



STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
DR. ROBERT L. ROBINSON
EXECUTIVE DIRECTOR

MEDICAID PROGRAM ACTION

Eligibility Transmittal

DATE: November 1, 2009

PROGRAM IDENTIFIER: 435.110109141
Medicaid Regional Offices

SUBJECT: Revised Policy for Medicaid Eligibility Policy and Procedures Manual

This transmittal issues revised policy for the Medicaid Eligibility Policy and Procedures Manual. In September 2008, staff was informed this generic manual would be compiled over time by adding additional sections as policy is re-issued or revised. The material on special reviews, notification and reinstatements completes Chapter 101, Application and Redetermination Processes. A revision of page 621 provides a clarification regarding QMB eligibility. In addition, we will begin building Chapter 300, Resources, starting with "Exceptions to Treatment of Trusts" which includes a discussion of Special Needs Trusts, Pooled Trusts and the following:

- **Income Trusts** - Effective July 1, 2008, the Division of Medicaid changed the method that is used to calculate the patient liability (Medicaid Income) for certain Institutionalized recipients who have income that exceeds the Medicaid limit and must establish an Income Trust in order to qualify for Medicaid. This change brings the Division of Medicaid into compliance with Federal requirements for patient liability. The recipient's cost of care will be determined by the total gross income and the daily rate that Medicaid pays the nursing facility where the recipient resides. If the Medicaid rate for the facility is more than the recipient's Medicaid Income, the income is payable to the facility and the Income Trust account will not be funded. If the Medicaid rate for the facility is less than the recipient's income, the excess income will fund the Income Trust account. An Income Trust document is required in both situations.
- **Model Income Trust Documents** - A model Long Term Care (LTC) Income Trust and model Home and Community Based Waiver (HCBS) Income Trust agreement are provided for use as sample forms that are acceptable to Medicaid. The Income Trust document should be notarized and filed at the Chancery Clerk's office. The regional office can provide each recipient with a Help Sheet that will assist in completing the document.
- **Revised Life Expectancy Tables** - The male and female life expectancy tables have been revised to coincide with the actuarial tables used by the Social Security Administration. The revised tables are to be used in evaluating annuities.

FILING INSTRUCTIONS

• **VOLUME III**

- Remove Pages 3300 through 3452 from Section C, Application and Redetermination Process, and note the Table of Contents for Section C to cross-reference these pages with the Medicaid Eligibility Policy and Procedures Manual.
- Remove Pages 6318 – 6321, Exceptions to Treatment of Trusts Under Trust Provisions, from Section F, Resources, and note the Table of Contents for Section F to cross-reference these pages with the Medicaid Eligibility Policy and Procedures Manual.
- Remove Pages 6325 and 6326, Life Expectancy Tables, from Section F, Resources, and note the Table of Contents for Section F to cross-reference these pages with the Medicaid Eligibility Policy and Procedures Manual.

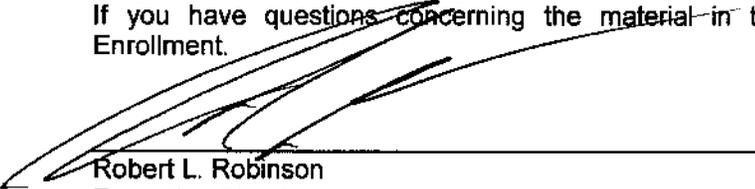
• **HEALTH BENEFITS MANUAL**

- Remove Pages 6005 through 6026 from Section F, Application Process, and note the Table of Contents for Section F to cross-reference these pages with the Medicaid Eligibility Policy and Procedures Manual.

• **MEDICAID ELIGIBILITY POLICY AND PROCEDURES MANUAL**

- Remove Page 621, Retroactive Medicaid Eligibility, Effective Month: June 2009, and replace with revised Page 621, Effective Month: November 2009.
- Remove Page iii, from the Table of Contents for Chapter 101, Effective Month: August 2009, and file pages iii and iv, Effective Month: November 2009.
- File Pages 800 through 975 of Chapter 101, Application and Redetermination Processes, Effective Month: November 2009, in sequence with previously issued material.
- File Page i, Table of Contents for Chapter 300, Pages 3000 – 3003, the Model LTC Income Trust agreement, Model HCBS Income Trust agreement and Pages 3050 - 3051 in sequence with previously issued material.

If you have questions concerning the material in this transmittal, contact the Bureau of Enrollment.



Robert L. Robinson
Executive Director

RLR: JB: jb

Attachments

cc: All Holders of Medicaid Eligibility

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101.12 SPECIAL REVIEWS

A special case review is completed when changes occur between regular reviews, which may result in adjustments to eligibility or benefit level. A special case review is not a full review. Instead the case (or an individual) is evaluated to consider the impact of the changed information. Factors unrelated to the change are not re-verified as part of a special review.

Example: An 85 adult recipient reports three months after her regular redetermination that she has a part-time job. The children in the case have income from child support which was last verified at the regular review. The child support income is not subject to re-verification since it is not part of the reported change.

A special review of eligibility is required when:

- The recipient reports a change in circumstances which could affect eligibility and benefit level;
- Information is received from any other source which could affect eligibility and benefit level;
- Potential changes in eligibility are indicated by information available to the agency.

The special review process may result in termination of benefits, benefit reduction or adjustments to Medicaid Income. It may also involve procedural changes, i.e., updating or correcting case information with no impact on eligibility or benefits. Procedural changes may include:

- Name corrections or changes;
- In-state address corrections or changes;
- Change or appointment of a guardian or conservator;
- Case transfers between regional offices;
- Program transfers such as a disabled or blind recipient turns age 65, becoming an aged client.

NOTE: In MEDSX, name, address, SSN, race and gender can be changed or corrected on a processed time span. However, eligibility must be re-processed to correct the date of birth in MEDSX. A special contact and time span are required to re-process eligibility in MEDS to change or correct demographic information.

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101.12.01 RECIPIENT REPORTING REQUIREMENTS

Recipients must report required changes within ten days of the date the change becomes known. Changes may be reported in person, by telephone or by mail. A change is considered reported on the date the report of change is received by the agency. If an individual fails to report timely or the agency fails to take timely action, causing the recipient to receive benefits to which he is not entitled, the specialist will take steps to report an overpayment.

101.12.01A CHANGE REPORTING REQUIREMENTS

❖ **Aged, Blind and Disabled Programs**

The following types of changes must be reported by ABD recipients within 10 days of the date the change becomes known:

- Changes in address in or out of state;
- Changes in marital status;
- Changes in income for the recipient and/or spouse;
- Change in any type of policy that would pay for medical services, such as health insurance, indemnity policies, major medical policies, CHAMPUS or legal settlements;
- Changes in a recipient's disability which would affect his Medicaid eligibility;
- Changes in living arrangements, such as a long term care (LTC) recipient entering a hospital or a nursing home, leaving a hospital or a nursing home, moving from one medical facility to another;
- Changes in resources, i.e., recipient buys, sells, gives away or receives an asset or any part of an asset; and.
- Changes in health insurance premiums for LTC recipients.

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101.12.01B CHANGE REPORTING REQUIREMENTS

❖ Families, Children and CHIP Programs

The following changes must be reported by FCC recipients within 10 days of the date the change becomes known.

All FCC Recipients

- Changes in address in or out of state;
- Changes in any type of policy that would pay for medical services, such as health insurance, indemnity policies, major medical policies, CHAMPUS or legal settlements.

85 Adults

- Increases in earnings or other income;
- Changes in marital status;
- Changes in household, such as spouse or parent entering or leaving the home and/or children entering or leaving the home.

85 Adults on Extended Medicaid

- Termination of employment when new or increased wages caused ineligibility;
- Termination of child support income when new or increased child support caused ineligibility.

Pregnant Women

- Change in the verified due date, i.e., earlier delivery/termination date or later due date than originally verified.

Child Only Cases

- Children leaving the home (includes institutionalization, death, foster care, etc.);
- Uninsured CHIP child becoming covered by creditable health insurance;
- CHIP child becoming pregnant.

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101.12.02 TAKING ACTION ON REPORTED CHANGES

Specialists must follow up on information which is reported by the recipient or otherwise becomes known to the agency to determine if the information is a reportable change. If the change is not reportable, the information will be considered at the next regular review. For instance, an income increase reported by the parent of a CHIP child is not a reportable change because of the continuous eligibility provision for children in FCC. The impact of an increase in parental income will be considered at the next review. However, if the parent reports the CHIP child has moved from the state, that is a reportable change which must be acted upon.

Action on a reportable change must be initiated no later than 10 working days from the date the change becomes known to the agency to determine its impact on eligibility and benefit level.

NOTE: It is imperative that timely action be taken on reported changes to prevent agency error. For instance, recipients frequently report address changes. Failure to take prompt action on these changes not only results in inconvenience to the recipient, but also may lead to benefits being terminated in error when notices are mailed to the wrong address. .

If verification of a reportable change is needed from the recipient, DOM-307 will be issued to provide written notice of the required information and due date. DOM-309 will be issued, when applicable, to ABD recipients. If the client fails to respond to the 307 or 307/309 requests, eligibility will be terminated allowing 10-day advance notice.

Documenting the Case Record

The case record/case narrative must reflect the following information about the reported change:

- Who reported the change;
- When the change was reported;
- How the change was reported;
- When action was initiated on the change;
- What was used to verify the change; and
- What action was taken in regard to the verified information.

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101.13 NOTIFICATION

The recipient and, when applicable, the medical facility must be notified in writing of the action taken on an application or an active case when eligibility or benefit level is affected by a change. Notices are generated by the MEDS and MEDSX systems based on the type of contact and the results of the eligibility determination.

NOTE: It is the specialist's responsibility to review and if needed correct notices printed in the regional office before they are mailed to the recipient.

If a manual notice is required for the recipient, refer to instructions for the DOM-305, Notice of Action, or DOM-306, Notice of Adverse Action. When a manual notice must be issued to a facility, DOM-317, Exchange of Information Between Nursing Home or Hospital and Medicaid Regional Office, is used.

101.13.01 ADVANCE NOTICE

Federal regulations require issuance of a notice of adverse action 10 days before the effective date of an action to reduce or terminate benefits. In MEDS, the adverse action deadline is 12 days from the end of the month. In MEDSX it is the 19th of each month except February when the deadline is the 17th.

During the advance notice period, the recipient is allowed time to fully comply with unmet requirements, provide information or verification that will alter the decision to terminate or reduce benefits, or request a Fair Hearing with continued benefits. If this occurs, the agency must take prompt and appropriate action to reinstate benefits.

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101.13.02 EXCEPTIONS TO ADVANCE NOTICE

Unless noted, the following actions require notification to the recipient; however, 10-day advance notice is not required.

Death

When the agency has factual information verifying the death of a recipient, the date of death and verification source must be recorded in the record. A notice is not generated by either system if the termination reason is death.

Some acceptable sources to verify the death date are:

- SVES or SDX;
- Report from recipient's representative or the FCC Head of Household;
- Viewing the death certificate,
- Contact with the funeral home or the attending physician;
- Contact with the hospital or nursing home where the patient died;
- Dated newspaper clippings;

Loss of State Residence

When the agency establishes that a recipient has moved from the state through information received from the recipient or because another state reports the client has been accepted as a resident for Medicaid in that state, advance notice of closure is not required.

Resident of a Public Institution

When the agency has established that the recipient has been admitted to a public institution, such as a prison or a state hospital in a non-Title XIX facility, advance notice of termination is not required.

Unable to Locate

When a recipient's whereabouts are unknown, the agency must take reasonable efforts to locate the recipient. When agency mail is returned by the post office with no forwarding address and other efforts to locate the recipient are unsuccessful, eligibility will be terminated. However, if the client's whereabouts subsequently become known during the time the client is eligible for services, the case must be reinstated. Refer to 101.14 for a discussion of the reinstatement process.

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EXCEPTIONS TO ADVANCE NOTICE (Continued)

Voluntary Request for Closure

If the recipient or his designated representative voluntarily requests closure, advance notice is not required. If the request is made in person, the specialist will obtain the request in writing. Otherwise, the specialist will document the case to reflect the specifics of the request.

Eligible for Medicaid through Another Source

If an FCC or ABD recipient becomes Medicaid-eligible through SSI or foster care, advance notice of termination of benefits authorized through the Medicaid Regional Office is not required.

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101.14 REINSTATEMENTS

Certain situations require a reinstatement of services, which means either eligibility is restored or Medicaid income is corrected for a prior period. Both types of reinstatements are completed without requiring that a new application be filed on behalf of the recipient. A reinstatement is in order in the following situations, as applicable, to ABD and FCC recipients.

NOTE: There is no reinstatement function in MEDSX. If a reinstatement of benefits is required for an FCC recipient, an application contact must be used. Information will be provided in the comments section of the notice to explain the action being taken to the recipient.

Hearing Decision

When a decision, granting eligibility or increased benefits is rendered as a result of a state or local hearing, the regional office may be required to reinstate eligibility or when appropriate correct Medicaid Income, retroactive to the date decided by the hearing official. If benefits were continued in an active case pending the hearing decision, reinstatement may not be required unless the decision at the hearing is to increase the level of benefits in effect prior to the hearing.

Advance Notice Period

When the client makes a timely hearing request during the advance notice period, benefits will be continued at the same level through the reinstatement process until a hearing decision is reached.

If the recipient provides information that changes the adverse action decision or fully complies with unmet requirements during the adverse action period, benefits must be reinstated to ensure no loss of benefits, if the recipient remains eligible.

If advance notice of benefit reduction or termination is not issued as required, benefits must be reinstated at the time the error is discovered, regardless of whether the client is currently eligible. After benefits are reinstated, advance notice would be issued.

NOTE: Medicaid benefits must be reinstated to ensure there is no loss of benefits. CHIP benefits must be reinstated for the next possible month. If the child incurred medical services in any lost CHIP months, handle through the CHIP agency error process.

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REINSTATEMENTS (Continued)

Whereabouts Unknown

As indicated previously, eligibility must be terminated if a client's whereabouts remain unknown after the agency has (1) received returned mail with no forwarding address and (2) made reasonable efforts to locate the recipient. If the client's location subsequently becomes known during the time he is eligible, benefits will be reinstated.

For a child who has continuous eligibility, Medicaid benefits must be reinstated with no loss. CHIP benefits must be reinstated for the next possible month. If the child incurred medical services in any lost CHIP months, handle in the same manner as CHIP agency errors. For an adult, the specialist must determine eligibility for each month that the adult recipient's whereabouts were unknown and reinstate for any period he would have been eligible.

Temporary Case Closure

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

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

In this situation a break in eligibility correctly exists; therefore, it is necessary to adjust the eligibility begin date to reflect the most recent eligibility begin date.

Reapplication

When an applicant has a prior application which has been in rejected status for 2 months or less, the rejected application form can be updated and signed by the applicant or representative to establish a new application date. Factors of eligibility which are not subject to change do not have to be re-verified. Income and, if applicable, resources may have to be re-verified, depending on the new application file date, the type of benefit, whether any changes are reported by the applicant, etc. The eligibility begin date is controlled by the second or updated application date.

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REINSTATEMENTS (Continued)

Agency Error

When the agency has denied or terminated eligibility in error or reduced benefits in error for reasons such as failure to act on information present in the record or provided during the advance notice period, misapplication of policy, miscalculation of income or resources, untimely processing, etc., benefits must be reinstated retroactive to the month the error occurred, when this is possible. If CHIP is involved, the reinstatement must be effective for the next possible month. If the child incurred medical services in any lost CHIP months, this would be handled through the CHIP agency error process.

The discovery source for the error may be:

- Case reviews;
- Applicant or recipient complaints;
- Recognition by the specialist;
- Other sources having knowledge of the error.

101.14.01 CORRECTIVE ACTION

At the time the agency becomes aware of an error which affects eligibility or level of benefits, action must be initiated to correct the error. Immediate corrective action is required to prevent further error. In some instances, it may also be necessary to correct an error retroactively into prior months.

When corrective action into prior months adversely affects the recipient, meaning the error caused the client to be totally ineligible or eligible for fewer benefits, DOM-354, Improper Payment Report, or DOM FCC-354, Improper Payment Report Families, Children and CHIP, is prepared.

When corrective action into prior months favorably affects the client, meaning the client was eligible or eligible for more benefits, the corrective action is handled through reinstatement.

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101.15 OTHER CHANGES

❖ Aged, Blind and Disabled Programs

101.15.01 CHANGES IN MEDICAID INCOME

The amount of income an institutional client must pay to the nursing facility toward the cost of his care is known as Medicaid Income. Changes in income, marital status or non-covered medical expenses will either increase or decrease Medicaid income. The effective dates of such changes are determined as follows:

Decrease in Medicaid Income

A change which results in a decrease in Income is effective the month in which the change is reported or becomes known to the agency. For example, a decrease in income reported any time in the month of June will be effective as of June 1. The notice issued to the client and to the facility will specify June 1.

Increase in Medicaid Income

A change which results in an increase in Medicaid Income requires advance notice to the client advising of the increase. However, advance notice for Medicaid Income increases is based on issuing notice 10 days before the date Medicaid makes its payment to the facility.

A nursing home cannot submit a claim for any month's payment until the first day of the following month. Payment is then made to the facility on the first Monday following receipt of the claim. This means the specialist has 10 days before Medicaid makes its payment to a facility to increase Medicaid Income for the current month. Since payment schedules may vary, policy governing increasing Medicaid Income in the current month is based on whether advance notice can be issued 10 calendar days before the first of the following month.

Example: An increase in a recipient's income is discovered on October 10, Medicaid Income can be increased effective October 1 if advance notice of the increase is issued no later than October 21.

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

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CHANGES IN MEDICAID INCOME (Continued)

Temporary Decrease in Medicaid Income

When Medicaid Income is temporarily decreased due to the allowance of a deduction, i.e., health insurance premium or other non-covered medical expense, and Medicaid Income is subsequently returned to the amount previously in effect, this action is not considered an increase in Medicaid Income subject to advance notice.

When the client is notified of the allowance of the deduction, the notice should also advise that Medicaid Income will return to the previous amount and specify the amount and date Medicaid income will resume.

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

Increase in Medicaid Income Combined with a Closure

In instances where income is counted in the month received, but receipt of the income also renders the client ineligible, the excess income is included in the Medicaid Income computation provided there are 10 calendar days left in the month of receipt to allow for advance notice. In addition to increasing Medicaid Income for the month of receipt, the case is also scheduled for closure.

Example: A client receives a lump sum VA payment of \$4,000 in December which is reported to the regional office on December 12. Action is taken to include the \$4,000 as income for December for Medicaid Income purposes. On December 19, notice is issued to allow advance notice of the increase in Medicaid Income effective December 1 and closure for December 31 due to excess resources for January.

The amount of Medicaid Income due for the month will be the actual shown on the notice or the Medicaid reimbursement rate for the facility, whichever is less. The client or representative must be advised to contact the facility to obtain the lesser of the two amounts.

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Temporary Increase in Medicaid Income

When excess resources are not an issue, but receipt of additional income results in the monthly income total being over the income limit for LTC, the case will remain open if, for whatever reason, there is not time to allow advance notice of closure. However, if there are 10 calendar days left in the month, Medicaid Income must still be increased to the amount of that month's income or the Medicaid reimbursement rate for the facility, whichever is less. The client or representative must be advised to contact the facility to obtain the lesser of the two amounts.

For the following month, eligibility will continue. The additional income will be removed from the Medicaid Income calculation and Medicaid Income will return to the amount in effect prior to the temporary income increase.

Example: A client receives a lump sum VA payment of \$2500 in December which is reported to the regional office on December 21. The office became aware of the income too late to close the case; however, action is taken on December 21 to include the \$2500 as income for December for Medicaid Income purposes. On December 21, notice is issued to allow advance notice of the increase in Medicaid Income effective December 1. The lump sum did not cause resources to exceed the limit; therefore, eligibility continues. The income is removed from the Medicaid Income calculation and Medicaid income returns to the prior amount effective January.

101.15.02 CHANGE TO A REDUCED SERVICE COVERAGE GROUP

Changing from a full service coverage group to a reduced coverage group requires advance notice before the change can be effective the following month. It is not possible to change an active full service case to a reduced service coverage group such as QMB, SLMB, or QI in MEDS for the following month unless there are at least 12 days remaining in the current month.

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101.16 OTHER CHANGES

❖ Families, Children and CHIP Programs

101.16.01 TRANSITIONING THE PREGNANT CHIP CHILD TO 88 MEDICAID

For most children, program changes are effective only at review because of the continuous eligibility provision for children. However, when the agency becomes aware that a CHIP child is possibly pregnant, a special review must be completed to verify pregnancy/due date and to determine if the minor is eligible for Medicaid coverage as a pregnant woman. If so, the child will transition from CHIP to 88 Medicaid for the duration of the pregnancy and 2-month post partum period. However, if the office learns of the change too late, i.e., the minor is at the end of her pregnancy or has already delivered, no action is taken to change the program.

The program transition from CHIP to Medicaid is not an adverse action. If action is taken for the current month by the CHIP deadline, CHIP will terminate at the end of the current month and the pregnant minor will move to 88 Medicaid the following month. The head of household is issued a notice which contains the following information about the child's eligibility:

- Date the pregnant child will be removed from CHIP;
- Date the child will be eligible for Medicaid as a pregnant woman;
- The verified delivery date and the requirement to report an earlier or later date;
- Date the child will become ineligible for Medicaid as a pregnant woman;
- Date CHIP eligibility will resume;
- The child's review due date;
- Information about coverage for a 2-month post partum period;
- The deemed eligible provision for children born to Medicaid-eligible women.

If there are months remaining in CHIP at the end of the post partum period, the child will return to CHIP until review. If the pregnant minor's review comes due while she is on 88, the review will be completed. If the child is eligible for full Medicaid, action can be taken immediately to change the child from 88 to 91 or if applicable, 85. If the child continues to be CHIP-eligible at review, the new 12-month eligibility period is effective at the end of the post partum period. For programmatic and system instructions for implementing the change from CHIP to 88 Medicaid, refer to the FCC program section.

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101.08.04 RETROACTIVE MEDICAID ELIGIBILITY

Retroactive Medicaid eligibility may be available to any Medicaid applicant who received medical care prior to applying for Medicaid. Applicants may qualify for coverage for a 3-month period prior to the month of the application. Retroactive eligibility can cover all 3 months of the prior period or any month(s) in the 3-month period. In addition:

- Each applicant must be informed of the availability of retroactive Medicaid coverage.
- The applicant's statement is accepted regarding medical expenses incurred in the retroactive period.
- Retroactive Medicaid may also be available to an individual who is added to a case (e.g., child returns home).
- The applicant does not have to be eligible in the month of application (or current month) to be eligible for one or more months of retroactive Medicaid.

NOTE: Children have continuous eligibility. Refer to the FCC program section for instructions on how to handle children who do not have current month eligibility, but are eligible in a retroactive month.

- The applicant or recipient may ask for retroactive Medicaid coverage at any time.
- The date of application, rather than the date of the eligibility determination, establishes the beginning of the three-month retroactive period.
- There is no provision for retroactive coverage in the Qualified Medicare Beneficiary (QMB) program. QMB eligibility begins the month following the month of authorization. It is not appropriate to place a QMB-only approval into an SLMB or QI-1 category of eligibility to provide retroactive payment of Part B premiums for the retro period.

101.08.04A DECEASED APPLICANTS

An application for retroactive Medicaid coverage may be made on behalf of a deceased person. Retroactive eligibility can cover all 3 months prior to the month of application or any month(s) in the 3-month period if the deceased person is found to be eligible.

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300.01 EXCEPTIONS TO TREATMENT OF TRUSTS

The rules concerning treatment of trusts do not apply to any of the following types of trusts, i.e., the trusts discussed below are treated differently in determining eligibility for Medicaid. Funds entering and leaving these trusts are generally treated according to SSI rules or more liberal rules under Section 1902(r) (2) of the Act, as appropriate.

As noted in each exception below, one common feature of all of these excepted trusts is a requirement that the trust provide that, upon the death of the individual, any funds remaining in the trust go to the Division of Medicaid, up to the amount paid in Medicaid benefits on the individual's behalf.

300.01.01 SPECIAL NEEDS TRUSTS

A trust containing the assets of an individual under age 65 who is disabled (as defined by the SSI program) and which is established for the sole benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court is often referred to as a Special Needs Trust. In addition to the assets of the individual, the trust may also contain the assets of individuals other than the disabled individual.

To qualify for an exception to the rules governing trusts in this section, the Special Needs Trust must contain a provision stating that, upon the death of the individual, the State receives all amounts remaining in the trust, up to an amount equal to the total amount of medical assistance paid on behalf of the individual.

When a Special Needs Trust is established for a disabled individual under age 65, the exception for the trust discussed above continues even after the individual becomes age 65. However, such a trust cannot be added to or otherwise augmented after the individual reaches age 65. Any such addition or augmentation after age 65 involves assets that were not the assets of an individual under 65 and therefore, those assets are not subject to the exemption discussed in this section.

To qualify for this exception to the rules governing trusts, the trust must be established for a disabled individual, as defined under the SSI Program. When the individual in question is receiving either Title II or SSI benefits as a disabled individual, accept the disability determination made for those programs. If the individual is not receiving those benefits, make a determination concerning the individual's disability.

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SPECIAL NEEDS TRUSTS (Continued)

Establishment of a trust as described above does not constitute a transfer of assets for less than fair market value if the transfer is made into a trust established solely for the benefit of a disabled individual under age 65. However, if the trust is not solely for the benefit of the disabled person or if the disabled person is over age 65 transfer penalties may apply.

300.01.02 POOLED TRUSTS

A pooled trust is a trust containing the assets of a disabled individual as defined by the SSI Program in Section 1614(a)(3) of the Act, that meets the following conditions:

- The trust is established and managed by a non-profit association;
- A separate account is maintained for each beneficiary of the trust but for purposes of investment and management of funds the trust pools the funds in these accounts;
- Accounts in the trust are established solely for the benefit of disabled individuals by the individual, by the parent, grandparent, legal guardian of the individual, or by a court; and,
- To the extent that any amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the Division of Medicaid the amount remaining in the account up to the amount equal to the total amount of medical assistance paid on behalf of the beneficiary. To meet this requirement, the trust must include a provision specifically providing for such payment.

To qualify as an excepted trust, the trust account must be established for a disabled individual, as defined in Section 1614(a)(3) of the Act. When the individual in question is receiving either Title II or SSI benefits as a disabled individual, accept the disability determination made for those programs. If the individual is not receiving those benefits, make a determination concerning the individual's disability.

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300.01.03 INCOME TRUSTS

This type of trust established for the benefit of the individual is limited to institutionalized clients, not those in a hospital setting. A recipient participating in the Home and Community Based Waiver program (HCBS) may also utilize an Income Trust for eligibility purposes. An Income Trust document is required. The Income Trust must meet the following requirements:

- The trust is composed only of the pension(s), Social Security, and other income of the individual, including accumulated interest in the trust; and,
- Upon the death of the individual, the Division of Medicaid receives all amounts remaining in the trust, up to an amount equal to the total medical assistance paid on behalf of the individual. To qualify for this exception, the trust must include a provision to this effect.

Income Included in an Income Trust

To qualify for this exception, the Income Trust must be composed only of income to the individual, from whatever source. The trust may contain accumulated income, i.e., income that has not been paid out of the trust. However, no resources, as defined by SSI, may be used to establish or augment the trust. Inclusion of resources voids this exception.

Income Not Included in an Income Trust

An individual's total income must go into the Income Trust each month. The only exception is for the types of VA payments that are not considered income, i.e., VA Reduced Pension benefits, VA Aid & Attendance payments and VA Pension payments attributed to Unreimbursed Medical Expenses.

Funding the Income Trust Account

All of a nursing home recipient's income, less deductions authorized by Medicaid, will be paid to the nursing home. In most cases no funds will be retained in the Income Trust account.

The recipient's cost of care, referred to as Medicaid Income, will be determined by the total gross income and the daily rate that Medicaid pays the nursing facility where the recipient resides. However, if the rate for the facility is less than the recipient's income, the recipient's excess income will fund an income trust account.

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Funding the Income Trust Account (Continued)

Example: The recipient's countable income is \$3,800 per month. The Medicaid daily rate for the facility where the recipient resides is \$3,500 per month. The excess income of \$300 per month must fund an Income Trust account. This example applies if income for only one month exceeds the Medicaid daily rate or if the income for all the months exceeds the Medicaid daily rate.

However, when the rate for the facility is more than the recipient's countable income, all of the recipient's income is payable to the facility and the Income Trust account will not be funded.

Example: The recipient's countable income is \$2,500 per month. The Medicaid daily rate for the facility where the recipient resides is \$4,500 per month. The recipient will pay the facility \$2,500, and the Income Trust account will not be needed. However, a trust document is still required.

Home and Community Based Waiver (HCBS)

For individuals in the Home and Community Based Waiver (HCBS), the difference between an individual's total income and an amount that is \$1 less than the current institutional income limit should fund the Income Trust account. The only allowable expenses from the amount funding the trust are actual expenses associated with the establishing the trust, which is limited to \$500 or actual cost if less than \$500. Bank charges associated with maintain trust accounts are limited to \$10 per month.

Other Income Trust Issues

- Trusts that are not properly funded into an Income Trust account do not meet the criteria for a trust exception.
- When an Income Trust is no longer needed due to the client's death, ineligibility or some other change, the Division of Medicaid receives all amounts remaining in the trust account, up to an amount equal to the total medical assistance paid on behalf of the individual. To qualify for this exception, the trust must include a provision to this effect.
- The Income Trust agreement which is located immediately following this section can be copied for execution by the recipient and trustee. The only changes to this legally binding document that the Division of Medicaid will accept will be to add language regarding a successor trustee or co-trustee. Changes must be approved by the Legal Bureau prior to execution.

LONG-TERM CARE INCOME TRUST

THE _____ INCOME TRUST

WHEREAS, _____, hereinafter referred to as the Settlor, now has a monthly income that exceeds the current Medicaid income limits, and;

WHEREAS, the total monthly income received by Settlor is not sufficient to pay for expenses associated with long-term care services and related services, and;

WHEREAS, Settlor's other assets have been exhausted by Settlor's long-term care expenses, and;

WHEREAS, the principal purpose of this Trust is to receive all income payments due Settlor in excess of the Settlor's cost of care, including Social Security benefits, retirement benefits, interest, dividends, or other income. The Settlor's cost of care will be determined by the daily rate that Medicaid pays the nursing facility in which the Settlor resides. If the rate for the facility is less than the Settlor's income, the excess income will be used to fund the income trust. If the rate for the facility is more than the Settlor's income, the Settlor's total income, less authorized deductions, will be paid to the nursing facility. Any income in excess of the Settlor's cost of care will be retained as part of the Trust.

WITNESSETH:

This _____ Income Trust Agreement is entered into between

_____, "Settlor", and _____, "Trustee", who agree as follows:

- (A) The Trustee shall place all income in excess of the Settlor's cost of care into the Trust, and the Trustee shall hold such income under the following terms and conditions:
 - (1) Trustee shall retain the income in excess of the Settlor's cost of care in the Income Trust Account.
 - (2) At the time of each review of the Settlor's Medicaid eligibility (at least annually) while this trust is in existence, if the Settlor's income exceeds the cost of care, the Division of Medicaid will notify the Trustee of the amount that should be accumulated in the trust. The Trustee will then be requested to make payment of this amount to the Division of Medicaid up to the total amount expended by the Division of Medicaid on behalf of the Settlor that has not previously been repaid to Medicaid. Failure to make the requested payments may result in the loss of Medicaid eligibility for the Settlor.
 - (3) This trust will terminate upon the death of the Settlor; when the Settlor's Medicaid eligibility is terminated; when the Settlor's income no longer exceeds the current Medicaid income limits; or when the trust is otherwise terminated. At that time, any income amounts accumulated in the trust shall be paid over to the Division of Medicaid, State of Mississippi, up to the total amount expended by the Division of Medicaid on behalf of the Settlor that has not previously been repaid to Medicaid.
- (B) When requested, the Trustee shall furnish to the Division of Medicaid, State of Mississippi, an annual accounting to show all receipts and disbursements of the trust during the prior calendar year.
- (C) The Trustee shall maintain the trust funds on deposit in a federally insured banking institution.
- (D) No Trustee shall receive a Trustee's fee for services rendered to the trust, however, reasonable bank charges will be allowed.
- (E) The Trustee shall give written notice to the Division of Medicaid, State of Mississippi when the Settlor dies or when the trust is otherwise terminated.
- (F) The provisions of this Trust shall be interpreted under the laws of the State of Mississippi.

The effective date of this trust shall be _____.

IN WITNESS WHEREOF, this _____ Income Trust Agreement

has been executed on this the _____ day of _____, 20__.

Trustee

Settlor

STATE OF _____
COUNTY OF _____

Personally appeared before me, the undersigned authority in and for said county and state, on the _____ day of _____, 20__, within my jurisdiction, the within named _____, who acknowledged that (he) (she) executed the above and foregoing instrument.

(NOTARY PUBLIC)

MY COMMISSION EXPIRES:

STATE OF _____
COUNTY OF _____

Personally appeared before me, the undersigned authority in and for said county and state, on the _____ day of _____, 20__, within my jurisdiction, the within named _____, who acknowledged that (he) (she) (they) executed the above and foregoing instrument.

(NOTARY PUBLIC)

MY COMMISSION EXPIRES:

TRUSTEE INFORMATION:

NAME: _____ SSN: _____

TELEPHONE NUMBER: _____

ADDRESS: _____

RELATIONSHIP TO SETTLOR: _____

INCOME TRUST HELP SHEET

Section 1917 (d) of the Social Security Act (42 U.S.C. §1396 p (d) (4)) defines certain provisions that qualify as an exception for the purpose of an individual qualifying for Medicaid benefits. One such exception is an "Income Trust". This type of trust, established for the benefit of an individual in a nursing facility, must meet the following requirements.

1. The purpose of the trust is to allow an individual with excess income who has exhausted all available resources to become eligible for Medicaid. The trust may be used only for income belonging to the individual. No resources (assets) may be used to establish or augment the trust. Inclusion of resources voids the trust exception.
2. Funds subject to the trust are all income due the individual from all sources such as Social Security, pension benefits, interest and any and all other types/sources of income.
3. Income Trusts, once accepted by Medicaid, cannot be modified without Medicaid's approval. Trusts must specify that the trust will terminate at the individual's death, when Medicaid eligibility is terminated, when the trust is no longer necessary or in the event the trust is otherwise terminated. Trusts may need to be terminated prior to an individual's death due to changes in the client's income or changes in Medicaid policy regarding how certain income must be counted or in the event the individual is discharged from the nursing facility.
4. If the income of the Settlor is less than Settlor's cost of care at the nursing facility, all income of the Settlor, less authorized deductions, must be paid directly to the nursing facility. In that case no funds will be retained in the Trust. If the income of the Settlor exceeds the cost of care at the nursing facility, the Trust must retain the income in excess of the cost of care.
5. At the dissolution or termination of the trust, the death of the Settlor, loss of the Settlor's Medicaid eligibility or in the event that the Settlor's income no longer exceeds the current Medicaid income limits, the trust agreement must provide that all amounts remaining in the trust up to an amount equal to the total medical assistance paid by Medicaid on behalf of the individual that has not previously been repaid will be paid to the Division of Medicaid.
6. In addition the trust agreement must provide that at the time of each review of the Settlor's Medicaid eligibility (at least annually) while this trust is in existence, when notified by Medicaid, the Trustee must pay to the Division of Medicaid the amount that should be accumulated in the trust up to the amount expended by the Division of Medicaid on behalf of the Settlor that has not previously been repaid. Failure to make the requested payments may result in the loss of Medicaid eligibility for the Settlor.
7. The trust agreement must provide for an accounting to be sent to the Division of Medicaid when requested to show all receipts and disbursements of the trust during the prior calendar year when requested by Medicaid.

8. No fees are allowed to be paid to the Trustee for their service. In the event funds are retained in the trust, administrative fees are limited to \$10 per month and are intended to cover any bank charges required to maintain the trust account.
9. Any disbursements not approved by Medicaid or provided for by the trust agreement will result in a loss of the trust exemption.
10. The trust instrument must specify an effective date. Unless the applicant is requesting retroactive eligibility of up to 90 days (which will require that the applicant have the funds necessary to fund the trust for that period) the effective date will be the date of execution. If a retroactive date is being sought the effective date will be determined through consultation with the Medicaid Regional Office. In that case the Regional Office should be consulted to determine the effective date prior to execution of the agreement.
11. Medicaid requires that the trust document be filed in the records of the Chancery Clerk.

An Income Trust is a very simple trust that accomplishes the specific goal of receiving income and disbursing it for the sole purpose of allowing an individual in a nursing facility with income in excess of Medicaid income limits to qualify for Medicaid. It is not intended to be a complex fiduciary trust. For more information, attorneys drafting an Income Trust may contact the Division of Medicaid's Legal Unit at (601) 359-6050.

HOME AND COMMUNITY BASED SERVICES WAIVER (HCBS)
INCOME TRUST

THE _____ INCOME TRUST

WHEREAS, _____, hereinafter referred to as the
Settlor, now has a monthly income that exceeds the current Medicaid income limits, and;

WHEREAS, Settlor's other assets have been exhausted by the expenses of the
Settlor's care, and;

WHEREAS, the principal purpose of this Trust is to receive all income payments
due Settlor, including Social Security benefits, retirement benefits, interest, dividends, or
other income, and to allow the Trustee to expend for the benefit of the Settlor each month
an amount equal to no more than \$1.00 less than the then current Medicaid limit, with any
excess income to be retained as a part of the Trust.

WITNESSETH:

This _____ Income Trust Agreement is entered into
between _____, "Settlor", and _____, "Trustee", who
agree as follows:

- (A) The Trustee shall place all income due the Settlor into the Trust, and the Trustee shall hold such income under the following terms and conditions:
 - (1) Trustee shall distribute to the Settlor, or for Settlor's benefit, any amounts allowed by the Division of Medicaid, but the total amount

distributed each month shall not exceed an amount equal to \$1.00 less than the then current Medicaid income limit.

- (2) At the time of each review of the Settlor's Medicaid eligibility (at least annually) while this trust is in existence, the Division of Medicaid will notify the Trustee of the amount that should be accumulated in the trust. The Trustee will then be requested to make payment of this amount to the Division of Medicaid up to the total amount expended by the Division of Medicaid on behalf of the Settlor that has not previously been repaid to Medicaid. Failure to make the requested payments may result in the loss of Medicaid eligibility for the Settlor.
 - (3) This trust will terminate upon the death of the Settlor; when the Settlor's Medicaid eligibility is terminated; when the Settlor's income no longer exceeds the current Medicaid income limits; or when the trust is otherwise terminated. At that time, any income amounts accumulated but undistributed shall be paid over to the Division of Medicaid, State of Mississippi, up to the total amount expended by the Division of Medicaid on behalf of the Settlor that has not previously been repaid to Medicaid.
- (B) When requested, the Trustee shall furnish to the Division of Medicaid, State of Mississippi, an annual accounting to show all receipts and disbursements of the trust during the prior calendar year.
 - (C) The Trustee shall maintain the trust funds on deposit in a federally insured banking institution.
 - (D) No Trustee shall receive a Trustee's fee for services rendered to the trust, however, reasonable bank charges will be allowed.
 - (E) The Trustee shall give written notice to the Division of Medicaid, State of Mississippi when the Settlor dies or when the trust is otherwise terminated.
 - (F) The provisions of this Trust shall be interpreted under the laws of the State of Mississippi.

The effective date of this trust shall be _____.

IN WITNESS WHEREOF, this _____ Income Trust Agreement

has been executed on this the _____ day of _____, 20__.

Trustee

Settlor

STATE OF _____

COUNTY OF _____

Personally appeared before me, the undersigned authority in and for said county and state, on the _____ day of _____, 20__, within my jurisdiction, the within named _____, who acknowledged that (he) (she) executed the above and foregoing instrument.

(NOTARY PUBLIC)

MY COMMISSION EXPIRES:

STATE OF _____

COUNTY OF _____

Personally appeared before me, the undersigned authority in and for said county and state, on the _____ day of _____, 20__, within my jurisdiction, the within named _____, who acknowledged that (he) (she) (they) executed the above and foregoing instrument.

(NOTARY PUBLIC)

MY COMMISSION EXPIRES:

TRUSTEE INFORMATION:

NAME: _____ SSN: _____

TELEPHONE NUMBER: _____

ADDRESS: _____

RELATIONSHIP TO SETTLOR: _____

INCOME TRUST HELP SHEET

Section 1917 (d) of the Social Security Act (42 U.S.C. §1396 p (d) (4)) defines certain provisions that qualify as an exception for the purpose of an individual qualifying for Medicaid benefits. One such exception is an "Income Trust". This type of trust, established for the benefit of an individual participating in a Home and Community Based Services (HCBS) waiver, must meet the following requirements.

1. The purpose of the trust is to allow an individual with excess income who has exhausted all available resources to become eligible for Medicaid. The trust must be composed only of income belonging to the individual. No resources may be used to establish or augment the trust. Inclusion of resources voids the trust exception.
2. The trust must be composed only of income due the individual from all sources such as Social Security, pension benefits, interest and any and all other types/sources of income. The individual's right to receive income should not be transferred to the trust; instead, the individual must first receive the income and then place it into the Income Trust.
3. Income Trusts, once qualified, cannot be modified without the approval of the Division of Medicaid. Trusts must specify that the trust will terminate at the individual's death, when Medicaid eligibility is terminated, when the trust is no longer necessary or in the event the trust is otherwise terminated. Trusts may need to be terminated prior to an individual's death due to changes in the client's income or changes in Medicaid policy regarding how certain income must be counted or in the event the individual is discharged from the nursing facility.
4. The Trust must distribute to the Settlor, or for his/her benefit, an amount equal to not more than \$1 less than the then current Medicaid income limit as approved by Medicaid. The trust should not specify the amount of the individual's income as this amount may change each year and the amount to be released from the trust will change to an amount equal to \$1 less than the current Medicaid income limit.
5. At the dissolution or termination of the trust, the death of the Settlor, loss of the Settlor's Medicaid eligibility or in the event that the Settlor's income no longer exceeds the current Medicaid income limits, the trust agreement must provide that all amounts remaining in the trust up to an amount equal to the total medical assistance paid by Medicaid on behalf of the individual that has not previously been repaid will be paid to the Division of Medicaid.
6. In addition the trust agreement must provide that at the time of each review of the Settlor's Medicaid eligibility (at least annually) while this trust is in existence, when notified by Medicaid, the Trustee must pay to the Division of Medicaid the amount that should be accumulated in the trust up to the amount expended by the Division of

Medicaid on behalf of the Settlor that has not previously been repaid. Failure to make the requested payments may result in the loss of Medicaid eligibility for the Settlor.

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7. The trust agreement must provide for an accounting to be sent to the Division of Medicaid when requested to show all receipts and disbursements of the trust during the prior calendar year when requested by Medicaid.
8. No fees are allowed to be paid to the Trustee for their service. Administrative fees are limited to \$10 per month intended to cover any bank charges required to maintain the trust account.
9. Any disbursements not approved by Medicaid or provided for by the trust agreement will result in a loss of the trust exemption.
10. The trust instrument must specify an effective date. Unless the applicant is requesting retroactive eligibility of up to 90 days (which will require that the applicant have the funds necessary to fund the trust for that period) the effective date will be the date of execution. If a retroactive date is being sought the effective date will be determined through consultation with the Medicaid Regional Office. In that case the Regional Office should be consulted to determine the effective date prior to execution of the agreement.
11. Medicaid requires that the trust document be filed in the records of the Chancery Clerk.

An Income Trust is a very simple trust that accomplishes the specific goal of receiving income and disbursing it for the sole purpose of allowing an individual participating in a Home and Community Based Services (HCBS) waiver with income in excess of Medicaid income limits to qualify for Medicaid. It is not intended to be a complex fiduciary trust. For more information, attorneys drafting an Income Trust may contact the Division of Medicaid's Legal Unit at (601) 359-6050.

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CHAPTER 300 – RESOURCES

LIFE EXPECTANCY TABLE - MALES

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<u>AGE</u>	<u>LIFE EXPECTANCY</u>	<u>AGE</u>	<u>LIFE EXPECTANCY</u>	<u>AGE</u>	<u>LIFE EXPECTANCY</u>
0	74.81	41	36.39	82	6.68
1	74.38	42	35.49	83	6.24
2	73.42	43	34.59	84	5.82
3	72.45	44	33.70	85	5.41
4	71.47	45	32.81	86	5.03
5	70.48	46	31.93	87	4.67
6	69.49	47	31.06	88	4.34
7	68.51	48	30.20	89	4.02
8	67.52	49	29.34	90	3.72
9	66.53	50	28.49	91	3.45
10	65.53	51	27.65	92	3.20
11	64.54	52	26.83	93	2.97
12	63.55	53	26.00	94	2.77
13	62.56	54	25.19	95	2.59
14	61.57	55	24.37	96	2.43
15	60.60	56	23.57	97	2.29
16	59.64	57	22.77	98	2.16
17	58.68	58	21.97	99	2.05
18	57.74	59	21.19	100	1.94
19	56.80	60	20.42	101	1.83
20	55.87	61	19.66	102	1.73
21	54.94	62	18.91	103	1.63
22	54.02	63	18.17	104	1.54
23	53.10	64	17.44	105	1.45
24	52.18	65	16.73	106	1.37
25	51.25	66	16.02	107	1.28
26	50.33	67	15.32	108	1.21
27	49.40	68	14.63	109	1.13
28	48.47	69	13.96	110	1.06
29	47.53	70	13.30	111	0.99
30	46.60	71	12.66	112	0.92
31	45.66	72	12.04	113	0.86
32	44.73	73	11.43	114	0.80
33	43.79	74	10.84	115	0.74
34	42.86	75	10.26	116	0.68
35	41.93	76	9.70	117	0.63
36	40.99	77	9.15	118	0.58
37	40.06	78	8.63	119	0.53
38	39.14	79	8.11		
39	38.22	80	7.62		
40	37.30	81	7.14		

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LIFE EXPECTANCY TABLE - FEMALES

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<u>AGE</u>	<u>LIFE EXPECTANCY</u>	<u>AGE</u>	<u>LIFE EXPECTANCY</u>	<u>AGE</u>	<u>LIFE EXPECTANCY</u>
0	79.95	41	40.51	82	8.04
1	79.45	42	39.57	83	7.52
2	78.48	43	38.64	84	7.02
3	77.50	44	37.71	85	6.54
4	76.52	45	36.79	86	6.08
5	75.53	46	35.87	87	5.65
6	74.54	47	34.96	88	5.25
7	73.55	48	34.05	89	4.87
8	72.56	49	33.14	90	4.52
9	71.57	50	32.24	91	4.19
10	70.58	51	31.35	92	3.89
11	69.58	52	30.46	93	3.61
12	68.59	53	29.57	94	3.36
13	67.60	54	28.69	95	3.13
14	66.61	55	27.82	96	2.93
15	65.62	56	26.94	97	2.75
16	64.64	57	26.08	98	2.58
17	63.67	58	25.22	99	2.43
18	62.69	59	24.37	100	2.29
19	61.72	60	23.53	101	2.15
20	60.74	61	22.70	102	2.02
21	59.77	62	21.88	103	1.89
22	58.80	63	21.08	104	1.77
23	57.83	64	20.28	105	1.66
24	56.86	65	19.49	106	1.55
25	55.88	66	18.70	107	1.44
26	54.91	67	17.93	108	1.34
27	53.94	68	17.17	109	1.25
28	52.97	69	16.42	110	1.16
29	52.00	70	15.69	111	1.07
30	51.03	71	14.97	112	0.99
31	50.06	72	14.27	113	0.91
32	49.10	73	13.58	114	0.84
33	48.13	74	12.90	115	0.76
34	47.17	75	12.24	116	0.70
35	46.21	76	11.59	117	0.63
36	45.25	77	10.96	118	0.58
37	44.29	78	10.34	119	0.53
38	43.34	79	9.74		
39	42.39	80	9.16		
40	41.45	81	8.59		