partnership Act (JTPA)

Under JTPA, there are two types of training that the JTPA participant may receive. The worker must determine the type of payment to apply the income correctly:

1. A person in JTPA institutional training may receive a weekly needs-based payment for child care for children under age 6. This income is disregarded as a reimbursement.
2. A person in JTPA on-the-job-training receives a regular salary from the employer. In this case, disregard the income earned by the child under age 18 (student income disregard), but treat the wages of the individual age 18 and over as any other earned income.

Job Corps

Job Corps is a part of JTPA targeting economically disadvantaged youth between the ages of 16 and 22 and designed to provide intensive programs of education, vocational training, work experience, counseling, and other activities to prepare the youth for self-sufficiency. Any earned income will be treated as in JTPA above.

National and Community Services Act (AmeriCorps)

Allowances and payments to individuals participating in programs administered under the National and Community Service Act of 1990 (NCSA) are generally treated the same as programs under JTPA. The living allowance (stipend) is treated as earned income and the earned income disregards apply. If the participant is a child under age 18, the earned income must be disregarded if the child qualifies as a student for the earned income disregard.

Summer Youth Employment and Training Programs (SYETP)

The summer youth employment and Training Programs operate under JTPA. Handle earned income the same as other JTPA earnings. Allow appropriate disregards for individuals age 18 and over, and allow the student earned income disregard if the child is under age 18.

INCOME

SELF-EMPLOYMENT

SELF-EMPLOYMENT INCOME

Earned income from self-employment means the total profit from a business enterprise, farming, etc., resulting from a comparison of the gross receipts with the business expenses, i.e., expenses directly related to producing the goods or services and without which the goods or services could not be produced. However, such items as depreciation, personal business and entertainment expenses, personal transportation, purchase of capital equipment, and payments on the principal of loans for capital assets or durable goods are not business expenses.

Self-employment differs from other employment because mandatory deductions are not withheld prior to the individual receiving pay. Gross self-employment income is determined by deducting allowable business expenses from the gross income of the business enterprise, farming, operation of a commercial boarding house (excluding income received from boarders in a noncommercial boarding house arrangement), etc.

Self-employment income may be received irregularly or on a regular basis and is handled as follows:

- Self-employment income that represents the household's annual support shall normally be averaged over a 12-month period, even when the income is received within only a short period of time during the 12 months.
- Self-employment income and expenses from the past year are usually used as income for the current year. If the averaged annualized amount does not accurately reflect the household circumstance because the household has experienced a substantial increase or decrease in business, such as a change in the type of farm operation or the amount of land farmed, crop failure or substantial change in market process, etc., the self-employment should be calculated on anticipated earnings rather than the basis of prior annual income.

Exceptions to Annualizing Income

1. If the household's self-employment enterprise has been in existence for less than a year, the income from the self-employment enterprise shall be averaged over the period of time the business has been in operation, and the monthly amount projected for the coming year. Possibly refer to the quarterly tax estimates. However, if the business has been in operation for such a short time that there is insufficient data to make a reasonable projection, the MA/85 adults in the household may be reviewed for less than a year until the business has been in operation long enough to base a longer projection. Request a review of income in three to six months to review the adults' status. Adults are not guaranteed a 12-month certification period. Do not shorten a child's period.

INCOME

SELF-EMPLOYMENT

2. Self-employment income which is intended to meet the household's needs for only part of the year shall be averaged over the period of time the income is intended to cover. For example, self-employed vendors who work only in the summer and supplement their income from other sources during the balance of the year shall have their self-employment income averaged over the summer months rather than a 12-month period. In an effort to determine the period of time for which self-employment income is intended to support a household, other factors, in addition to the household's own statement, would have to be examined and evaluated.

Such factors would include, but not be limited to, previous year's business and personal expenses, tax records, anticipated expenses for the current year, income received from other sources during the previous year, income expected to be received from sources during the previous year, income expected to be received from sources during the coming year, etc. Such factors, when compared with the income from seasonal self-employment, would provide a basis for making a determination as to how long the income is intended to support the household. For example, if the previous year's expenses were proportionate to the household's income from self-employment, it could be an indication that the income would sustain the household for a year; therefore, the income would be annualized. If expenses were not proportionate with the income, it could be assumed that such income could not sustain the household for a year; therefore, income would be averaged over the period of time for which such income is received.

3. If the self-employment income is received monthly, use the self-employment income and expenses from the budget month. For example, a self-employed house painter or plumber who works by the hour would have a fairly regular income with few business expenses incurred less than monthly. The income should be reviewed over the prior three months to determine if the income is consistent and use the monthly amount or average if so. If the income fluctuates strongly, the income must be averaged over the full 12 months.

Determining Net Self-Employment

For the period of time over which self-employment income is determined, add all gross self-employment income, (including capital gains), exclude the allowable costs of producing the self-employment income, and divide the balance by the number of months over which the income will be averaged.

Note: Capital gains are proceeds from the sale of capital goods or equipment when the sales price is greater than the cost of the property less costs associated with the sale, improvements, etc. An example would be a person who purchases houses, does renovations, and then sells the house at a profit; a person who restores old cars and sells the car for profit; profits from the sale of business equipment such as tractors in a farming operation, a potter's kiln, etc.

INCOME

SELF-EMPLOYMENT

Expenses must always be handled the same as the self-employment income to which they apply, i.e., annualize expenses if income is annualized, average expenses over the period of time they are intended to cover if income is averaged over the period of time it is intended to cover, and count expenses in the month billed if income is counted in the month received.

Costs of Producing Self-Employment Income

Costs are allowed when billed or otherwise become due. When the income is annualized, only expenses billed or otherwise due in the current 12-month period are allowed. Costs that were billed or otherwise became due in a prior year which are not expected to recur in the current year may not be brought forward to the current year regardless of when paid.

Allowable Expenses

Allowable costs of producing self-employment income include, but may not be limited to:

1. Identifiable costs of labor, stock, raw materials, supplies, seed, plants, fertilizer, etc.;
2. The interest portion of:
 - Payments on business or operating loans, and/or
 - Payments on income-producing real estate and capital assets such as equipment, machinery, or other durable goods;
3. Insurance premiums related to the business operation;
4. Taxes paid on income-producing property;
5. Privilege taxes such as licensing fees and gross receipts and general excise taxes that must be paid in order to earn self-employment;
6. Business transportation costs, such as costs of carrying goods to market, trips to obtain needed supplies, travel and lodging (but not meals and entertainment) away from home for a self-employed salesperson, if necessary for the employment operation;
7. Rental payments on income-producing equipment (If rental payments are made on a piece of equipment with an option to buy, the rent payments may be allowed until the purchase is made. See #2 above. Once the purchase contract is set, only the interest portion of the expense can be allowed.);
8. Costs of maintenance of equipment; and
9. Storage and warehousing charges.

INCOME

SELF-EMPLOYMENT

These business expense items are not allowable deductions:

1. Amounts for depreciation since these amounts represent a decrease in the value of the asset for wear and use and are not a real financial cost (Refer to capital gains.)
2. Mortgage costs
3. Payment on fixed assets or durable goods
4. Personal business and entertainment expenses, including personal transportation expenses; federal, state, and local taxes; money set aside for retirement purposes (These costs are the same as withholding from salaries or wages and cannot be excluded from gross income.)
5. Repayment of the principal of a bank loan (interest costs only are allowed)
6. Net losses from previous work periods
7. Charitable contributions allowed as a deduction for tax purposes

Calculating Self-Employment Income Without Adequate Records

It is reasonable to expect that a person who is self-employed will have documents available to verify business expenses. For many families, this may be the case with a second job. For the applicant or recipient who is self-employed and has no records documenting his business income and expenses, follow these guidelines:

1. Assist the applicant or recipient to make the best possible estimate of gross earnings and expenses. Document the case carefully to identify each item included.
2. If gross income can be determined, but not expenses, average the income over the appropriate months, allowing no expenses or only the very basic expenses which can be reasonably expected for that business.

Example: A person makes his living pressure washing houses but does not keep records of the enterprise. Determine the charge to the homeowner for the service and how many jobs are regularly done each month. Since the water and electricity for the job are the expense of the homeowner, the cost of doing business could be limited to bleach and cleaning supplies. Estimate the amount spent on supplies per job and deduct this from the gross income. If the income is considered monthly, do not average.

INCOME

SELF-EMPLOYMENT

3. Inform the self-employed applicant/recipient that for future eligibility determinations, he must keep and submit an account of income and expenses. Document the case record that the explanation was made. If MA/85 is involved, set a reasonable future date (based on the normal income cycle of the self-employment enterprise) to review the case for correct income. Example: A self-employed yardman has regular maintenance agreements with ten customers and picks up other jobs on a one-time basis. Based on discussion with the individual, establish a three to six month period for him to keep appropriate records and recalculate the family's income. If the income would make the family ineligible, terminate the adults in the MA/85 case and allow the children to complete their 12-month certification. A claim may be necessary if it appears that the individual intentionally misrepresented the income at the initial approval.

4. If the recipient fails to provide the necessary information at the next review after he has been given the opportunity to keep records of income and expenses, notify the recipient that his eligibility on financial factors cannot be determined and his case will be closed. If only the gross income can be verified without expenses, use the gross amount and allow the up to \$90 earnings work expense only from the calculated monthly average.

INCOME

FARM INCOME

FARM INCOME (Use when tax records are not available.)

Farm income made from growing and selling crops is a type of self-employment that will require special handling. The sale of crops may be combined with the sale of livestock or with dairy farming. Income from the sale of cotton and grains/soybeans and other crops is usually received annually at harvest and represents the net income the farm family will have to live on for the coming year. The countable income is determined by deducting the costs of producing the crop(s) from the proceeds of the crop(s). The farm operation may be on land that the farmer owns or is buying or may be under lease or may be farmed on shares with the land owner.

The net self-employment from any farm operation must be added to other earned and unearned income received by the family before the income disregards can be applied as in the general self-employment instructions described above.

Determining the Annual Farm Income Cycle

The period of time over which the farm income is calculated must cover the annual cycle from one crop settlement time to the next. This must be established in discussion with the farmer to identify the type of farming involved and the period of time over which the income is produced. If more than one farm crop is involved in the annual cycle, it may be necessary to determine the crop income separately and then combine the totals. The farmer may grow cotton for the major fall crop income and may grow and sell fresh produce in the spring and summer months. Or the farmer may have a combination of livestock and farming with the sale of extra grain crops or hay/silage. The different types of farm operations will determine the annual cycle of income from each type. Document the case to establish the annual cycle that will be used for future reviews as well.

If the farming operation is too new to have completed a full crop cycle, see discussion below on determining farm income. If the farmer reports that he will discontinue the farming operation at the close of the current season, the income must still be annualized to make the best estimate of the averaged income for the budget month. If the farmer has already moved into other employment but has not made a final settlement on the farm income, the worker must determine whether there will be continuing income from the farm source based on the final settlement for the farm year. Combine any annualized farm income with other employment or unearned income of the family. Document the case and explore the farm operation again at the next review to see if income continues from that source.

INCOME

FARM INCOME

Determining Farm Income

The county Consolidated Farm Service Agency (CFSA) is the USDA umbrella agency that handles most of the programs that provide income to farmers. There are many different programs and funding may change yearly according to Congressional appropriations, crop disasters or other factors. Past programs handled by the CSFA to provide support to farmers include:

- Production Flexibility Contract Program (PFC) – payment is based on contracted acres
- Loan Deficiency Payment (LDP) – income guarantee
- Conservation Reserve Program (CRP) – land rented to government not to plant crops or to plant trees
- Crop Disaster Program (CDP) – declared by the President
- Loss payment for crop failure
- Noninsured program payments

Note: Federal Crop Insurance is handled by a separate USDA office.

When farm income must be verified through the county CFSA, request verification of “all government payments” made to the individual through that office rather than requesting information from specific programs. The general request will allow that office to verify all farm-related income, including designated sharecropper arrangements.

Farm income is computed by deducting the allowable expenses of production from the gross income received from the sale of the crop. The net is then averaged over the 12-month period for the monthly income.

If more than one family group is included in the farming operation, the net income must be shared with the other working members. Document the discussion with the family to determine how to divide the income appropriately, such as, an adult son may farm with his father and receive a prorata share of the income.

Deductible Expenses for Crops

The following items are generally required to produce a crop and are to be allowed after verification is received of the gross proceeds:

1. Seed, fertilizer, and chemicals for insect control and/or soil treatment.
2. Hired labor not to exceed the average local wage for farm day labor.
3. Machinery rental not to exceed the average local rate for rental.

INCOME

FARM INCOME

4. Feed and veterinary expense for work stock, if any, specifically required in the production of the crop.
5. Gas and oil for machinery used in the production of the crop.
6. Purchase and/or repair of small tools and equipment such as hoes, plows, etc. Repair of large machinery, such as a tractor, can be included in this item, but the purchase of expensive farm machinery cannot. See above for general self-employment for similar exclusions.
7. Interest paid on the crop loan or credit account for the current year only – no expenses for prior years may be carried over.
8. Cash rental paid for the use of land or the value of the percentage of the crop given in lieu of a cash payment.
9. The net loss on the crop for the previous year when the loss must be repaid from the proceeds of the current completed crop if the same farming arrangements have continued. If the farmer has moved, did not repay the loss on the previous crop, and his source of credit suffered the loss, then the loss was not his and no deduction can be made.

Follow these general guidelines when calculating income from other types of farming operations, such as chicken, livestock and dairy operations. These may not be an annual cycle of settlement as crops. These operations must be handled as self employment and annualized unless the family demonstrated that the income is received and work done over a shorter period of time.

The key to calculating farm income is verification and documentation. If expenses cannot reasonably be verified by the farmer or confirmed by the CSFA as reasonable expenses in such an operation, do not allow. Do not rely solely on the farmer's IRS tax return for countable income because various deductions and/or expenses cannot be allowed. Refer to allowable expenses in Self-Employment section above.

INCOME

UNEARNED INCOME

ESTABLISHING UNEARNED INCOME

Payments from benefits, pensions, and compensations must be considered in determining financial need for HB eligibility. These payments are usually received monthly or weekly and are continuous. However, some are received for only limited periods and some are received as retroactive lump sum payments that may include a current month's payment for a benefit that will continue.

Unearned income from all sources must be reported and verified, unless specifically excluded. (See the list of excluded income sources later in this section.) SSI recipients, both parents and children, are excluded from the HB budget groups so that income amount and verification is not required. Other sources of unearned income may include RSDI, child support, workers' compensation, unemployment benefits, interest income and dividends, rental payments not considered self-employment, regular cash contributions to the family, veterans' benefits, retirement payments, etc. Returns from a capital investment in the form of dividends are considered unearned income when the person is not himself actively engaged as a business.

All sources of income must be explored with the family during the face to face interview with the parent/caretaker at the time of the application, annual review, or when a new case member is being added. The worker must require the client to take all necessary and appropriate steps to obtain other benefits for which they appear to be potentially eligible unless good cause can be shown for not doing so. Failure or refusal of the person to apply for other benefits without good cause will result in denial or termination of the adult at any time and the children at application or annual review. Failure or refusal of an individual to provide verifications of all required income sources will cause the case to be denied or closed.

The following is a list of the most common sources of unearned income:

- **Social Security** - Retirement, Survivors, and Disability Insurance (**RSDI**) - This program is administered by the Social Security Administration for the purpose of providing workers and their dependents with a partial replacement of loss of income due to retirement, disability, or death of the worker. The amount of the payment is based on the wages the worker received and the amount of Social Security taxes paid in before he/she retired, became disabled, or died. Employment in government at the federal level is not covered by Social Security. Federal employees are covered by a federal retirement plan. Verify by requesting a SVES record and/or by reviewing documents in the applicant's possession.

INCOME

UNEARNED INCOME

- **Supplemental Security Income (SSI)** - This Program is also administered by the Social Security Administration to insure that the aged, blind, and disabled individuals have sufficient income to meet basic needs. The amount of SSI varies with the amount of other income the individual has for basic maintenance. The benefit is measured against a standard amount after allowing certain disregards. Individuals may qualify for both RSDI and SSI to a maximum combined total. SSI individuals also receive Medicaid and will not be included in the HB budget group. Verify by requesting a SVES record and/or by viewing documents in the applicant's possession.
- **Unemployment Compensation** - This program is administered by the Department of Employment Security and provides weekly payments to qualified workers who have been employed in jobs that are covered by State law for such benefits and who have been laid off or lost their jobs through no fault of their own. Unemployment compensation is terminated when the accrued benefits have been received or when the person returns to work. Verify by contacting the Department of Employment Security or by viewing documents in the applicant's possession.
- **Trade Adjustment Assistance (TAA)** - TAA is available to workers who lose their jobs or whose hours of work and wages are reduced because of increased imports. Benefits include reemployment services such as job training, job search, and relocation services. Group eligibility for the employees of the affected company must be determined and certified by the Labor Department. Maximum coverage period is up to two years. Verifications can be made by viewing check stubs or statement from the company or contact Department of Employment Security. Count as income only the cash assistance through this resource.
- **Trade Readjustment Assistance (TRA)** - In addition to the TAA services, a weekly trade readjustment allowance (TRA) may be payable to eligible workers when all unemployment benefits have been exhausted. Request verification from Department of Employment Security when there is reason to believe the person is eligible for TRA and the benefits cannot be verified by the individual's notice or check stubs.
- **Workers' Compensation** - The Workers' Compensation Act provides compensation for disability or death from an injury occurring on the job. Most employers with five or more employees are required to have this coverage. Temporary workers' compensation payments are considered earned income when the payments are employer-funded and made to an individual who remains employed during recuperation for a temporary illness or injury pending his/her return to the job. Verify income by check stubs or contract or send name and Social Security Number to the Training Officer at DOM State Office.

INCOME

UNEARNED INCOME

- **Severance Pay** - This is considered unearned income. This is not the same as wages and salaries paid after employment ends, such as the last pay check which is considered earned income. If received in ongoing installments, it would be considered normal, recurring income.
- **Railroad Retirement Benefits** - Employees who retire with at least ten years of service from railroads engaged in interstate commerce may receive benefits administered by the Railroad Retirement Board. When the income cannot be verified by the award notice, check stub or direct deposit or write for verification to the Railroad Retirement Board's office that serves the county in which the person resides.
- **Mississippi Teachers' and Public Employees' Retirement Benefits** - State retirements are based on length of service and salary. If income cannot be verified by check stubs or award notices, write to PERS, Room 1400, State Office Building, Jackson, MS 39201. Remember that a check stub or direct deposit proof will not be the gross income because insurance and other withholdings may not be shown.
- **Veterans' Benefits** - Veterans' payments and benefits may be made to individuals who have served on active duty in any branch of our military services and to their dependents. Benefits include: payments for disability for the individual and dependents, payments to widows and dependent children or to dependent surviving parents, benefits for education or training, and in some cases, increased compensation for attendant care. Verification may be made by award notices or check stubs or by calling the VA toll-free line in Mississippi at 1-800-827-1000. Veterans' benefits are not the same as retirement pay. Retirement is handled from the Finance Centers of the various services and should be verified by award notices or check stubs. Look for gross pay before any withholdings.
- **Military Service Allowances and Allotments** - Allowances and allotments received from individuals in active military service (absent parents) are considered support payments and treated as such. Allotments from stepparents in the military will be handled as any other unearned income for the family. The entire amount of this allotment is deducted from the service individual's pay. The worker should be alert to the family situation for parents who are absent because of military duty. If the applicant/recipient family reports no support from the absent parent, the caretaker should be made aware that a request for assistance should be made through the Veterans' Service Division of the Veterans Administration, 100 West Capitol Street, Jackson, MS 39269. The Service does not provide an "award notice" since this is not a military payment, so the best verification is to see the check or proof of direct deposit.

INCOME

UNEARNED INCOME

- **Income from the Mississippi Band of Choctaw Indians** - The semiannual cash payments usually distributed in July and December are not excluded income. The payments will be averaged over the months intended to cover. The payments can be verified by the Tribal office and are usually the same for each individual so that repeated verifications may not be necessary once the specific amount for each payment is determined. Document the case at the initial application and include these payments as regular income.
- **Grants, Loans and Scholarships for Educational Purposes** - Title IV educational income and income funded by the Bureau of Indian Affairs for educational or training assistance shall be totally excluded. The income from these sources must be reported but does not need to be verified as excluded income unless the source is questionable.

Non-Title IV, HEA/BIA grants and scholarships including work study funds and funds provided by the Carl D. Perkins Vocational and Applied Technology Education Act must be handled according to the purpose for which received and whether or not the funds are available directly to the student for maintenance purposes or paid to the school. Exclude funds paid directly to the school. Educational income is to be counted for the period it is intended to cover. Count as unearned income the maintenance funds received and deduct student expenses that must be paid from the income, such as tuition, books, fees, etc. Income from work-study is earned income; allow appropriate earned income disregards. The student will be responsible for providing verification of the income and deductions claimed.

- **Support from Absent Parents** - When a child's parent(s) is absent from the home, the worker must ask about income from child or spousal support. There may be income because of a court order for child and/or spousal support, or there may be voluntary contributions in cash or in-kind. In-kind payments may be in the form of furnishing shelter, making other payments for the family, providing transportation, or providing clothing or other essentials for the child. In-kind contributions are not counted as income unless the arrangement is in lieu of court ordered support. If the parents have agreed that the court ordered support may be made in-kind instead of a cash payment, the value of the in-kind payment must be counted as unearned income not to exceed the amount specified in the court order. If the verification shows that the parent is paying less than the court-ordered amount, use the amount actually received by the client. The parent/caretaker should be able to verify the support income by a copy of the check, verification from the Division of Child Support Enforcement, direct bank deposits, or court order. This income is considered to belong to the child and should be entered as such in the system.

INCOME

UNEARNED INCOME

- **Benefits from Insurance Policies** - Many types of insurance policies make ongoing payments to policy holders for sickness, medical bills, disability, or death. The insurance policy should distinguish between payment to the individual for period of illness or disability and payment for medical expenses directly to the provider. Payment for medical services should be reported as third party coverage. Payments received by the individual for sickness or accidents must be counted as unearned income when there are recurring payments. Verification is the responsibility of the applicant.
- **Interest Income and Dividends, Trust Fund Payments** - Income received monthly or less frequently as regular ongoing payments from these sources must be considered as unearned income to the family. If paid less frequently than monthly, average the amount over the period intended to cover and include as income to the family. Verification is the responsibility of the applicant.

INCOME

DISREGARDED INCOME

INCOME TOTALLY DISREGARDED

The following types and sources of income are totally disregarded by Federal Regulations when establishing eligibility for Health Benefits. Families with income from these sources should report the amount and type of income, but verification is not necessary unless questionable.

1. Temporary Assistance for Needy Families (TANF) and Refugee Cash Assistance (RCA).
2. Any payments distributed per capita or held in trust and any interest and investment income from purchases made with funds pursuant to any judgment of the Indian Claims Commissioner or the Court of Claims in favor of any Indian Tribe. The semiannual bonus payments made to members of the Mississippi Band of Choctaw Indians are not excluded under this section.
3. Payment for supportive services or expenses to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to those serving under the Domestic Volunteer Service Act of 1973 including VISTA and ACTION.
4. The value of supplemental food assistance received under the Child Nutrition Act of 1966 or the National School Lunch Program, as amended.
5. The weekly needs-based payment made to certain trainees under the Job Training and Partnership Act of 1983 (JTPA).
6. Payments for supportive services made to participants under the TANF Work Program (TWP) See Earned Income list for the treatment of non-excluded earned income received from TWP.
7. The tax-exempt portions of payment made pursuant to the Alaska Native Claims Settlement Act.
8. Value of food stamps or surplus commodities received from USDA and meals furnished through the Nutrition programs for the elderly.
9. Payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act.
10. Supplemental Security Income (SSI) payments (recipient is excluded from HB budget group).

INCOME

DISREGARDED INCOME

11. All student financial assistance, including Work Study, provided under programs in Title IV of the Higher Education Act (HEA, Title IV), such as BEOGG or Pell Grants, or under Bureau of Indian Affairs student assistance programs (BIA) See Educational Income earlier in this section.
12. Foster care board payments, Title IV-E and Mississippi Adoption Assistance payments.
13. Payments made under various Housing Acts. These payments are handled by HUD, and can be identified by that agency.
14. Earnings of full-time students under age 18 who are not full-time employees, or earnings of students under age 18 who are in school at least half time. This includes on-the-job training through JTPA.
15. Payments received by persons on home dialysis or made to a home dialysis aide under the Incentives for Home Dialysis experiment funded by the Department of Health and Human Resources NOTE: The earnings of the person providing this service are considered as earned income.
16. Income from other agencies or organizations provided for a designated purpose, such as rehabilitation services, emergency payment of energy bills, home dialysis, JTPA training allowances, etc.
17. Income in kind.
18. Any non-recurring income received too infrequently or irregularly to be reasonably anticipated. This may include cash gifts for birthdays, graduation, etc.
19. Redress monies paid to eligible Japanese and Aleuts who were unjustly treated during World War II.
20. Payments received as a result of Agent Orange litigation.
21. Any payment from earned income tax credit (EITC).
22. Monthly allowance paid to a child of a Vietnam veteran for any disability resulting from Spina bifida suffered by the child.
23. Payments from emergency or major disaster, such as from FEMA.
24. Payments provided under Chapter 35 of Title 42 of the U. S. Code, Programs for Older Americans, that are not wages or salary.

TABLE OF CONTENTS
SECTION E

BUDGETING

<u>Subject</u>	<u>Page</u>
BUDGETING GUIDELINES	
Introduction	5000
Budgeting Method	5000
Income Verification Periods	5000
Budgeting Guidelines	5001
INCOME DISREGARDS	
Child Support Disregard	5004
Income Disregards	5004
Disregard from Earnings	5004
Special Disregards for MA/85-\$30 + 1/3 Disregard	5005
EXTENDED MEDICAID	
Extended Medicaid Coverage for MA/85	5006
Adding a Child to the Extended Medicaid Case	5007
SPECIAL BUDGETING PROCEDURES	
Special Budgeting Procedures	5008

BUDGETING

BUDGETING GUIDELINES

INTRODUCTION

When all nonfinancial eligibility factors have been met, i.e., children are under age 19, pregnancy and due date are verified, third party coverage is documented, and for MA/85, deprivation and child support factors are satisfied, the next step in the application process is testing eligibility on income. The worker must have clearly established the persons for whom eligibility will be tested and will have the earned and unearned income verified for each individual who will be included in the budgeting process.

Budgeting Method

Eligibility of all HB categories is determined using normal monthly income. This means that eligibility must be established on all factors, including need, that can be reasonably expected to exist in the application or review month and/or in future months as applicable. Use income verification from the prior calendar month to establish household income unless there are known changes for the application/review month or the following month.

Income Verification Periods

“Normal” income is usually defined as income from the most recent full calendar month, prior to the interview month, excluding income not usually received in a month. The verification must cover a full month and should not be averaged, except for the sources of income that must be annualized (or averaged over the period intended to cover, such as a contract). Regular income should not include overtime not usually received, a third or fifth paycheck, a one-time bonus, etc. However, known changes for the review month or following month should be taken into account.

If a future change is indicated at the time of application or review, eligibility must be based on the future change. Future changes must be verified and may include changes such as a job change, increase or reduction of hours or salary, normally recurring overtime, a layoff, etc. Document the case to show why the prior month’s income is not being used.

BUDGETING

BUDGETING GUIDELINES

Use the following guidelines for obtaining verifications of income:

- An application is received on February 10th. Income for the full month of January should be verified to determine eligibility.
- An interview for December redetermination is completed on November 5th. Income from October should be used to determine eligibility.
- An application is received on March 29th. Income verification for all pay periods in March was provided at application and may be used to determine eligibility. In this case, do not require income verification for the prior month unless the March income does not reflect the household's regular monthly income. Use income for the application or review month only when the application/review occurs at the end of the month and all regular paychecks/income for the month have been received based on normal pay cycles. Otherwise, use the prior month.

Once eligibility is established, the child will have an annual certification period (12 months). Adults are not guaranteed a 12-month certification period; changes, such as the end of the postpartum period, failure to cooperate with child support, increased earned income for the adult in MA/85, etc., may cause ineligibility prior to the end of the adult's review period. Take action to close eligibility when these changes occur.

Budgeting Guidelines

Testing eligibility on income will include these general guidelines:

- The MA/85 category requires eligibility to be tested on both a gross and net income standard, and the family must be eligible on both levels.
- If the only child in the family is receiving SSI but would be eligible for 85 (deprivation, age, etc.) other than the receipt of SSI, the parent(s) can be covered in the 85 case. The SSI received by the child does not count as income, nor is the child included in the budget or household size.
- The income of the legal parent(s) in the home must be tested with their children except for the SSI recipient (parent or child) who is excluded from the AU with his/her income.
- The applicant may opt to include or exclude a child and his income from the AU and eligibility testing in all COE's except MA/85.
- When the application is for children only, include the legal parents in the home in the AU and begin testing household income for all applicant children in the PL/91 category.
- When the application is for children and non-pregnant adults (parents or needy caretaker relative), follow the specific requirements for the MA/85 category.

BUDGETING

BUDGETING GUIDELINES

- When the application is for the pregnant woman only, the spouse in the home and any minor children she chooses will be included in the AU with their income. In this instance, coverage may or may not be requested for the children. A legal spouse in the home cannot be excluded unless he receives SSI.
- When the pregnant woman under age 19 applies solely due to pregnancy, test for eligibility in 88 using the minor's income. Parental income is disregarded in this instance.
- When application is made for a child under 19 who is also pregnant, test eligibility for ongoing coverage based on living arrangements, household composition, and income.
- A stepparent's income can affect the spouse's eligibility in the 85 program, but it cannot affect the stepchildren's eligibility in any HB program.
- When the application includes legal parents with their children and other children who are relatives or non-relatives, test eligibility separately for the different groups of children. Parents and their legal children must be tested together. Other children in the home should be tested in sibling groups.
- The income of a caretaker who is not a legal parent cannot make a child ineligible for benefits. Likewise, the income or needs of a related or nonrelated child must not make the caretaker's own child(ren) ineligible. Test separate budget groups when there is more than one group of siblings within the household, such as the parent's own child or grandchildren.
- Children with third party coverage cannot be tested for CHIP eligibility although siblings with coverage may be included in the household size to test CHIP eligibility for a child who is not covered.
- Apply appropriate disregards of earned income for students under 18 in all HB categories of eligibility and for households who receive child support.
- Apply appropriate disregards for earned income in MA/85 cases after eligibility has been established on the gross test.
- Refer to the Income section for instructions for handling self-employment and farm income and other income that must be averaged or annualized, such as contractual income.
- Refer to the Income section for instructions on handling "zero income" situations.
- The income and needs of a non-qualified or illegal alien with children who meet citizenship/alien status requirements will be included in the AU; however, the ineligible alien(s) cannot receive Medicaid in an HB program.

BUDGETING

BUDGETING GUIDELINES

- The income of the sponsor for the qualified alien or nonqualified alien must be included in the budget for the 85 program only.

BUDGETING

INCOME DISREGARDS

CHILD SUPPORT DISREGARD

Up to \$50 per month will be disregarded when the family receives child support. Disregard the actual amount up to \$50 from the gross amount of countable child support. This is the only disregard or deduction applied to unearned income.

INCOME DISREGARDS

The gross earned income from all sources will be calculated and allowable earnings disregards deducted before the resulting net income, including all child support and other countable unearned income for the budget group, is used to test eligibility for HB categories. The disregards are the same for all HB categories, except that the Medical Assistance (MA/85) category has additional earnings disregards and extended coverage.

Deductions from Earnings

The following disregards will be allowed from earned income to calculate net countable income:

1. Work Expense - Up to \$90 for each employed person in the AU will be deducted from the verified gross earnings. Disregard the actual earned income if the amount is less than \$90.
2. Dependent Care Deduction - Dependent care expense may be deducted from earnings when the family reports actual out-of-pocket expense for dependent care for children or for a disabled adult household member in the AU or who would be in the AU if eligible (SSI recipient). Verification of the expense is not required, unless the expense is questionable such as the age of the child. The expense must be reasonable and work related. The dependent care allowance maximums are:
 - Actual expense up to \$200 per month for a child under age 2 years, or
 - Actual expense up to \$175 per month for a child or disabled member age 2 years or older.

Note: Dependent care expenses for a child over age 12 should be documented to explain the need for the expense.

Convert child care paid weekly to a monthly amount by multiplying the weekly amount by 4.33 and the biweekly amount by 2.17. Actual child care should be entered on the financial screen of the child for whom it is being paid to allow the system to control the maximums. If a future change in child care expenses is indicated at the time of application or review, eligibility must be based on the future change.

BUDGETING

INCOME DISREGARDS

Special Disregards for MA/85 - \$30 + 1/3 Disregard

When the MA/85 case has passed the gross income test but must be denied or closed on net income that includes earnings, the case must be tested for eligibility allowing the \$30 + 1/3 earnings disregard. However, this disregard may be allowed only once beginning October 1996, unless there is a break in Medicaid eligibility of at least 12 consecutive months for the assistance unit that includes the adult. In addition, the new or increased earnings must be reported within 10 days of the date the change occurred for the \$30 + 1/3 disregard to be applied. If the change is not reported timely, the disregard is forfeited. The case should be clearly documented with the reason the family is not eligible when the \$30 + 1/3 is not applied to new or increased earnings. Apply the disregard as follows to the new or increased earnings of eligible individuals:

- The \$30 + 1/3 earned income disregard may continue for 4 months. The months do not have to be consecutive.
- Then the \$30 disregard may continue for up to 8 more months, provided the family remains eligible on the gross and net income tests. These months are consecutive.

Note: When the eligible family's earned income fluctuates monthly, the disregard may be applied as needed to allow the family to continue to be eligible. The first four-month \$30 + 1/3 disregard period may spread over more than a four-month period, but may not exceed four months for this disregard. Refer to the tracking sheet for this disregard. Once used, this earnings disregard shall not be applied again unless there is a break in Medicaid eligibility of at least 12 consecutive months for the assistance unit that includes the adult. Document the case carefully to show when this disregard was applied.

It is possible for the family to receive the \$30 + 1/3 disregard for four months and the \$30 disregard for eight months for a total of 12 months.

When the earnings increase is reported timely as a change report or at redetermination and the family is otherwise eligible for the disregard, test for continued eligibility with the \$30 + 1/3 disregard beginning the month following the increase. If a change in household income is reported timely and would close the MA/85 case on net income, test eligibility allowing the \$30 + 1/3, if applicable. After determining eligibility for the adult and children in MA/85 with the \$30 + 1/3 for 4 months, test allowing only the \$30 disregard. If eligible, continue in the MA/85 COE until redetermination or the end of the 12 months, whichever is sooner. The household must comply with redetermination requirements in order to receive coverage for any months remaining beyond their redetermination.

The MA/85 family must be informed at application and case reviews of the possibility of the earnings disregard (if eligible for it) and the requirement to report changes timely.

BUDGETING

EXTENDED MEDICAID

EXTENDED MEDICAID COVERAGE FOR MA/85

As indicated previously in Section B, there are two opportunities available **only** in the MA/85 category for extended Medicaid coverage periods.

1. Families with adults included for Medicaid coverage in the MA/85 category who have received Medicaid in MA/85 in three of the prior six months who lose eligibility because of increased earnings or loss of the \$30 + 1/3 disregard, are eligible for Extended Medicaid for up to 12 consecutive months. This is the only way the adult(s) can remain covered beyond the point of ineligibility. The increase in income cannot terminate the children's coverage during their 12-month guaranteed coverage period.

If the income change is not reported timely, eligibility is determined by a "look back" process where actual normal income information is gathered after the fact, and the worker determines the month at which the income increased to the point of causing ineligibility. The month after the month of ineligibility is the first month of Extended Medicaid.

If the change is reported timely, coverage would be extended to include 12 months of Extended Medicaid benefits at the time of review (caused by the reported change). However, it should be noted that the client is not exempt from redetermination requirements during the Extended Medicaid period. Therefore, if the change is reported during the family's 12-month review period, the case will be documented with the months of eligibility for Extended Medicaid; if redetermination requirements are met, the remainder of the Extended Medicaid period will be allowed. At the end of this period, the adult's eligibility will be terminated and the children placed in another COE, if otherwise eligible.

If at any time the adult reports loss of earnings or decreased earnings such that the family is eligible in MA/85 again, the case should be documented to indicate ongoing eligibility and the end of Extended Medicaid. There is no limit to the number of times a family can be eligible for Extended Medicaid provided they have been eligible three out of six months. If the case would be ineligible after the 4 months of \$30 + 1/3 or after the 8 months of \$30, the worker must document the case record of the first month of ineligibility as the first month of Extended Medicaid and allow Extended Medicaid in accordance with policy discussed above.

2. The members of a MA/85 case may be eligible for up to 4 months of Extended Medicaid when an increase in Child Support income will cause ineligibility. The month after the month of ineligibility is the first month of Extended Medicaid.

If the change is reported timely, coverage would be extended to include 4 months of Extended Medicaid benefits at the time of review (caused by the reported change). The redetermination requirement must be met if the four month period extends beyond the family's 12-month eligibility period. If not reported timely, the worker will determine the remaining months, if any. If the adult was ineligible after the 4 months, a claim for overpayment should be worked.

BUDGETING

EXTENDED MEDICAID

Adding a Child to the Extended Medicaid Case

A child may only be added to the Extended Medicaid Program when

- The child was in the case at the time that eligibility for Extended Medicaid was determined,
- The child leaves the home after receiving Extended Medicaid benefits, and
- The child returns home during the Extended Medicaid period

BUDGETING

SPECIAL BUDGETING PROCEDURES

SPECIAL BUDGETING PROCEDURES

It is imperative that correct relationship codes be entered in MEDSX to ensure the system works these budgets correctly.

Stepparent Without a Common Child

A stepparent's income can affect his/her eligibility in the MA/85 program, but it cannot affect the stepchildren's eligibility in any HB program.

MA/85

If the parent is requesting Medicaid coverage, first determine if the stepparent's income is adequate to meet the needs of the stepparent, the stepparent's legal dependents (own children) and the MA/85 parent. This is called a deeming budget and is a net test budget using the stepparent's income and any income of his dependents in the home (excluding the income of the MA/85 spouse). If a deficit exists, the MA/85 parent and the parent's children are tested for eligibility in the MA/85 program using only their income. They may or may not be eligible. If a surplus exists, the MA/85 parent is not eligible to be included in the MA/85 Program and the children will be tested in an FPL program using the income of the parent and the children.

Example: A mother and her 3 children live with her spouse who is not the father of her children. She has \$500 gross wages and he has \$200 gross wages per month. Coverage is requested for her and her children.

Deeming Budget

Mother
Spouse \$200 - Wages
 - 90 - Work Expense
 \$110 - Net Wages

\$293 - Net Need Standard for 2
-110 - Net Wages
\$183 - Deficit - She can go in 85 budget with her children

85 Budget

Mother - \$500 - Wages
Child 1
Child 2
Child 3

 \$500 - Gross income

BUDGETING

SPECIAL BUDGETING PROCEDURES

\$819 - Gross test for 4
-500 - Gross income
\$419 - Passed gross test

\$500 - Gross Wages
- 90 - Work Expense
\$410 - Net Income

\$443 - Net Need Standard for 4
-410 - Net Income
\$ 33 - Deficit - She and children eligible for MA/85

If the stepparent has children in the home and wants coverage, a deeming budget as discussed above can be worked to see if they can be covered in a separate assistance unit within the same 85 case. This would be the only way a stepparent without a common child could receive Medicaid coverage. Eligibility for the stepparent's children can be tested in an FPL program using the income of the stepparent and the children if ineligibility exists in the MA/85 Program.

87, 88, 91

Test the blended family with no common child as one assistance unit to determine if all children will be eligible for Medicaid. If all children are eligible for Medicaid, one AU may be approved. Do not test the blended family for CHIP as one AU when all children are ineligible for Medicaid. In this instance, the case should be split into two assistance units including the woman and her children and the man and his children to determine eligibility for each family group. Eligibility for the children in each separate unit will be determined for Medicaid first and then for CHIP. A stepparent's income cannot cause ineligibility for the stepchildren.

BUDGETING

SPECIAL BUDGETING PROCEDURES

Example: A mother and her two children (ages 3 and 4) live with spouse and his child (age 12). Her wages total \$1800 a month and she pays \$100 a month child care for each child. His wages total \$1200 a month.

Test all of them together first for Medicaid

Mother - \$1800 - Wages
 Spouse - \$1200 - Wages
 Her child 1
 Her child 2
 His child _____
 \$3000 - Total gross wages
 - 90 - Her work expenses
 - 90 - His work expenses
200 - Child care
 \$2620

<u>91</u>	<u>87</u>	<u>88</u>
\$1885	\$2506	No children
<u>-2620</u>	<u>\$2620</u>	Under age 1
Surplus	Surplus	

None are eligible for Medicaid

1. Mother \$1800 - Wages
 Her Child 1
 Her Child 2 _____
 \$1800
 - 90 - Work expense
- 200 - Child care
 \$1510

<u>91</u>	<u>87</u>
\$1341	\$1784
<u>-1510</u>	<u>-1510</u>
Surplus	\$ 274 - Deficit

BUDGETING

SPECIAL BUDGETING PROCEDURES

2. Her children are eligible for 87

Spouse	\$1200 - Wages
His child	
	\$1200
	- 90 - Work expense
	\$1110

<u>91</u>	<u>87</u>	<u>88</u>	<u>99</u>
\$1070	No one	No one	\$2139
-1110	Under 6	Under 1	-1110
Surplus			\$1029 - Deficit

His child is eligible for CHIP

CHIP

If eligibility failed in any Medicaid Program for the blended family or for each his/her family unit when split into separate AU's, test the units separately for CHIP. Do not test the blended family for CHIP as one AU. The needs of an unborn are not included in the CHIP budget.

Stepparent with a Common Child

MA/85

When the case includes a common child, both parents must be included and, therefore, no deeming is required in the initial budget. However, if the common child is ineligible, and either parent is requesting Medicaid coverage, first determine if the stepparent's income is adequate to meet the needs of the stepparent, the stepparent's legal dependents (own children, including the common child), and the MA/85 parent. Work a deeming budget using the stepparent's income and any income of his dependents in the home (excluding the income of the MA/85 spouse). If a deficit exists, the MA/85 parent and the parent's children (not including the common child) are tested for eligibility in the MA/85 Program using only their own income. They may or may not be eligible. If a surplus exists, the MA/85 parent is not eligible to be included in the MA/85 Program, and the children will be tested in an FPL program using the income of the parent and the children.

87, 88, 91, CHIP

First, budget the family as one unit. Do not split into separate AU's at this point. If Medicaid eligibility exists for children in the AU, place the common child and other eligible children in the appropriate Medicaid program, and then test CHIP eligibility for any remaining children.

BUDGETING

SPECIAL BUDGETING PROCEDURES

If total ineligibility exists for the family unit in any Medicaid program, the common child is not eligible for Medicaid. Medicaid eligibility will then be determined for each separate (his/her) AU excluding the common child. Children eligible for Medicaid will be authorized for coverage in the appropriate program. When Medicaid eligibility/ineligibility has been determined for all the children in this manner, test CHIP eligibility for the common child and any other children who do not yet have a program assignment by budgeting the entire family unit in the 99 Program.

Example: A mother and her 2 children (ages 2 and 4) live with her husband and his child (age 10), and they have a one-year-old child in common. She has monthly wages of \$2200 and she pays \$150 a month child care for each child. His monthly wages are \$2600 and they pay \$200 child care for the baby. They are requesting coverage for the children.

Test them all together as one AU for Medicaid only.

Mother -	\$2200 - Wages	
Father -	\$2600 - Wages	
Her child 1		
Her child 2		
His child		
Their child		
	\$4800 - Total gross income	
	- 90 - Her work expense	
	- 90 - His work expense	
	- 200 - Child care - 1-year-old	
	- 150 - Child care - 2-year-old	
	- 150 - Child care - 4-year-old	
	\$4120	
<u>91</u>	<u>87</u>	<u>88</u>
\$2156	\$2868	\$3989
<u>-4120</u>	<u>-4120</u>	<u>-4120</u>
Surplus	Surplus	Surplus

None are eligible for Medicaid

Split into separate AU's to determine Medicaid eligibility – common child is not eligible for Medicaid

BUDGETING

SPECIAL BUDGETING PROCEDURES

1.	Mother - Her child 1 Her child 2	\$2200 - Wages <hr style="width: 10%; margin-left: 0;"/> \$2200 - Total gross income - 90 - Work expenses - 150 - Child care - 2-year-old - 150 - Child care - 4-year-old <hr style="width: 10%; margin-left: 0;"/> \$1810 - Net income			
	<u>91</u>	<u>87</u>		<u>88</u>	
	\$1341	\$1784		\$2481	
	<u>-1810</u>	<u>-1810</u>		No one	
	Surplus	Surplus		Under 1	

Her children not eligible for Medicaid

2.	Spouse His child	\$2600 - Wages <hr style="width: 10%; margin-left: 0;"/> \$2600 - Total gross income - 90 - Work expense <hr style="width: 10%; margin-left: 0;"/> \$2510 - Net income			
	<u>91</u>	<u>87</u>		<u>88</u>	
	\$1070	\$1422		\$1978	
	<u>\$2510</u>	No one under 6		No one under 1	
	Surplus				

Father's child not eligible for Medicaid

BUDGETING

SPECIAL BUDGETING PROCEDURES

After Medicaid tests fail for all children, put back together to determine CHIP eligibility.

Mother - \$2200 - Wages
Spouse - \$2600 - Wages
Her child 1
Her child 2
His child
Their child _____
\$4800 - Total gross wages
- 90 - Her work wages
- 90 - His work wages
- 200 - Child care 1-year-old
- 150 - Child care 2-year-old
- 150 - Child care 4-year-old
\$4120 - Net income

99

\$4312
\$4120
\$ 192 - Deficit

All children eligible for CHIP

Minor Parent Living at Home

A child under 19, living at home with one or both parents, who has a child(ren) of his/her own is a minor parent. The needs and income of the minor's parent(s), i.e., the grandparent(s), must be included in the budget to determine the minor parent's own eligibility; however, the income of the grandparents cannot make the minor's own child(ren) ineligible. For this reason, the eligibility determination for the minor parent will be made separately from the determination for the minor's own child(ren).

First budget the needs and income of minor parent, his/her parent(s) and any siblings to determine the eligibility for Medicaid or CHIP. Test for the MA/85 Program if the minor's own parents request coverage, noting that if the minor parent is over age 18, an 18 year old's income cannot make the parents and siblings ineligible in the MA/85 Program. If eligible for MA/85 or another FPL COE, authorize coverage in the appropriate COE for the members of this AU. If ineligibility results, the minor parent cannot be approved for coverage.

Next budget only the needs and income of the minor parent and his/her own child(ren) to determine eligibility for the minor parent's child(ren)

BUDGETING

SPECIAL BUDGETING PROCEDURES

Minor Living Independently

When a child under 19 has moved out on his/her own and is no longer under parental control or responsibility, the needs and income of the minor's parents are not considered in the eligibility determination. In this instance, the minor is the head of her own household. This is applicable to single minors living independently or married minors living independently or with their parents, whether they have children or not.

Pregnant Minor

Only the needs and income of the pregnant minor requesting coverage solely due to pregnancy and the unborn are tested for eligibility in the 88 Program when the application requests coverage for the pregnant minor only. The needs of the parents and their income should not be included even though the pregnant minor lives in their home.

If the application contains a request to include the parents or other minor siblings, information must be provided on the parents and other children too. The AU would be tested for Medicaid eligibility beginning with the MA/85 Program if the parents request coverage for themselves. If the AU is eligible for Medicaid, the pregnant minor would be placed as a child in the age and income appropriate program, i.e., MA/85 or 91. If the AU is ineligible for Medicaid, the pregnant minor would be tested as an adult in the 88 program including the needs and income of the pregnant minor and the needs of the unborn. The remaining siblings would be tested for CHIP eligibility using the needs and income of the parents, the pregnant minor, and the siblings. The needs of an unborn are not included in the CHIP budget.

TABLE OF CONTENTS
SECTION F

ELIGIBILITY DETERMINATION PROCESS

<u>Subject</u>	<u>Page</u>
APPLICATION PROCESS	
Filing the Application	6000
Timely Processing Standard	6001
Right to Apply	6001
Where to Apply	6002
Accepting and Handling HB Applications	6002
Residence	6004
Residence Change during Application Process	6004
Face to Face Interview	6005
Conducting the Interview	6005
Collecting and Documenting Information	6007
Withdrawal of Application	6008
Determining Eligibility	6008
Verification Required	6008
Documentary Verifications not Required	6009
Evaluating Information for Eligibility Determination	6009
Testing Eligibility	6010
Authorization Procedures	6010
Certification and Notification	6011
Types of Notices	6011
Approvals/Benefit Start Dates	6011
Approval Notices	6012
Adverse Actions	6013
Denials	6013
Denials/Terminations for Other Reasons	6014
Denial/Termination Notices	6015
Notices to Request Information	6014
Notice of Case Review	6015
Appointment Letter	6015
Special Procedures	6015
Retroactive Medicaid	6015
Children in DHS Custody	6017
Children in Independent Living or Other Arrangements	6018
Reapplications	6018
Request for Assistance by an Employee	6019

TABLE OF CONTENTS
SECTION F

ELIGIBILITY DETERMINATION PROCESS (cont'd)

<u>Subject</u>	<u>Page</u>
APPLICATION PROCESS – Cont'd	
Request for Assistance by an Immediate Family Member	6019
Addition of Individual to an Active Case	6019
Transfer of Cases between Offices	6021
Individual Transfers	6021
Admission to an Institution	6022
Voluntary Request for Closure	6022
Medicaid Reinstatements and Corrective Action	6023
Benefits during a Hearing Process	6023
REDETERMINATION PROCESS	
Redetermination Process	6024
Face to Face Interview	6024
Frequency of Reviews	6024
Verification Requirements	6025
Changes Reported	6026
Reporting Requirements	6026

ELIGIBILITY DETERMINATION PROCESS

APPLICATION PROCESS

FILING THE APPLICATION

The application process consists of all the activities during the thirty (30) day timely processing period from the time the signed Mississippi Health Benefits Application is received by the RO until the notice of approval or denial is mailed to the applicant. This includes a face to face interview with the applicant. The applicant may make the request on behalf of the child(ren) in the home, for him/herself and children in the home, as a pregnant woman with children, for herself only as a pregnant woman, or for herself for family planning services only.

The HB application may be obtained at the DOM Regional Offices, from local Health Departments, clinics, service providers, outreach workers, etc., but must be the official document, either published by DOM or authorized for printing from the DOM website. A photocopy or facsimile of the authorized form will also be accepted but must include all sections of the authorized HB application. All applications must include an original signature of the applicant.

The parent with whom the child lives must make the application; or, if there is no legal parent in the home, the application for the child may be made by a relative or non-relative adult caretaker with whom the child lives. If there are two legal parents in the home, only one parent who will be the case head/head of household is required to sign the HB application. In some instances minors can make application for themselves, i.e., pregnant minor requesting coverage solely due to pregnancy or independent minor.

The application process includes multiple steps to determine eligibility:

- Submitting a completed and signed HB application to the RO in person or by mail or fax or completing the application with the worker in the RO or with the outstationed worker
- Participating in a face to face interview with the RO worker to review the Health Benefits application, determine the individuals who will be tested for benefits, identify other needed verifications and information, receive explanations about services available and how to access services, including EPSDT, child support, etc. The worker must explain the individual's rights and responsibilities, the timeliness standard for processing the application, and the importance of the applicant responding promptly to provide needed information. Review the statements on the HB application above client's signature. Workers must explain that failure to provide information timely can mean denial of the case, denial of individuals in the case, or impact the eligibility start date.
- Providing verifications of income, dates of birth, SSN, citizenship, and other information required to determine eligibility.
- Documenting the case, evaluating evidence, and testing for eligibility in possible categories to support the approval or denial of benefits.

ELIGIBILITY DETERMINATION PROCESS

APPLICATION PROCESS

- Authorizing or denying benefits based on case evidence
- Notifying the applicant of the decision and, if eligible, giving the beginning dates of coverage to set the next case review.

Note: The annual review to determine continued eligibility will follow the same steps as the initial application, including the face to face interview, except that verification of basic data information, such date of birth, SSN, etc., will not be required again. Income must be verified at each certification and whenever an individual is being added to the case. A face to face interview will be scheduled when the family requests to add an individual other than a deemed infant to the case. The reason for this is that the income must be verified and, if eligibility is found, the other household members may also be given a new certification period.

Timely Processing Standard

Mississippi Health Benefits applications must be processed within thirty (30) days beginning with the date the signed application is received in the RO. Not more than 30 days may lapse between the receipt of the application and the date of approval or notice of denial, including the time required for supervisory review and data entry into MEDSX. If there is a delay in processing, the reason must be clearly documented by the worker with a supervisory review prior to the 30th day. The delay should always be client caused or requested.

The 30-day standard of promptness includes the administrative processing time. Each RO should have a plan for timely processing, which allows sufficient time for supervisory review and corrections. Authorization or denial by the 30th day is mandatory.

Applications should generally be processed in the order in which received, taking into consideration promptness or delays in receipt of verifications or, in some cases, urgent need. In no case shall an application be approved without the proper verifications and documented eligibility established for the individual. Note: The monthly processing deadline for CHIP is 5:00 on the 21st of each month except February, which is the 17th. If the 17th or 21st falls on a week end or holiday, the disposition must be completed by the last working day prior to the 21st. Because there is no retroactive coverage in CHIP, timeliness is especially critical to prevent possible loss of coverage.

Right to Apply

Under Federal law and State plans, an individual must be given the opportunity to apply without delay and to have eligibility determined in a timely manner, within the standard of promptness. When an individual inquires about making an HB application at any RO, an application must be given, and the person should be offered the opportunity to file the application that day.

ELIGIBILITY DETERMINATION PROCESS

APPLICATION PROCESS

Where to Apply

The HB application should be filed in person or by mail or fax with the RO that serves the county or specific area in which the individual for whom the application is being made resides. However, HB applications received for persons who reside in other RO service areas will be accepted at any Regional Office; these applications will require special handling as described below. The receiving RO must review each application upon receipt to determine which RO should serve the applicant. Confirm the accuracy of the address with the person presenting the application if there is a question.

The 30-day time for processing HB applications begins whenever any RO receives the signed application, whether or not it is the appropriate RO based on the actual residence of the applicant.

The RO accepting the HB application must offer to conduct the in-person interview on the day the application is received. If the applicant declines the opportunity for an interview on the day the application is brought into the RO, the required interview must then be scheduled as soon as possible but no later than ten days.

Note: If the initial HB application is received by fax, the applicant should add an original signature at the face to face interview.

Accepting and Handling HB Applications

Follow these guidelines for receiving and handling all HB applications for the standard of promptness:

When the HB application is received in the appropriate RO, the RO will immediately take the following action:

1. Date stamp the application form to establish the timely processing period.
2. Register the application prior to the interview that day or within 48 hours of receipt.
3. Provide the applicant who has brought the application to the office the opportunity to have a face to face interview that day. If the applicant declines to be interviewed that day, schedule the interview for the next possible date within ten (10) calendar days from the date the application was received.
4. If the HB application is received in the mail (or other than in person) at the correct RO location, date stamp it upon receipt, register the application within 48 hours, and mail the applicant an appointment notice for the required face to face interview to be conducted within 10 days by the RO. Include information the applicant should bring to the interview to facilitate the completion of the eligibility determination.

ELIGIBILITY DETERMINATION PROCESS

APPLICATION PROCESS

5. The RO will conduct the face to face interview on the day the HB application is received or at the scheduled appointment time, provide the applicant a list of all needed information to complete the eligibility determination, and process the application within the 30-day processing period.

When the HB application is presented in person to the incorrect RO location, the receiving RO will accept the application and must immediately take the following steps:

1. The receiving RO will accept the application and date stamp to begin the timely processing period; however, that RO will not register the application in the system for processing.
2. The receiving RO will offer to conduct the in-person interview. If the offer is accepted, the interview will be conducted by an intake worker and the completed application form will be mailed to the appropriate RO for eligibility determination. (The RO receiving the application will not register the application in the system regardless of whether or not the person chooses to be interviewed that day.)
3. Inform the applicant of the RO location that will complete the application and handle future HB contacts and case reviews.
4. If the walk-in applicant chooses to have the face to face interview conducted in the receiving RO, the intake worker will include with the application form all copies of needed documents and verifications presented at the interview and will write a narrative of the interview and explanations made on the DOM-367 contact form for the case record, including the information requested to complete the eligibility determination and document the explanations for EPSDT, child support and other HB services.
5. The RO that initially receives the HB application must mail it (and all verifications and documentation from the in-person interview) to the appropriate RO within 24 hours of receipt.
6. The appropriate RO must then register the HB case within 48 hours of receipt using the actual application date, i.e., the date the application was received and date stamped by the receiving office.

When the HB application is received by mail (or otherwise not in person) by the incorrect RO, the following steps must be taken:

1. The 30-day processing standard starts with the date an application is received by the RO, regardless of the location.
2. Date stamp the application but do not register the application in the system.

ELIGIBILITY DETERMINATION PROCESS

APPLICATION PROCESS

3. The RO receiving the HB application must mail it (with any attachments provided) to the appropriate RO within 24 hours of receipt.
4. The appropriate RO will register the case within 24 hours of receipt using the actual application date, i.e., the date the application was received and date stamped by the receiving office.
5. Complete the application following regular timeliness standards.

Note: If the HB application is already registered and is being processed when the receiving RO discovers that the case should have been handled by another RO, the receiving RO will complete the determination of eligibility before transferring the case to the correct office. The RO supervisory staff will coordinate the case completion and transfer as needed. The head of household will be notified of the RO transfer if the case is approved.

Residence

The applicant household must be residing in Mississippi at the time of application and indicate his/her intent to reside in the State. Inquiries and applications received from out of state require a response from the receiving RO. Applications received from out-of-state residents will be denied and the notice must be mailed to explain that the applicants will need to reapply upon their arrival with the intent to remain in Mississippi. There is no durational requirement for residence. However, persons who are in Mississippi for a visit with the intent to return to their home out of state shall not be eligible for Mississippi Health benefits. Applicants must always be given the right to make an application and receive a decision on their case.

Residence Change During Application Process

Follow these general guidelines:

- If the applicant reports during the application process that the family is moving to another location in the State, the application should be completed by the first RO and, if approved, transferred to the new RO location.
- If the application is denied, do not transfer the record until the person reapplies in another location.
- If the family reports that they are all moving out of state, determine when the move will occur and that all individuals in the HB request will be leaving. If the family meets all Medicaid eligibility requirements, the case may be approved for requested retroactive months and possibly the month of application. However, the family must be informed that they cannot be covered in two states for the same month. If the move is early in the month, it may be to the family's advantage to apply in the new State. In such case, deny the application and approve any retroactive months if applicable. If the family would be eligible for CHIP, deny the case since they would not be eligible in a future month.
- If only a part of the family is leaving the state, identify the remaining household/applicants and work the case accordingly.

ELIGIBILITY DETERMINATION PROCESS

APPLICATION PROCESS

FACE TO FACE INTERVIEW

At least one face to face interview must be held with the head of household or designated representative during the application process. It is permissible in cases in which the worker is assured that the head of household is unable to act for himself for a designated representative to act on his behalf. The head of household should sign the DOM-302, Designated Representative Statement, authorizing the representative to participate in the interview and eligibility process. A DOM-302 will also be required when the head of household is someone other than a legal parent who is applying on behalf of children other than his/her own and who is not applying as a needy caretaker relative.

The initial interview appointment must be scheduled no later than 10 days from the application receipt date. If the applicant fails to keep the interview appointment and does not contact the RO office to request and attend another interview, the application will be denied no later than the 30th day, or next working day when the 30th day falls on a weekend or holiday.

The applicant is the primary source of information about eligibility for the household or budget group. Certain eligibility factors must be verified and other information simply provided. The worker should also make reasonable efforts to assist the applicant to secure the needed information, such as suggesting alternate sources of verifications when the preferred document is not available. The parent may have lost the child's birth certificate, but she can ask the school to provide a copy of the birth certificate from the student's record to verify the date of birth, etc.

Conducting the Interview

The worker must include at least the following discussion and explanations during the initial and annual face to face interviews:

1. Explain the appropriate Health Benefits categories and eligibility requirements for each. For example, the discussion for an application for a 25 year old pregnant woman requesting benefits for herself only need not include a description of CHIP, EM/87, etc., but should include the details of IS/88, the postpartum extension, the deemed eligible infant provision, and the required information and verifications to determine eligibility.
2. Explain that eligibility must be tested for Medicaid categories first before considering CHIP. Persons who qualify for a Medicaid category cannot be eligible for CHIP.
3. The worker and applicant should complete the application together during the interview if one has not already been completed. When a completed form is available at the interview, the worker will review the HB application for completeness and identify the persons for whom benefits are requested. Ask for information that has been omitted from the application form. Confirm residence and citizenship. Question zero income households as outlined in the Income Section.

ELIGIBILITY DETERMINATION PROCESS

APPLICATION PROCESS

4. Explain the use of documentary evidence and other records for verifying factual data. Explain the requirements for age proof, income verification, providing the SSN, reporting third party insurance, options for child support, etc.
5. Define the items that must still be verified and the items that must still be provided to complete the eligibility determination. Do not request verifications on household members who are not considered in the application process, such as children the parent chooses to exclude from the application or caretakers other than parents. The household cannot exclude a legal parent unless he/she receives SSI.

An application made by an aunt for a two-year-old niece should include the child's SSN or enumeration proof, documentation to show that the legal parents are not in the home with the child, status of third party insurance coverage or medical support, and verification of the child's age and sources of income, such as child support, contributions, Social Security, etc. Unless the aunt requests coverage for herself as a needy caretaker relative, do not request the aunt's income, proof of relationship, etc. If coverage is not requested for other children in the home and all other eligibility factors are met, HB eligibility would be tested for a household of one with only the child's income. The aunt should be made aware of voluntary child support services.

6. Explain the 30-day timeliness standard for application processing. Encourage the applicant to respond promptly to all requests for information/verifications. Provide applicant with a list of needed items and a time frame to return the information, no later than 12 days from the interview. If it appears that CHIP eligibility will be tested, explain timeliness when the date the required information is received could affect the child's start date.
7. Review the explanations on the HB application regarding the use of the SSN to verify information, the exchange of information with SSA, IRS, and Employment Security, etc.
8. Review the Rights and Responsibilities section of the application, including the non-discrimination statement, assignment of all third party insurance rights to DOM, and the right to a fair hearing.
9. The RO must provide an explanation of HB services available. The explanations must include information about the EPSDT program and referrals for the services. The parent or caretaker must be asked if he/she would like to select an EPSDT provider. If one is chosen, the referral will be made to the Maternal and Child Health Bureau for processing.
10. Explain child support requirements and other factors specific to 85 when coverage is requested for the adult with the children or for the pregnant woman. Also, explain that child support services can be voluntarily requested if needed for a child with an absent parent or for a child for whom paternity has not been established in the Poverty Level Programs (not CHIP).

ELIGIBILITY DETERMINATION PROCESS

APPLICATION PROCESS

11. Explain that verifications must be provided for each individual in order for that person to be approved. Failure to provide birth verification for the second child could mean that only one child could be approved and the other denied benefits until the verification is completed.
12. Explain the eligibility certification periods, the requirements for regular case reviews, and the changes that must be reported during the certification period, such as address changes, the child leaving the home, etc.
13. Let the applicant know when to expect a decision/notification on the application and what to look for in the mail.
14. Encourage the adults approved for full Medicaid benefits to get a yearly health screening from their doctor or clinic. This physical examination will not be used to determine eligibility for the Medicaid program.

Normally the interview will be held in the RO or at the location of the outstationed worker. However, the interview may be held at another location by mutual agreement, such as at a hospital when the child is admitted for an extended stay or for critical care, to complete the application timely. In rare situations (again such as hospitalization of the child or parent requesting benefits and no designated representative is available), the receiving office may request a worker in another location to conduct the interview. It will be the responsibility of the original RO to coordinate the scheduling of the interview through appropriate administrative channels and to notify the applicant of the schedule.

Collecting and Documenting Information

During the initial interview, the worker should collect and document as much information as possible to support the eligibility determination. Steps should be taken to identify and secure all necessary items by giving the applicant a list of things to provide within the next 12 days, or shorter period, depending on the timely processing period. The case documentation must include at least the following:

- The completed and signed HB application
- Verification documents for proof of age and citizenship
- Verification of citizenship for adults requesting coverage
- SSN's or proof of application for a SSN
- Verifications of income for all persons in the Assistance Unit/Standard Filing Unit
- Documentation of expenses
- Proof of pregnancy and due date if applicable
- Budget forms (or system documentation)
- Forms/notices requesting information
- Third party insurance information
- All other screen prints, data matches, and other documents necessary to determine eligibility

ELIGIBILITY DETERMINATION PROCESS

APPLICATION PROCESS

Withdrawal of Application

After the applicant has signed the appropriate documents and discussed his situation, or at any point during the application interview, the worker may find that eligibility requirements will not be met, such as income over 200% FPL, no eligible child in the home, etc. The worker will explain this to the applicant and give him/her the opportunity to decide whether to continue the application or withdraw his request.

When the applicant decides to withdraw the request for HB, it is not necessary to complete the remaining eligibility verifications and evaluation. The worker will document the case to show the withdrawal and, whenever possible, get the applicant to complete a written request for withdrawal. The form can be signed with the notation "withdrawn." Deny the application and send the client notice of the action.

DETERMINING ELIGIBILITY

All eligibility factors must be met before the individual and/or case may be approved. The application is a combination of information that must be verified and information that must be provided by client's statements/self-declaration. Explain the verification requirements to the applicant/recipient during the interview and provide written documentation of needed items. Remind the applicant/recipient that eligibility cannot be approved or continued without all required verifications.

In the initial interview, the worker should explain the specific sources of information to be consulted, if known at the time, and tell the applicant that other sources will be consulted as necessary. The application form signed by the applicant provides consent that allows DOM to verify all factors of eligibility and to share information with other agencies as necessary to secure information, unless that outside source requires written permission from the applicant. The worker will use outside references only when necessary and at the request of the applicant to obtain outside information to establish eligibility and will protect the confidentiality of the individual in performing this task.

Verifications Required

The following documentary verifications are required to establish eligibility at application:

- Age proof for all children for whom benefits are requested
- Proof that a Social Security number has been applied for when the number is not provided
- Income of all individuals in the Assistance Unit(s) or Standard Filing Unit for MA/85
- Pregnancy and due date, if applicable
- Alien status for noncitizens requesting coverage
- Cooperation with child support. If the adult has been sanctioned for noncooperation through MDHS Division of Child Support, verification of compliance must be provided before the adult can be covered by Medicaid.

ELIGIBILITY DETERMINATION PROCESS

APPLICATION PROCESS

- Proof of relative within the specified degree for needy caretaker determination in MA/85 only
- Termination of third party insurance prior to approval for CHIP
- Cooperation with the TANF Work Program if applicable
- SSN of all applying - A SVES response is required to validate the number provided, displayed on the card, or legal document. If the Error Condition, Verification, or Record Type indicates the number is not valid or not verified due to discrepant date, the discrepancy must be resolved and documented in the case record. The contact type of application or redetermination will initiate a SVES request. The household members should be entered into MEDSX at the time of the application interview or at the time the redetermination appointment letter is mailed to insure the response will be received prior to action being taken.
- Identity of the head of household or authorized representative – view a picture ID or 2 (two) forms of other non-picture identification that verify the identity of the person. Worker knowledge can be used if the individual is personally known and attested to by the DOM employee.

Documentary Verifications not Required

The following information must be provided/self-declared by the applicant and must be documented in the case record, but it does not require verification (unless questionable) to establish eligibility at application: (If the worker has reason to believe that statements given by the applicant are not correct, the case should be documented and further information requested.)

- Residence / address
- Household size for the Assistance Unit or SFU
- Third party insurance coverage
- Deprivation if MA/85
- Absent parent information for MA/85 (Absent parent information is usually self-declared until MDHS verifies the information). Other COE's may voluntarily request referral to Child Support Enforcement.
- Dependent care expense, paid out of pocket.

Evaluating Information for Eligibility Determination

The worker must review the application following the interview to be sure that all information needed for eligibility determination has been provided or requested to be provided within 10 days. If there is still information pending, the application will be held for receipt of this information before further action can be taken, or will be denied no later than the 30th day if the information essential to the eligibility determination is not provided.

ELIGIBILITY DETERMINATION PROCESS

APPLICATION PROCESS

When the income verification is provided by check stubs, the worker must carefully review the check stubs to confirm that the information shows a full month's income representative of a normal month's income. Check the dates on the check stubs to be sure the dates are consecutive. Stubs from various pay periods are not acceptable unless year to date totals can be used to calculate a missing check.

The worker will promptly resolve any conflicting information and make a decision regarding information to be considered valid. The worker and worker's supervisor must be alert to inconsistencies in information and use the concept of the "prudent" or "reasonable" man. This refers to the element of judgment that must be exercised by all individuals in making choices, evaluating statements made by others, and the like. When the information is questionable or conflicting, the applicant should be contacted to provide additional information or clarification.

Example: The HB application form shows the name of the employer as Acme Car Services, but the check stubs are from an employer named Auto Specialty Shop. This could mean that the person has changed jobs recently, at which point a review of prospective income must be made to determine what is anticipated from the new job vs. past income. The discrepancy could mean that the business is under new management and the name changes have not been properly made on the payroll records. Or it could mean that the check stubs belong to someone else. In any case, the information must be resolved before a determination of eligibility can be made.

Example: The parent applies on February 2nd and reports wages paid weekly on Fridays by check. The proper calendar month of wage verifications would be the four Fridays in January. However, the worker discovers that the 4 check stubs provided for verifications are 2 weeks in January, one week in December and a week in October. The worker must request more verification of income to receive four consecutive weeks in January.

Testing Eligibility

The worker must review each eligibility factor to be sure that all needed information has been collected and that family income and ages of children have been verified or that the pregnancy and due date has been verified. The information will be entered into MEDSX and eligibility will be determined, and appropriate COE placement will be made for each eligible applicant. If a child is denied for failure to provide a required verification, a reapplication must be filed for a future determination of eligibility.

Before completing the application for supervisory review, the worker must be sure that all supporting documentation is in the case to validate the worker's recommendation for approval or denial. Approval or denial notices will be prepared for release by MEDSX. Remember that the disposition of the application must be completed with sufficient time allowed for completion of the supervisory review and disposition within the 30-day processing period.

ELIGIBILITY DETERMINATION PROCESS
APPLICATION PROCESS

AUTHORIZATION PROCEDURES

Authorization procedures must follow Division of Medicaid guidelines for timeliness and supervisory/administrative functions. Follow system procedures for data entry to ensure that the case/individual will be correctly handled and reported, coverage dates are established correctly, and the review and eligibility periods will be handled timely.

CERTIFICATION AND NOTIFICATION

When the decision is reached concerning eligibility or ineligibility of the application, case review, or individual, a written system-generated notice of the decision will be sent to the head of household. Notices also provide the client a notice of rights and responsibilities and the opportunity to request a fair hearing.

Types of Notices

Notices will be available in MEDSX to cover the variety of situations that require written notices to the client. The wording of the notice is dictated by the type of contact and/or the denial/closure reason code or the decision made by the system according to data entered. Application and redetermination contacts will always initiate a notice. Special review contacts will initiate a notice in few instances. Automated eligibility will take care of most notices in traditional special reviews such as address and demographic changes, age out, etc.

Approvals / Benefit Start Dates

The following general principles apply to benefit start dates:

- If the person is eligible in the application month for a Medicaid category, the start date will be the 1st day of the application month.
- If the family is not eligible for Medicaid in the application month based on income, but would be eligible in the following month, the benefit start date will be the 1st of the month following the application month.
- The start date for the CHIP category will be the 1st day of the month following the approval if completed prior to the 21st.
- If the family has requested retroactive Medicaid and was found eligible in the retroactive months, the start date will cover the retroactive period and forward through the 12-month regular certification period. Do not include the retroactive months in the 12-month certification period.
- If the retroactive eligibility could not be determined during the 30-day timely processing period and may be approved later, use the 1st day of the application month as the start date. If the family is determined eligible for retroactive coverage when verifications are provided later, enter the retroactive period of eligibility (start and end date), special review contact, and process eligibility for the retro period.

ELIGIBILITY DETERMINATION PROCESS

APPLICATION PROCESS

- If the family requested retroactive Medicaid for unpaid medical bills in the three months prior to the application but are found eligible for CHIP in the application month, it is possible to approve retroactive Medicaid coverage in one or more of the prior months and application month when eligibility for Medicaid can be proven for that period. The circumstance could occur when there has been an income increase in the application month that is expected to continue, or when there was a decrease in household size in the month of application.
Example: The mother of two children has received a job promotion and higher salary in the month of application. Her income in the application month and prospectively for the coming months makes the children eligible in CHIP. However, she has unpaid medical bills from two months ago that she needs help to pay. Approve the CHIP category for the next possible month and process by the same steps in the preceding bullet.
- If the family or an individual is not eligible in any HB category, deny the individual or case.

Approval Notices

- Approval for Medicaid must include names and ID numbers, start dates, names of persons denied, and the review due date.
- Approval for CHIP must include names and ID numbers, names of persons denied, explanation that it is a 12-month coverage period, and explanation that BC/BS will provide notice of start dates, CHIP card, and provider information.
- Approval of Medicaid for a pregnant woman must include an explanation of coverage limits, postpartum coverage, expected date of delivery/early termination, and deemed eligible infants provisions.
- Approval of retroactive benefits separately from the initial approval must include the names, ID numbers, and retroactive coverage dates.
- Approval of annual redetermination for continuation of HB must include names of persons to continue, names to be terminated, names moving between Medicaid and CHIP categories, and the next annual review date.

Identification number is assigned permanently for the individual. An individual should not destroy the cards because the cards can be re-activated if the case reopens in the future.

ELIGIBILITY DETERMINATION PROCESS
APPLICATION PROCESS

Adverse Actions

Adverse actions include denials and terminations of an individual or case. Notices involving adverse action require supervisory approval no later than the 19th of the month (the deadline for February is the 17th) to be effective the following month. However, some adverse actions require notification to the household but do not require 12 days advance notice. These actions are:

- Client request
- Moved out of state
- Approval for SSI
- Death
- Public institution

Each adverse action notice must include the following information: explanation that a reapplication can be done at any time, phone number of RO to respond to questions, and a notice of the opportunity to request a fair hearing.

Note: Terminations and adverse changes require a 12-day Advance Notice prior to the effective date of the action.

A “just in time” notice is issued on CHIP actions with a future date. This notice is issued on the first day of the month prior to the effective day of the action.

Actions taken after July 2005 and worked through automated eligibility will generate notices in advance for known changes that will occur prior to next redetermination such as age out and pregnancy ending.

Denials

The application or request to add a person must be denied when:

- The individual or family is ineligible on verified income or age.
- The family or individual failed to verify income or a child’s date of birth, or to provide the SSN, or failed to meet some other eligibility factor, such as cooperation with child support in MA/85. (For child support noncooperation, deny the adult but approve the child in another HB category, if possible.)
- The individual or group fails to meet one or more of the eligibility criteria, such as the pregnant woman failed to verify pregnancy and due date, but did provide verification of family income and ages of her other children. If the children qualify, approve the children but deny the mother because she failed to meet eligibility criteria.

Note: Remember that the entire case or an individual within the case may be denied or approved.

ELIGIBILITY DETERMINATION PROCESS

APPLICATION PROCESS

Denials / Terminations for Other Reasons

Applications or requests to add a person may also be denied because of:

- Aging out in the month of application when approval for CHIP cannot be processed by the 21st of the application month.
- Inability to locate the applicant,
- At the request of the applicant,
- The applicant moves out of state before the application is completed, or
- Because the individual has become incarcerated or institutionalized.

HB benefits may be terminated because:

- Child ages out and is no longer eligible for any HB category,
- Family/individual is no longer eligible on income at regular review,
- Individual dies
- Adult is no longer eligible when last child becomes ineligible in MA/85 (includes last child turning age 18 and moving to PL/91),
- Family/individual moves out of state,
- Parent/caretaker requests closure,
- Status changes from FCC to Foster Care
- End of postpartum period,
- Adult is sanctioned for failure to cooperate with Child Support Enforcement,
- Failure to complete the annual review, etc.
- Approved in error

Terminations defined as “early out” reasons because they shorten the regular 12-month certification period of a child include:

- Child aging out (becoming too old for a category) Eligibility in other HB categories must be tested to complete the 12-month certification period whenever possible up to age 19,
- Child dies,
- Parent or caretaker requests closure,
- Child moves out of state, or
- Child becomes institutionalized or incarcerated.
- Child becomes covered by Medicaid through SSI or Foster Care
- Approved in error
- Unable to locate after reasonable efforts

“Early out” termination reasons specific to CHIP include:

- Becoming covered by other full health insurance (third party coverage),
- Becoming eligible for IS/88, or
- Becoming covered by Medicaid through SSI or Foster Care

ELIGIBILITY DETERMINATION PROCESS

APPLICATION PROCESS

Denial/Termination Notices

Each adverse action notice must include the following information: explanation that a reapplication can be done at any time, phone number of RO for possible questions, and fair hearing information. Additionally, the notice will contain the following:

- Date of ineligibility must be stated
- Reason(s) for denial/terminations must be stated based on denial/terminate code or decision made by system according to data entered
- When the Medicaid category closes and the child moves to CHIP, the notice must also include the end date of Medicaid and start date of CHIP to prevent duplication of service.
- No notice is required when moving from one Medicaid COE to another except when moving to or from 88

Notices to Request Information

- Requests for information must include the specific information needed to complete the application or review.
- Used to schedule appointments for interviews

Notice of Case Review

- The household must receive timely notice of the annual review due date and will be notified of the time frame and steps to complete the review to determine eligibility for continued benefits. The notice will include the requirement for a face to face interview in the RO.

Appointment Letter

- This notice will be initiated by the RO to schedule appointments for interviews.

SPECIAL PROCEDURES**Retroactive Medicaid**

Applicants and recipients may request retroactive Medicaid for up to 3 months prior to the application month provided they were eligible at the time and state they have unpaid medical expenses. Verification of medical expenses is not required. If the retroactive period is requested at application and the family/individual is eligible in those months, the benefit start date is the first month of continuous retroactive eligibility. The retroactive months are not included in the 12-month certification period. If retroactive coverage is requested after approval, or eligibility could not be determined by the approval date, or if eligibility is non-continuous due to a change in regular income, work and approve the retroactive months in a separate time period. Document the case.

ELIGIBILITY DETERMINATION PROCESS

APPLICATION PROCESS

The income for the retroactive months must be verified if the normal income for those months requested is significantly more or less than the income verified for the most recent full month used to determine ongoing eligibility. If it is not significantly different according to the client's statement and is not questionable, the verification received to determine ongoing eligibility can be used to determine retroactive eligibility.

Example: Mary Smith applies on April 7th. The case is approved and is certified for April 2005 through March 2006. If 3 months retroactive coverage was requested at application and all months approved, the time period start date should be January 2005.

Example: Jane Jones applies on July 25th. The case is approved and is certified for July 2005 through June 2006. Retroactive coverage was requested for April, May, and June. After working the budget, the worker determined that Ms. Jones was ineligible in May. The worker must work a time period of April 1st – April 30th. June is the first month of continuous eligibility in MEDSX with a time period of June 2006 ongoing. The review due date is July 2006.

As noted in Section E, the \$30 +1/3 earned income disregard can be used in retroactive months in MA/85, if needed in order to be eligible. The retroactive months will be counted as part of the 4 months of \$30 + 1/3 disregard and must be documented in the case record.

There is no retroactive coverage in CHIP, except for a newborn eligible only in CHIP and for whom application is made within 31 days of the birth. There is no automatic/deemed coverage for an infant born to a CHIP-eligible mother (teen not moved to IS/88 to cover the pregnancy or who meets the income standard for 99). Deemed eligible infants must not be placed in CHIP.

A CHIP approval could possibly be approved for up to 3 months of retroactive Medicaid. This could occur at application when regular monthly income places the children in CHIP, but the income was less prior to application, allowing eligibility in a Medicaid category. It is also possible the application month could be included for Medicaid coverage, but it is not one of the 3 retroactive months. The income must be verified and entering in separate time periods will be required in this situation to authorize Medicaid eligibility.

Note: An individual cannot be authorized for CHIP for any month in which the individual is covered by a Medicaid category, and vice versa.

ELIGIBILITY DETERMINATION PROCESS

APPLICATION PROCESS

CHILDREN IN DHS CUSTODY

Foster Children in the custody of the Mississippi Department of Human Services (DHS), Division of Family and Children Services, are normally placed in licensed foster homes in the community with relatives or nonrelatives or in group homes. The type of placement generally determines which agency, i.e., DHS or Division of Medicaid (DOM), is responsible for Medicaid eligibility.

- Children placed in licensed foster homes where a board payment is received normally have eligibility for Medicaid (IV-E and CWS programs) determined by DHS. If the child's income exceeds the income maximum with DHS, an application may be filed with DOM by either the Social Worker or the foster parent so that eligibility can be determined in a Federal Poverty Level Medicaid Program or CHIP based on the child's needs and income. Siblings placed together will be included in one Assistance Unit (AU) when applicable.
- DOM determines eligibility for foster children placed with relatives or nonrelatives. The responsible adult will file the application with DOM and the child's eligibility will be based on the needs and income of the child and siblings when applicable. Eligibility for the appropriate COE, 91, 87, 88, or 99, will be determined. If the adult requests coverage, eligibility for MA/85 should be assessed.
- Older children may be placed by DHS in group homes or independent living arrangements. The social worker will usually file the application with DOM and act as the designated representative; however, the case will be set up in the minor's name. Eligibility in a Federal Poverty Level Program or CHIP will be determined based on the minor's needs and income. Siblings placed together will be included in one Assistance Unit when applicable.
- In a foster care board payment case, special procedures are used to handle an application for a child in foster care through Family and Children's Services (FCS) who is not eligible for Medicaid through FCS. The application can be made through FCS or by the parent and can be put in the child's name with the Social Worker or the foster parent as the representative. Regardless of the method of application, the RO should work with FCS to approve the application. If the HB application is received from the caretaker of a foster child, whether relative or board payment placement, the RO should contact FCS to confirm ineligibility through FCS Medicaid.

The application for a foster child can be registered in the foster parent's name or in the child's name. If the foster parent has an existing case, the foster child may be added to the case. A case registered in the foster child's name should never be approved in the MA/85 Program. The guaranteed 12-month eligibility period is applicable to a foster child.

If the foster child moves from one placement to another during the guaranteed 12 months, the child should not lose coverage during the regular 12-month certification period unless he/she meets an early out reason.

ELIGIBILITY DETERMINATION PROCESS

APPLICATION PROCESS

The Division of Youth Services with DHS receives custody of children for placement in the Oakley or Columbia Training Schools. These children are considered residents of a public institution for the duration of their incarceration and are not eligible for Medicaid. Regional Offices may receive reports from parents or DHS that a child included in an F/C/C program has entered a training school. Action should be taken for the next possible month to terminate the child's Medicaid/CHIP eligibility. Entry into a public institution is an early out reason for F/C/C programs.

CHILDREN IN INDEPENDENT LIVING OR OTHER ARRANGEMENTS

Children may be placed in group homes, schools, orphanages, adoption agencies, etc., by their parents/guardians or the courts. In some situations, legal custody may be retained by the parent/guardian with the facility having physical custody of the child. In other instances, the facility may have both legal and physical custody. The custody arrangement generally determines whether the child is an independent minor or remains a dependent of his parents or guardian.

- When legal responsibility for the child remains with the parent/guardian, the application should be filed with the RO responsible for the parent's/guardian's county of residence. (If the child is not from Mississippi, application would be made in the state where the child's parent/guardian resides.) Regular Assistance Unit (AU) policy applies. The AU will include the needs and income of the parents, the child, and any siblings included in the application. In the case of a guardian, the AU will include the needs and income of the child and any siblings included in the application.
- When the facility has both legal and physical custody of the child, the application will be filed with the RO responsible for the county where the facility is located. A social worker or other responsible person with the facility will usually file the application with DOM and act as the designated representative; however, the case will be set up in the minor's name. Eligibility in a Federal Poverty Level Medicaid Program or CHIP will be based on the minor's needs and income. Siblings placed in the same facility will be included in one AU.

Reapplications

A person whose application has been denied or whose case was terminated may reapply at any time. The ID number for the individual or other family members will already be assigned and other information not subject to change may be available in the case record. The applicant will not be required to verify previously verified eligibility factors that are not subject to change, such as date of birth and SSN. However, the individual must verify current income and provide verifications or information on any other factor that is subject to change. All eligibility factors must be documented and eligibility tested just as for the initial application, including the face to face interview.

Generally, the same procedures are required on the reapplication as for the initial application. See discussion of reapplication processing on page 6024.

ELIGIBILITY DETERMINATION PROCESS

APPLICATION PROCESS

REQUEST FOR ASSISTANCE BY AN EMPLOYEE

When an employee of the Division of Medicaid wishes to apply for medical assistance, the RO Branch Director will be responsible for taking the application and determining eligibility.

The Branch Director may delegate the application to the Assistant Supervisor or Medicaid Specialist who has no close relationship to the employee applying. The Branch Director remains responsible for ensuring that eligibility has been determined objectively. An eligible employee may be certified to receive Medicaid benefits. After the determination has been made, the Branch Director will submit the case to the Division Director for review and signing of appropriate forms, including the notice to the applicant of approval or rejection and the authorization of MEDSX. The exception to the procedure is an instance in which the staff member is related to the Branch Director. In that instance, an eligibility employee other than the Branch Director will take the application. The Division Director will review the facts, make the decision, and sign off in MEDSX. Staff members are prohibited from determining eligibility for relatives.

REQUEST FOR ASSISTANCE BY AN IMMEDIATE FAMILY MEMBER

When an immediate family member of an employee wishes to apply for assistance, the Branch Director in the RO will be responsible for assigning the application to the Assistant Supervisor or Medicaid Specialist. The Branch Director remains responsible for ensuring eligibility has been determined correctly. After the determination has been made, the Branch Director will sign the appropriate forms, including the notice to the applicant of approval or rejection and the authorization of MEDSX.

If an immediate family member to the Branch Director applies, the Assistant Supervisor will be assigned the application. Send it to the Division Director for approval.

Case records for employees and family members should be locked in the Branch Director's file cabinet. For cases on immediate family members of the Branch Director, the Division Director will keep the case locked in his/her file cabinet.

The immediate family is defined as spouse, parent, stepparent, sibling, child, stepchild, grandchild, grandparent, son-in-law, daughter-in-law, mother-in-law, father-in-law, brother-in-law, or sister-in-law. Child means a biological or adopted child or a child for whom the individual stands or stood in loco parentis.

Division of Medicaid employees are to be designated as such in MEDSX to provide additional privacy and security.

ELIGIBILITY DETERMINATION PROCESS

APPLICATION PROCESS

Addition of Individual to an Active Case

The request to add an individual including a deemed eligible infant to an active case is an application, and all eligibility factors for the new individual must be met and documented for testing eligibility. All required verifications must be completed to add the new case member, including that person's income, age proof, third party insurance status, child support cooperation, etc. The Request for Newborn Health Benefits Identification Number form meets all the verification requirements to add a deemed eligible infant to the case.

Retroactive Medicaid coverage may also be requested and approved if the new person would have been eligible in the retroactive months. If the person is new to this household, retroactive eligibility must be based on the new individual's own circumstances in the retroactive months. It will be the responsibility of the applicant to provide this documentation. Before approving retroactive benefits for a new person, be sure that the person was not already covered in another case or category in any of the retroactive months.

When there is a request to add a new individual to the active HB case, a new application form should not be completed. A face to face interview with the case head is required as is the 30-day timely processing standard. Income must also be verified for the individual and assistance unit. If the new applicant is eligible and all other members will remain eligible in the same program type (Medicaid or CHIP) as a result of the redetermination, a new 12-month certification period will be established for the entire group giving the new member a full 12-month period and extending the other members' certification period to make the review due date the same for all household members.

Follow these guidelines when adding a new member:

- If the new member would not be eligible and/or would make the other members ineligible, deny the new individual and allow the currently eligible children or pregnant woman to complete their authorized certification period.
- If the addition of the new member would cause the family to move from a Medicaid category to CHIP, approve only the new member in CHIP and leave the others for the remainder of their certification period in Medicaid.
- If the addition of a new household member would cause the family to qualify in a Medicaid category, approve the new child on Medicaid and leave the other children in CHIP for the remainder of their certification period.
- In no situation should the attempt to add an individual to an active HB case cause a participating child's HB eligibility period to be shortened or terminated except for the ongoing reasons, including age out, death, leaving the state, institutionalization, or parent's request.

ELIGIBILITY DETERMINATION PROCESS

APPLICATION PROCESS

Example: The MA/85 case was approved effective 10-01-05, with eligibility through 09-30-06. On March 3, 2006, the mother requests to add a child who has returned home. The new 12-month eligibility period for this child would be 03/2006 through 02/2007. Because all other family members continued eligible at the review to add the new child, the new review due date for all family members will be February 2007.

Example: The PL/91 case was reviewed effective 12/05 and continued eligible through November 2006. In May 2006, the mother requests to add a 17 year old who has returned to the home from his other parent out of state. The case is redetermined, including income, and found continued eligible. The new child's eligibility period would be May 2006 through April 2007, so the other children in the 91 case would also have their eligibility period certified through April 2007.

Example: Use the above example to review the 91 case to add the child. However, this child has SSA income from the absent parent and this income added to the other income would make the new child ineligible in the 91 case. The family's income now falls within the 200% FPL scale. In this case, approve the new child in CHIP and leave the other children in Medicaid until the regular case review is due. Then, if the income remains at the 200% FLP, all of the children in this AU would move into CHIP and begin a new 12-month eligibility period.

For all HB Programs:

Do not shorten a child's annual eligibility period unless it meets one of the exceptions for early termination, i.e., the child ages out, the child dies, moves from the state, becomes institutionalized, or the parent requests closure, etc. The CHIP-eligible child's certification may also be shortened when he/she becomes covered by a third-party health insurance program.

Transfer of Cases between Offices

When the family reports a change of address within the state that will cause the entire HB case to be transferred to another RO, transfer the case in open status to the new RO for service. Enter the new address in MEDSX. A new case review is not required. The review due date remains the same.

If only a child(ren) moves to another county to live with a new caretaker while the original HB case remains open for another child(ren), the child who moved remains eligible through the remainder of the original 12-month period. See Individual Transfers.

Individual Transfers

When the family reports that an eligible child has left an active HB case and moved to a new household either in the same RO service area or in a new RO service area, the transfer will require special handling. The transfer may be reported by the original household or may be reported by the new household into which the child has moved.

ELIGIBILITY DETERMINATION PROCESS

APPLICATION PROCESS

If a child leaves an ongoing Health Benefits case, the child's 12-month eligibility period does not end unless he/she meets one of the reasons for termination (ages out, dies, leaves the state, enters an institution, or parent requests termination).

If the new caretaker relative applies for Health Benefits for the child assigned to a case in another RO, that RO should be notified of the application and a request made to remove the child from the current case and transfer to the new RO. When this has been completed, the child can be added with a redetermination contact to the new case.

When the RO learns the child has moved from the service area, the case will be documented with the date the child left the home, the name and address of the new caretaker, etc. However, no action will be taken during the 12-month eligibility period unless the RO is notified that the new caretaker has applied for the child or an early out reason has occurred. A new 12-month eligibility period will be assigned whenever a full case review finds the child eligible. If the child is not eligible in the new household based on the review, the receiving RO will not terminate his/her eligibility until the end of his/her 12-month period, unless the child ages out or meets some other "early out" termination reason.

If the child is still out of the house at the next regular or age out review, remove the child from the AU when determining continued eligibility for the family. The new caretaker must apply for the child to continue eligibility.

Coordination and communication between the two offices is imperative. Document all case records and case narratives carefully to show where and with whom each child resides and action taken by each RO. It is the responsibility of the caretaker to ensure that the child's ID card is available for the child at all times. A new ID card will not be issued when a child moves.

Admission to an Institution

When the family reports (or the worker learns) that an eligible child or adult has been admitted to an institution, either long-term medical care or incarceration, the worker must take immediate steps to terminate benefits effective the date of admission. Document the case and send appropriate termination notices. If the institutionalized person is the parent/caretaker, the children must remain eligible through their regular certification period.

Voluntary Request for Closure

When the parent or caretaker requests that the HB case be closed, the case must be carefully documented to show the request. If the request is made to the worker by phone, the worker will ask the reason for the request, document the client's statements, and request that the parent also put the request in writing whenever possible. If the request is made in person, a written request for closure should be obtained. The worker will terminate benefits for the next possible month. A 12-day advance notice of the adverse action is not necessary, but a closure notice must be sent.

ELIGIBILITY DETERMINATION PROCESS

APPLICATION PROCESS

Medicaid Reinstatements and Corrective Action

Corrective action must be taken when it is determined that the individual or family had benefits denied or terminated improperly. Each incident must be clearly documented in the case record and must be approved by the supervisor before authorization. Follow these guidelines:

- When the Health Benefits were improperly denied, terminated, or withheld, the case or individual will be reinstated/approved with the benefit start date beginning with the first applicable month of eligibility for Medicaid and the first possible month for CHIP actions.
- When the case/individual was terminated but the fair hearing decision is found in client's favor, action will be taken to reinstate the Medicaid coverage period and reinstate CHIP for the first possible month.
- When the RO failed to authorize the Medicaid benefits for the child or adult, take steps to authorize benefits immediately for coverage applicable to Medicaid or CHIP to the proper effective date.

Benefits During a Hearing Process

Benefits can be continued pending a fair hearing decision when a hearing is requested within the advance notice period for termination. Reopen CHIP for the first possible month. No action on benefits is required on a denial until the hearing decision is completed.

ELIGIBILITY DETERMINATION PROCESS
APPLICATION PROCESS

REDETERMINATION PROCESS

The process of reviewing the HB case is referred to as a redetermination. A full review of all variable eligibility factors must be conducted at specific intervals to determine whether or not eligibility continues for the HB individual or household. The regular case review is similar to the initial eligibility determination, including the face to face interview, except that basic information such as age and SSN do not have to be verified.

Face to Face Interview

A face to face interview will be required to complete the annual case review just as for the initial review. See the discussion and requirements for the interview earlier in this section.

Frequency of Reviews

Health Benefits cases must be reviewed every twelve (12) months.

A full review on all case members must also be completed:

- At the end of the earliest 12-month certification period; other AU members have different redetermination dates.
- When a new biological/legal child is requested to be added, and
- When a CHIP child was moved to the PL/88 category due to pregnancy, and at the end of the postpartum period, she does not have any months remaining in CHIP.

When a redetermination is due for some, but not all, of the Assistance Unit, the redetermination will be completed on everyone in an effort to align the redetermination dates. If all members remain eligible in their current COE, a new 12 month period of eligibility will be established and all will be due at the same time.

A child who is determined to be ineligible, and redetermination was due at this time, will be terminated at the end of the 12-month period of eligibility. The start date of the time period will be edited to be the month following the review due month.

When a child whose review is not yet due is changing from CHIP to Medicaid or Medicaid to CHIP prior to end of the 12 months, the start date of the time period will be edited to be the month following the review due month. The review dates for all children will not be aligned in this situation.

ELIGIBILITY DETERMINATION PROCESS

APPLICATION PROCESS

The following procedures should be followed depending on the action to be taken:

- Application denial or case closure other than failure to comply with redetermination – Treat like an application. Factors that were previously verified and not subject to change will not be verified again. Appropriate income verification will be required.
- Redetermination closure for failure to meet face to face interview requirement – When a reapplication is filed prior to effective date of closure and the client comes in for the interview, regular processing procedures apply. When additional information is needed and requested, the worker should allow the applicant 12 days to provide it. Depending on the response by the applicant, the worker will approve or deny the application within 30 days.

Example: On 12-02-05, the client fails to come in for interview and the Medicaid case is set for closure 12-31-05. The client comes in to the office and is interviewed on 12-27-05, but does not have birth certificates or income verification. An application contact with a time span beginning 01-01-06, is added and a request for information is given to her at the interview allowing until 01-08-06, to provide the information. She provides the information on 01-05-06, and is approved January 2006 for Medicaid.

- Redetermination closure after interview due to failure to provide information – The application form completed at interview may be used to process a reapplication if needed information for the family or family member is provided on or before the effective date of closure.

Example: Client was interviewed for redetermination on 11-29-05, and information requested that day was due 12 days later. Information was not provided, and the case was set to close effective 12-31-05. The client provided all needed verification on 12-28-05. The worker uses the application form completed on 11-29-05, to process the reapplication. The application date is 11-29-05, but the time span will start 01-01-06.

Note: An application contact will be required for any person with a closed end date and denied ongoing. Otherwise, an approval notice will not be generated to inform the household of the approval.

Verification Requirements

Income must be verified at every redetermination as well as any other eligibility factors that have not been previously verified such as age and citizenship. Documentary verification is not required for child care or dependent care expense, but the case must be documented to show that the cost is paid by the family. Do not exceed the maximum allowance per person. If additional children or individuals are to be added to the case, the verifications required at the initial application will be required for these individuals.

Information that must be provided at review will include all other information subject to change: household composition changes, address and phone numbers, SSN for previously exempt deemed infant, absent parent information for previously exempt infant in MA/85, third party insurance information, etc.

ELIGIBILITY DETERMINATION PROCESS

APPLICATION PROCESS

CHANGES REPORTED

Although children in HB categories are guaranteed a 12-month certification period, except for the “early out” reasons, parents are not obligated to report changes other than those generally related to leaving or entering the household. However, cases that include adults covered by HB benefits (as in MA/85) do require these adults to report changes that would affect their eligibility. The time frame for reporting these changes should be within 10 days from the date the change becomes known.

Reporting Requirements

- **Child-only Cases** - Report changes that would affect the child’s eligibility, such as child leaving the home, leaving the state, becoming institutionalized, etc.
- **Pregnant Woman** - The pregnant woman should report the early termination of the pregnancy or any changes in her due date that would affect the postpartum extended coverage. This information will also be received when the Newborn form is received from the hospital.
- **Adults with Children (MA/85)** - Adults are not guaranteed a 12-month certification period and must report changes that would affect their eligibility, such as increased earnings or children entering or leaving the home.