MEDICAL SERVICES POLICY MANUAL

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Medical Services Policy Manual Appendices

A-100 General Program Information

MS Manual 01/01/14

The Medicaid Program is a Federal-State Program designed to meet the financial expense of medical services for eligible individuals in Arkansas. The Department of Human Services, Divisions of County Operations and Medical Services have the responsibility for administration of the Medicaid Program. The purpose of Medical Services is to provide medical assistance to low income individuals and families and to insure proper utilization of such services. The Division of County Operations will accept all applications, verification documents, etc. and will make eligibility determinations.

Benefits for the Arkansas Medicaid and ARKids Programs include, but are not limited to the following:

- Emergency Services
- Home Health and Hospice
- Hospitalization
- Long Term Care
- Physician Services
- Prescription Drugs
- Transportation-Refer to Appendix B for a description of Transportation Services

Generally, there is no limit on benefits to individuals under age 21 who are enrolled in the Child Health Services Program (EPSDT). There may be benefit limits to individuals over age 21. Consult "Arkansas Medicaid, ARKids First & You, Arkansas Medicaid Beneficiary Handbook" (PUB-040) for specific information and covered services.

The Health Care Independence Program coverage for most individuals will be provided through a private insurance plan, i.e., a Qualified Health Plan or QHP, available through the Federally Facilitated Health Insurance Marketplace (FFM). Medicaid will pay the premium for the private plan. QHP coverage will include:

- Outpatient Services
- Emergency Services
- Hospitalization
- Maternity and Newborn Care

- Mental Health and Substance Abuse
- Prescription Drugs
- Rehabilitative and Habilitative Services
- Laboratory Services
- Preventive and Wellness Services and Chronic Disease Management
- Pediatric Services, including Dental and Vision Care

EXCEPTION: Individuals eligible for the Health Care Independence Program who have health care needs that make coverage through the Health Insurance Marketplace impractical, overly complex, or would undermine continuity or effectiveness of care, will not enroll in a private QHP but will remain in Medicaid. This determination will be made through a Health Care Needs Questionnaire which the individual must complete at *insureark.org* as part of the plan selection process.

A-110 Cost Sharing Coinsurance/Copayment

MS Manual 01/01/14

The types of cost sharing in the Medicaid Program are coinsurance, co-payment, deductibles and premiums. Medicaid recipients are responsible for paying a coinsurance amount equal to 10% of the per diem charge for the first Medicaid covered day per inpatient hospital admission. Medicaid recipients are also responsible for paying a copayment amount per prescription based on a graduated payment scale, not to exceed $3.00 per prescription.

The coinsurance and copayment policy does not apply to the following recipients and/or services:

1. Individuals under the age of 18 receiving coverage through ARKids A or Newborn
2. Pregnant women
3. Individuals residing in a nursing or ICF/MR facility who are approved for vendor payment
4. Emergency services
5. Health Maintenance Organization (HMO) enrollees
6. Services provided to individuals receiving hospice care
7. Health Care Independence enrollees with household income at or below 100% FPL for their household size are not required to pay co-pays or other cost-sharing.

A-120 Dual Eligibles-Medicare/Medicaid

MS Manual 01/01/14

Medicare is a Federal Insurance Program which pays part of hospital and medical costs for persons 65 years of age and over, certain disabled persons and others determined eligible by the Social Security Administration. Medicare Insurance in Arkansas is processed by Arkansas Blue Cross and Blue Shield. Medicare consists of 2 types of coverage, Part A - Hospital Insurance and Part B - Medical Insurance.

Part A-Hospital Insurance is available to certain eligible Medicare recipients without cost. Other individuals, age 65 and over, may purchase Part A for a premium. Part A provides hospital insurance coverage for inpatient hospital care, post-hospital extended care and post-hospital home health care. The Medicaid Agency (DHS) purchases this coverage for individuals entitled as Qualified Medicare Beneficiaries (QMB) (Re. MS B-322) and Qualified Disabled Working Individuals (QDWI) who must pay the Part A premium (Re. MS B-325).

Part B-Medical Insurance for persons eligible for Medicare and Medicaid (with the exception of Medically Needy Spend Down) and for Specified Low Income Medicare Beneficiaries (SMB) (Re. MS B-323) is purchased by the Agency. Medical Services include physician services, supplies, home health care, outpatient hospital services, therapy, and other services.

Limitations for recipients with joint Medicare/Medicaid coverage:

1. Medicaid pays Part B deductible and coinsurance of allowable charges on assigned Medicare claims filed by a participating provider. Medicare determines covered services and allowed charges on all joint claims. Medicaid benefit limits do not apply to Medicare allowable services under Part B.
2. Medicaid covers all medically necessary days of hospitalization. This coverage may be in the form of deductible, coinsurance, and/or per diem payments.
3. Medicaid participates in payment of extended care and skilled nursing care coinsurance days which are allowed by Medicare.

   The Division of Medical Services pays Medicare Part B premiums for eligible Medicare-Medicaid recipients on the basis of their Medicare claim number supplied in the system. For recipients who report that the premium is still being deducted from their monthly Social Security or Railroad Retirement check, the County Office will complete Form DCO-53, Report of Buy-In Problem Cases and fax (501-682-1597) or mail to the Buy-In Coordinator, Slot S333.

Part D-Prescription Drug coverage is available for persons eligible for Medicare and Medicaid. Full benefit dual eligibles (FBDE) are entitled to premium free Part D enrollment, however, they may elect enrollment in an enhanced plan. Those who enroll in an enhanced plan are responsible for that portion of the premium attributable to the enhancement. When an institutionalized FBDE is enrolled in an enhanced plan, the portion of the premium that remains the individual's responsibility is an allowable deduction in the post eligibility calculation.

A-130 Disclosure of Information/Confidentiality

MS Manual 01/01/14

Generally, information concerning an applicant or recipient will not be released to other parties without the individual's written consent. Upon reasonable notice to the county and during county office hours, an applicant or recipient has the right to view copies of the information in his or her case record. The applicant/recipient can only obtain copies of information that he or she provided to the county office.

Information may be released without an individual's written consent to:

1. Authorized employees of the Agency and the Social Security Administration;
2. The individual's attorney, legal guardian or someone with power of attorney;
3. An individual who the recipient has asked to serve as his representative AND who has supplied confidential information for the case record which helped to establish eligibility (i.e., bank statements, income verification);
4. A court of law, when the case record is subpoenaed.
5. The Federally Facilitated Health Insurance Marketplace (FFM) when the individual is determined Medicaid ineligible for specific reasons, e.g., income, in one of the Families and Indivduals Eligibility groups.

Confidential information should not be released over the telephone unless county workers are assured that they are talking with individuals who are entitled to the information being requested.

A-131 Authorized Representatives

MS Manual 01/01/14

Information may be given to Authorized Representatives that have been named on the DCO-153, Consent for an Authorized Representative. In the absence of a completed DCO-153, the fact that a person's name is in the authorized representative space on an application form does not necessarily mean that he or she is an authorized representative or that information should be released to him or her. For example, if an Area Agency on Aging (AAA) employee helps an elderly person complete an application and the employee puts his name in the authorized representative blank, information should not be released to this person unless requested by the applicant/recipient. If the applicant/recipient is incapacitated, if the person who completed the application has supplied information for the case record, and if the person has a need to use information in that record to act in some capacity for the benefit of the applicant/recipient, then information can be released.

An authorized representative may change, i.e., the authorized representative who helped to establish original eligibility may not necessarily be the same person who will help reestablish eligibility at reevaluation. For example, if a NF administrator completes the DCO-7781, Long Term Care Annual Renewal Notice, at reevaluation and the original representative was the recipient's daughter, the recipient and/or daughter should be contacted to determine if the daughter will continue to act as representative to reestablish eligibility.

A-132 Medical Records and DCO-109s

MS Manual 01/01/14

Medical records and the DCO-109 are a part of an applicant's or recipient's case record and, as such, will be considered according to (MS A-130). The DCO-109 must be indexed in the recipient's electronic record and remain as proof of the disability determination made by MRT.

A-133 Medical Providers/Services Organizations

MS Manual 01/01/14

If a provider furnishes an individual's full name (including middle initial), date of birth, Social Security Number, and date of service, the County Office may release limited information. Information which may be released is limited to Medicaid ID #, beginning date of eligibility, whether or not a recipient was eligible on a specific date, services for which an individual is eligible, and TPL information (including policy numbers and type of coverage, if known). It will be an administrative decision whether or not time and staff are available to provide the information.

A-134 Collateral Information

MS Manual 01/01/14

Collateral information (evidence provided by persons other than the applicant/ recipient or by written documents) will be obtained only when necessary to establish eligibility. The applicant or recipient will be informed that the source of collateral information will be contacted.

The caseworker will protect the rights of the applicant/recipient during collateral interviews, and will give only the information necessary to enable the collateral to understand the need for the information requested.

A-140 Retention of Medicaid Case Records

MS Manual 01/01/14

The Medicaid electronic case record must be kept for a minimum of five (5) years after case closure.

EXCEPTION: If an audit by or on behalf of the Federal Government has begun but is not completed at the end of the five year period, or if audit findings have not been resolved at the end of the five year period, the records will be retained until resolution of the audit findings. (Central Office will notify the County Office when an audit by the Federal Government is to be conducted, of the cases to be audited, and when the audit has been completed.)

Documents provided to the county office that do not have to be returned to the applicant will be destroyed by burning or shredding once scanned into the electronic case record.

A-150 Quality Assurance

MS Manual 01/01/14

As a condition of eligibility, all Medicaid recipients are required to cooperate with the Quality Assurance (QA) Unit during their review process.

Upon notification from a QA reviewer that a Medicaid recipient has refused to cooperate, the caseworker will send a 10-day notice to the recipient stating that the Medicaid case will be closed for failure to cooperate with the QA reviewer. The notice will also specify that the family will be ineligible until the client cooperates with the QA reviewer.

EXCEPTION: A newborn case cannot be closed because of the parent's failure to cooperate with QA.

A-160 Referral Process for Counties

MS Manual 01/01/14

There are several standardized processes for hospitals/physicians to refer needy individuals to the County Office. There are also several programs that receive referrals from the County Office. These processes and county office responsibilities are described in the sections below.

A-161 Hospital/Physician Referral

MS Manual 01/01/14

The hospital/physician should inform needy individuals of possible medical assistance available under the Medicaid Program. The hospital/physician should refer all interested individuals to the Arkansas Department of Human Services by means of Form DMS-630, Referral for Medical Assistance.

The hospital/physician should be prepared to provide itemized statements on all individuals referred to the Arkansas Department of Human Services for potential use in the eligibility determination. The hospital's/physician's representative is responsible for the accurate completion of the form DMS-630. After the required information has been entered on the form, the hospital/physician representative will read and explain the authorization section to the client before securing the client's signature. Once the signature is obtained, the hospital/physician representative will sign and date the form and forward it to the DHS Office in the client's county of residence.

Upon receipt of the DMS-630, the caseworker will contact the client. Action must be completed within forty-five (45) days on all applications taken during follow-up. Once a determination has been made, the caseworker will notify the hospital/physician by completing Section 2 of Form DMS-630. The three (3) types of dispositions are:

1. Did Not Respond or No Longer Interested - Client failed to respond to follow-up contact or client stated he/she was no longer interested.
2. Denied - Application taken, client was determined ineligible or eligibility could not be determined.
3. Approved - Application taken, client was determined eligible effective month/day/year.

A-162 Hospital/Physician/Certified Nurse-Midwife Referral for Newborns

MS Manual 01/01/14

Federal law mandates Medicaid coverage for a period of 12 months for a newborn infant whose mother is certified for Medicaid at the birth of the infant, or is determined Medicaid eligible after the birth for the birth month. The newborn is not required to reside with the mother during this period but must be an Arkansas resident. Refer to (MS C-210) for additional information on hospital/physician/certified nurse-midwife referral of a newborn.

A Hospital/Physician Referral Form for Newborns (DCO-645) must be completed to report the birth of a Medicaid eligible infant. The referring providers must complete and mail the form to the DHS County Office where the baby will be residing within 5 days of the infant's birth, when possible. The form will serve the Division of County Operations as verification of the birth date of the infant.

A-163 Child Health Services Program (EPSDT)

MS Manual 01/01/14

The Child Health Services Program (EPSDT) is a program designed to provide early and periodic screening, diagnosis and treatment services at no cost to Medicaid eligible individuals under age 21 (including parents under age 21).

The Division of Medical Services (DMS) administers the Child Health Services Program (EPSDT). Questions regarding eligibility and services should be directed to the Provider Relations Unit in DMS at 501-320-6220.

A-164 Client Representative Services Program

MS Manual 01/01/14

Client Representation is a program available through the Division of Aging and Adult Services (DAAS) for eligible persons age 60 and over. It is designed to individualize and coordinate delivery of social and health care services for the person being served.

NOTE: This program should not be confused with the Title XIX Targeted Case Management Program which is funded by Medicaid.

A-164 Client Representative Services Program

Client Representation includes developing individual service plans, arranging for necessary care and services, doing follow-up, monitoring client and service delivery, and periodically reviewing and revising overall service plans.

Client Representation services are administered through the State's Area Agencies on Aging.

Location of Area Agencies on Aging (AAA)

Region	Counties	Agency
REGION I	Serving Baxter, Benton, Boone, Carroll, Madison, Marion, Newton, Searcy and Washington counties.	AAA of Northwest Arkansas Harrison, Arkansas **870-741-1144, Toll Free: 1-800-432-9721**
REGION II	Serving Cleburne, Fulton, Independence, Izard, Jackson, Sharp, Stone, Van Buren, White and Woodruff counties.	White River AAA Batesville, Arkansas **870-612-3000, Toll Free: 1-800-382-3205**
REGION III	Serving Clay, Craighead, Crittenden, Cross, Greene, Lawrence, Lee, Mississippi, Phillips, Poinsett, Randolph and St. Francis counties.	East Arkansas AAA Jonesboro, Arkansas **870-930-2239, Toll Free: 1-800-467-3278**
REGION IV	Serving Arkansas, Ashley, Bradley, Chicot, Cleveland, Desha, Drew, Grant, Jefferson and Lincoln counties.	AAA of Southeast Arkansas Pine Bluff, Arkansas **870-543-6300, Toll Free: 1-800-264-3260**
REGION V	Serving Faulkner, Lonoke, Monroe, Prairie, Pulaski and Saline counties.	Central Arkansas AAA (Care Link) North Little Rock, Arkansas **501-372-5300, Toll Free: 1-800-482-6359**
REGION VI	Serving Conway, Clark, Garland, Hot Spring, Johnson, Montgomery, Perry, Pike, Pope and Yell counties.	AAA of West Central Arkansas Hot Springs, Arkansas **501-321-2811, Toll Free: 1-800-467-2170**
REGION VII	Serving Calhoun, Columbia, Dallas, Hempstead, Howard, Lafayette, Little River, Miller, Nevada Ouachita, Sevier and Union counties.	Southwest Arkansas AAA Magnolia, Arkansas **870-234-7410, Toll Free: 1-800-272-2127**
REGION VIII	Serving Crawford, Franklin, Logan, Polk, Scott and Sebastian counties.	Western Arkansas AAA Fort Smith, Arkansas **479-783-4500, Toll Free: 1-800-320-6667**

Services which are arranged for or provided by the Client Representation Program are: Advocacy Assistance, Adult Day Care, Chore Services, Companionship, Congregate Housing, Congregate Meals, Emergency Life Response, Escort, Home Delivered Meals, Home Health Services, Home Repair/Modification/Maintenance, Homemaker Services, Information and Assistance, Job Placement, Medical Transportation, Outreach, Personal Care, Respite Care, Protective Services, referral for Legal Assistance, providing information on and determining eligibility for public benefits such as QMB and SMB, assistance with completion of applications and paperwork, and attending meetings on behalf of client. Note, not every service is available in every region and a service available within a region may not be available in every location.

To refer an individual for Client Representation Services, the caseworker should complete form DHS-3350 and route to the AAA listed above which serves the county where the referral is located.

A-165 Inpatient Psychiatric Services

MS Manual 01/01/14

The Arkansas Medicaid Program provides coverage of inpatient psychiatric care for eligible individuals under age 21. Individuals over the age of 21 are not Medicaid eligible while institutionalized at a psychiatric facility.

EXCEPTION: Coverage may continue to age 22 if the individual is an inpatient at an approved facility at the time of the 21st birthday.

Individuals under age 21 who are already eligible for Medicaid can be covered for inpatient psychiatric care services at an approved facility without making an application.

Information on an approved facility may be obtained from:

Medicaid Provider Enrollment Unit
HP Enterprise Services
P.O. Box 8105
Little Rock, AR 72203-8105
Toll free 1-800-457-4454 or 501-376-2211

A primary care physician (PCP) referral is required before a Medicaid recipient under age 21 is eligible for inpatient psychiatric services. Exceptions for PCP referrals are listed at the following link: https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/apdwvr.aspx

A PCP referral is not required for emergency admissions.

Individuals under age 21 who are not eligible for Medicaid when they enter one of these facilities will be referred to the County DHS Office in the individual's county of last residence or parent's residence for eligibility determination.

Individuals admitted into an approved psychiatric facility from an in-home or non-institutional setting will be evaluated against the following criteria:

1. Individuals Under Are 19-Apply the rules of ARKids A or U-18 spend down for eligibility determinations. ARKids B does not pay for inpatient psychiatric services.
2. Individuals Age 19-21-Apply the rules for the Health Care Independence Program. Refer to B-270.

A-166 DDS Children's Services

MS Manual 01/01/14

The Division of Developmental Disabilities Services (DDS) has the administrative responsibility for Children's Services (CS), formerly known as Children's Medical Services (CMS). Within the Division, the Children's Services (CS) section is charged with the administration of all such services to children with disabilities.

DDS Children's Services (CS) is limited to Children with Special Health Care Needs (CSHCN) under the age of 18 years, who will benefit from surgical or medical intervention or require extensive case coordination.

The county office will refer inquiries to DDS Children's Services Community Based Office located in the DHS County Office servicing the area where the applicant resides or by contacting DDS Children's Services Central Office at 501-682-2277.

A-170 Expedited Services for Child Abuse Cases

MS Manual 01/01/14

Special consideration for immediate action will be given to cases involving child abuse (where the perpetrator has left the home) that are identified by the DCFS worker as needing expedited services. The caseworker will forward the application and a summary of why special consideration is requested to the supervisor or his/her designated representative along with a recommendation for immediate action.

The application will be reviewed by the supervisor or the designated representative. If the caseworker's recommendation for immediate consideration is approved by the supervisor or the designated representative, the application will be assigned for immediate disposition and have priority over all other pending applications.

If the supervisor does not accept the caseworker's recommendation, the application will be disposed of in regular, chronological order.

A-180 Medicaid/Health Insurance Marketplace Interactions

MS Manual 01/01/14

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act) allow individuals under the age of 65 to obtain affordable health insurance coverage through a Health Insurance Marketplace established in each state. A Health Insurance Marketplace is an online marketplace where individuals can shop for a health insurance plan that is both affordable and meets the individual's specific health care needs. In addition, an individual can apply through the Health Insurance Marketplace for assistance in meeting the cost of health insurance through an insurance affordability program. In Arkansas, the Health Insurance Marketplace is a State Partnership with the Federal government and is referred to as the Federally Facilitated Health Insurance Marketplace (FFM).

The term "Insurance affordability program" includes the Medicaid program, premium tax credits including advance payment of the credit, and cost-sharing reductions. Only individuals who are determined ineligible for an appropriate Medicaid coverage group are potentially eligible for the premium tax credit and cost-sharing reductions. The upper income limit for any amount of premium assistance is 400% of the federal poverty level for the individual's household size.

When an individual applies for an insurance affordability program through the FFM, Medicaid eligibility will first be determined for all household members applying for coverage. If eligible, the FFM will notify the individual of the Medicaid eligibility and send the individual's electronic account to the State Medicaid agency (DHS) for enrollment in the applicable Medicaid eligibility group. If all members of the individual's household are Medicaid eligible, no further action to select or enroll in a Qualified Health Plan (QHP) is required of the individual, with the exception of individuals eligible for the Health Care Independence Program. Upon receipt of the HCIP individual's electronic account from the FFM, DHS will notify the individual of the next steps to complete the HCIP enrollment process. See MS C-150.

For any individual determined ineligible for Medicaid, the FFM will then continue to determine eligibility for the premium tax credit and cost-sharing reductions. Once eligibility and the amount of the tax credit and cost-sharing reduction is determined, the individual will be given insurance plan options from which to select the plan that best suits the individual and family. Enrollment in the selected plan will then occur through the FFM.

Since Medicaid is one of the insurance affordability programs under the Affordable Care Act, an individual may apply directly to DHS for Medicaid eligibility. To coordinate and streamline the application process for the insurance affordability programs, DHS uses the same Single Streamlined Application used by the FFM. Although DHS will not make a determination of eligibility for the premium tax credit or cost-sharing reductions for individuals determined Medicaid ineligible, DHS will send the individual's electronic account to the FFM which will include the needed application data for the FFM to make those determinations.

In addition to the interactions resulting from the application process, the Affordable Care Act mandates that the Medicaid agency and the FFM coordinate enrollment activities for the individual when changes occur that result in either Medicaid ineligibility or eligibility. For example, the parent in a family who was Medicaid eligible starts a new job which results in the loss of Medicaid eligibility. In this situation, DHS will send the electronic account to the FFM and notify the individual to go to the FFM to have eligibility for the premium tax credit and cost-sharing made and then select and enroll in a Qualified Health Plan (QHP). The loss of Medicaid eligibility triggers a 60 day Special Enrollment Period at the FFM.

A-190 Twelve Month Filing Deadline on Medicaid Claims

MS Manual 01/01/14

The Medicaid Program has a twelve month filing deadline from the date of service for all Medicaid claims, (e.g., claims with a 7/1/12 date of service must be received by the Claims Processor on or before 7/1/13 if payment is to be made). Claims which are not received within the twelve-month period will be routinely denied. Recipients are not liable for payment of any claim denied due to the timely filing policy.

In situations when the recipient's Medicaid eligibility has not been determined until after the service has been rendered, the provider must still submit the claim within twelve months from the date of service. If the claim is denied for recipient ineligibility, the provider may resubmit the claim when eligibility is determined. If the initial claim for payment was submitted within the filing deadline, the claim will be considered timely filed, regardless of when the eligibility determination is finalized for the date of service.

A-190 Twelve Month Filing Deadline on Medicaid Claims

In order for Medicaid to consider the claim for payment, the case worker must key the eligibility dates in the system even if the date of service exceeds the 365 day filing deadline (e.g. SSA approves disability retroactively, an Administrative Appeal Decision ruled in the applicant's favor, etc.) If the age of the application prevents registration, the case worker should contact System Support regarding updates for the period of coverage. Narrative documentation must support this action.

If the county made an error in processing the application and caused the claim process to go beyond 12 months, an email will be sent to the Assistant Director (AD) of Field Operations explaining the county error in causing the claim process to go beyond 12 months. If approved by the AD, the case worker will send correspondence to the Division of Medical Services, Medical Assistance Unit, Slot S410 requesting special consideration and explaining the reason for the application processing delay.

NOTE: The above procedure is not a guarantee that the bills will be paid. Arkansas Medicaid only considers payment if billing is correct, the client has not exceeded his or her benefit limits and is eligible for the services.

Medicare determines covered services and allowed charges on all joint Medicare/ Medicaid claims. Medicaid is only responsible for the deductible and/or coinsurance on the allowed charges. For dually eligible recipients, a claim filed with Medicare will serve as the claim for Medicaid payment of the deductible/coinsurance amounts. The provider must submit the claim to Medicare within twelve months from the date of service in order to meet the Medicaid filing deadline. If the provider submits the claim to Medicare within twelve months from the date of service, the claim will be considered timely filed, regardless of when Medicare crosses the claim to Medicaid for payment of the deductible/coinsurance.

In cases where the recipient is reporting problems regarding Medicaid payment of claims to a provider, refer the recipient to the Medicaid Claims Unit at **501-682-8501** or **1-800-482-5431**. If the provider is reporting problems regarding Medicaid payment of claims, refer the provider to the Medical Assistance Unit at **501-682-8315**.

A-200 Medicaid Coverage Periods

MS Manual 01/01/14

The coverage period is the period of time the individual has coverage for Medicaid. Once eligibility has been determined, the Medicaid coverage period begins from the point of application and generally is open-ended. Pregnant Woman and Newborn categories have a fixed eligibility period as do the Spend-Down categories. In addition, fixed eligibility may be authorized in any category. See MS A-220.

The effective first and last date of coverage is dependent on the eligibility group in which the individual is placed as identified below:

1. Families and Individuals Eligibility Groups (ARKids First, Parents/Caretaker Relatives, Former Foster Care Adults, Pregnant Woman and Health Care Independence Program)

   The effective first day of coverage is the first day of the month of application unless retroactive coverage is approved. Coverage will end on the last day of the month eligibility ceases.

2. AABD Eligibility Groups (Nursing Facility, Home and Community Based Waivers, TEFRA, Medicare Savings Program)

   An individual's coverage period may begin or end on any day of the month. When eligibility is established, the effective first day of coverage is the date of application, unless retroactive coverage is approved or one of the exceptions listed below applies. For most categories, coverage may be terminated at any time within the month eligibility ceases. The end date of eligibility will be the last day of the 10-day notice period, unless the recipient requests a hearing within the advance notice period.

   The begin date exceptions are as follows:

   a. AAPD Waiver

      Eligibility will begin the day the approval is entered into the system, unless a prior date is authorized by the DHS RN

   b. ElderChoices Waiver

      Eligibility will begin the day the approval is entered into the system, unless a prior date is authorized by the DHS RN.

c. Autism

Eligibility will begin the day the approval is entered into the system.

d. DDS Waiver

Eligibility will begin the day the approval is entered into the system. For an ICF/MR resident who leaves a facility, the begin date can be no earlier than the date his or her facility residence was terminated.

3. Medicare Savings Program exceptions:

   a. QMB-The effective date of coverage is the first day of the month following the month of approval.

   b. SMB-The effective first date of coverage is the first day of the month of application. Coverage must always begin on the first day of the month.

   c. QI-1- The effective day of coverage is the first day of the month of application. Coverage must always begin on the first day of the month.

   d. QDWI-The effective day of coverage will be the first day of the month based on the date of the application and the date on which all eligibility factors are met, including the effective month of Medicare Part A.

4. Families and Individuals Eligibility Groups (U-18 and Pregnant Woman Medically Needy Spend Down)

   The spend down period is the three calendar months used in determining eligibility. The spend down quarter can be any continuous three calendar month period between the first day of the three month retroactive period (three calendar months prior to the application month) and the last day of the three month period beginning after the application month. The three months chosen for the spend down period should be the three months in which the applicant has the greatest medical expenses, or the three months in which he or she would receive the greatest benefit. See MS E 300-340.

Refer to MS A-210 through MS A-215 for retroactive eligibility for each category listed above.

A-210 Retroactive Eligibility

MS Manual 01/01/14

The State is required to provide retroactive eligibility for up to three full months prior to the date of application to applicants who:

1. Received medical services in the retroactive period; and
2. Were eligible in the month the medical services were received.

Retroactive eligibility will be provided to applicants who were otherwise eligible in the month services were received regardless of whether they were ineligible at other times during the retroactive period. Retroactive eligibility is separate and apart from current eligibility, i.e., applicants not eligible for the current period may be eligible for the retroactive period. Retroactive eligibility determinations are required for all categories, except DDS Waiver, QMB and Autism.

NOTE: Retroactive coverage for Newborns will not be given prior to the date of birth.

NOTE: Retroactive coverage for Former Foster Care and Health Care Independence Program cannot begin prior to January 1, 2014. Medicaid will provide retroactive coverage for services received prior to approval for the Health Care Independence Program and prior to the individual's enrollment in a private insurance plan.

An application for retroactive eligibility may be made on behalf of deceased persons and eligibility will be provided if they were eligible when the services were received.

For cases in which an applicant has not resided in Arkansas for three full months prior to the date of application, the retroactive period begins with the date the individual established residency in Arkansas. The "previous state" is responsible for the retroactive period prior to the time the applicant established residency in Arkansas. The caseworker is responsible for providing the "previous state" with information necessary to determine eligibility for its portion of the retroactive period.

Services for the retroactive period are subject to the same restrictions as services for the current period (i.e., utilization review, benefit limitations, medical necessity, etc.). Prior authorization cannot be a condition of payment for services received during the retroactive period. However, such services are subject to the same Utilization Review standards as all other services financed under the State's Medicaid program. The State is not required nor obligated to pay for services which have been retroactively determined by Utilization Review to be unnecessary.

For cases in which an applicant has made partial or full payment for services received during the retroactive period, the state will make payment to the servicing provider if:

1. The services were necessary and the applicant was eligible when the services were received; and
2. The provider is willing to refund the payment to the applicant and bill the State for the services.

A-211 Retroactive Eligibility-Long Term Services and Supports

MS Manual 01/01/14

For Long Term Services and Supports (LTSS) retroactive eligibility is determined according to the guidelines for each Long Term Services and Supports eligibility group as described below:

1. Nursing Facility (NF)

   For any month that an individual was in an NF during the retroactive period, the eligibility determination for retroactive LTSS is the same as the eligibility determination for current eligibility.

   The caseworker will indicate the begin date of retroactive eligibility in the system in conjunction with current facility vendor payment.

   The caseworker should be aware that eligibility for retroactive Medicaid based on LTC criteria can only be determined for applicants who were institutionalized prior to the month of application. Applicants who first qualify for LTC in the month of application will have to be determined eligible for retroactive Medicaid in another eligibility group.

2. AAPD Waiver

   In some cases deemed critical by the DHS RN, the begin date of eligibility may be prior to the date of completion of the case if all eligibility criteria have been met, if the Waiver applicant and Waiver provider made a request for services to the DHS RN prior to certification, and if the provision of services was approved by the DHS RN.

3. ElderChoices Waiver

   Eligibility beginning before the date the case is approved by the caseworker will be established only when the DHS RN has recommended the applicant for medical approval based on the medical criteria. The Waiver eligibility date will never be established retroactively by the caseworker unless the retroactive eligibility date is provided by the DHS RN.

4. Assisted Living-There is no retroactive coverage in this group.

A-212 Retroactive Eligibility-Other Waiver Programs

MS Manual 01/01/14

Retroactive eligibility is determined according to the guidelines for each Waiver eligibility group as described below:

1. TEFRA Waiver

   Retroactive coverage can begin three months prior to the date of application if all eligibility requirements are met.

2. Autism Waiver

   There is no retroactive coverage in this group.

3. DDS Waiver

   There is no retroactive coverage in this group.

A-213 Retroactive Eligibility-Medicare Savings Programs (MSP)

MS Manual 01/01/14

MSP does not follow the general rule for retroactive coverage. These retroactive coverage periods are described below:

1. For ARSeniors, retroactive coverage can begin three months prior to the date of application.
2. For QMB, there is no retroactive coverage for this group.
3. For SMB and QI-1-retroactive coverage can begin on the first day of the month, three months prior to the application month if all eligibility requirements are met.

NOTE: Retroactive coverage for QI-1 cannot begin before January 1 in the current calendar year.

A-214 Retroactive Eligibility-SSI Eligibles

MS Manual 01/01/14

The caseworker is notified of SSA Retroactive Blindness and Disability Determinations for SSI recipients on Form DCO-109A. The DCO-109A identifies the month(s) to be considered for retroactive eligibility determination.

The DCO-109A will be retained in an alphabetical file for a period of three years unless the caseworker receives notification of alleged medical expenses for the retroactive period. Notification of alleged medical expenses may be by means of:

1. Data processing printout (sent periodically as SSA makes information available); or
2. Direct contact by recipient.

When the caseworker has been notified of alleged medical expenses of AB or AD SSI recipients, but has not received a DCO-109A, the AB or AD SSI recipient will be referred to SSA to secure verification of blindness or disability. If difficulty is encountered in securing the DCO-109A, the Central Office Customer Assistance Unit may be able to assist.

The caseworker will also receive notification of AA SSI recipients who have alleged medical expenses for the retroactive period by the same means as described above. The caseworker will need to make retroactive eligibility determinations on these AA SSI recipients only if they reached age 65 prior to the month of application with SSA.

Once notification of alleged medical expenses and verification of age, blindness or disability for the retroactive period have been received, the County Office will contact the SSI recipient to make an appointment for the retroactive eligibility determination.

Eligibility for AA, AB or AD SSI recipients will be determined against LTSS criteria using MS E-400 thru E-452 for income and MS E-500 thru E-530 for resources. The County Office will use the SSA application date for purposes of determining the retroactive period. Applications for retroactive eligibility by SSI recipients will be secured on Form DCO-777. Income eligibility will be determined on Form 707, Notice of Action, Long Term Care, by completing sections 1, 2, and 5. Countable income determined in section 2 will be compared with the SSI income standards for individuals or couples to determine income eligibility (Re. MS Appendix S).

NOTE: Individuals (or couples) living in the household of another may be considered to be in the "A" Living Arrangement when it is documented that they pay an equal share of the total household expenses.

Resource eligibility will be determined by verifying and evaluating the resources, if any, of the recipient.

Retroactive Medicaid eligibility for all SSI recipients, whether the case is open or closed, will be completed by ANSWER System Support. The begin date cannot be more than three months prior to the SSI application date. The caseworker will send an e-mail to the Program Eligibility Analyst which will include the Name of the Master Case, the Master Case Number and the Budget Unit Name/Client Name where the retro is needed. This email will be forwarded to ANSWER System Support to enter the information for the retroactive coverage.

A-215 Retroactive Eligibility-Recipients Not Currently Eligible for SSI

MS Manual 01/01/14

Under current SSA regulations, an SSI application will not be completed for an applicant who dies before income and resource eligibility is determined and for an applicant who is not survived by an eligible spouse. Therefore, the caseworker will have the responsibility for the income and resource eligibility determination for the month of application and up until death, in addition to the retroactive period. An individual responsible for the medical debt of the deceased may make the application. Individuals who have been denied SSI for reasons other than disability may also apply for retroactive eligibility. In either case, the eligibility determination will be the same as the determination for eligible SSI recipients. The caseworker will need a DCO-109A from SSA on applications for AB or AD.

Applications for deceased individuals, or individuals denied by SSI, will be registered in the system in the Aged, Blind, or Disabled categories.

Deceased individuals or individuals denied by SSI who qualify for retroactive eligibility will be certified for fixed eligibility in the system in the appropriate category (Aged, Blind, or Disabled).

A-216 Retroactive Eligibility-Foster Children

MS Manual 01/01/14

Retroactive coverage for foster children follows the rule for the coverage category in which the foster child is placed with the following exceptions:

1. Non-Title IV-E Adoptive Children with Special Needs-May be certified for retroactive coverage for up to three months prior to the month of application if all the conditions of eligibility are met and if there are unpaid medical bills for this period. If the adoption assistance agreement was not in effect in the retroactive months, then eligibility cannot

be established under these provisions but must be established under other Medicaid guidelines.

2. Title IV-E Children who enter Arkansas from another State-May receive up to 3 months retroactive coverage if it is established the child did not receive Medicaid benefits from the sending state in the retroactive months and if the child incurred medical bills in Arkansas during the retroactive months.

A-220 Fixed Eligibility

MS Manual 01/01/14

Applicants in any Medicaid category may qualify for "Fixed" eligibility (retroactive and/or current) under certain conditions. The State is required to provide "fixed" eligibility to applicants who:

1. Received medical services in the eligibility period (retroactive and/or current); and
2. Were eligible when the services were received;
3. Died before eligibility was determined; or
4. Became ineligible following the month of application, but before eligibility was determined.

The caseworker will certify an individual for fixed eligibility in the system by showing a begin date and end date.

A-230 Twelve Month Continuous Coverage

MS Manual 01/01/14

Twelve month continuous coverage means that the individual is guaranteed 12 months of continuous coverage regardless of income changes which could result in ineligibility.

The following eligibility groups are provided 12 months of continuous coverage:

1. ARKids B
2. Newborns

Changes in income and other eligibility criteria that occur during the year will not affect the child's eligibility. Therefore, participants are not required to report changes in income until renewal. The only time a child loses eligibility during the 12 month period is if he moves out of state or an ARKids B child reaches the age of 19.

A-200 Medicaid Coverage Periods

A-230 Twelve Month Continuous Coverage

For ARKids B, the 12-months of continuous coverage will begin with the later of the last approval date or last renewal date and will end on the last day of the 12th month. For Newborns, coverage will begin on the date of birth and will end one day prior to the child's first birthday (See MS I-230 for transitioning a newborn to ARKids First.)

EXAMPLE: Mary's ARKids B application date was January 2, 2014 and her application was approved on February 2, 2014. Her coverage will begin January 1, 2014. An income change occurs in July, which caused ineligibility. Mary's ARKids B case will not be closed until December 31, 2014 unless she moves out of state or turns 19 before then.

A-300 Identification Cards

MS Manual 01/01/14

Identification cards will be sent to all new eligible recipients at the time of approval. The recipient is responsible for presenting his/her identification card to the hospital/physician for billing purposes each time he/she receives a service.

A-310 Medicaid Identification Cards

MS Manual 01/01/14

Medicaid cards are produced and mailed directly to recipients by a card production facility. Cards are normally mailed within five business days of approval. Refer to MS A-330 for cards issued to those in the Health Care Independence Program.

The following information is imprinted on the Medicaid card:

- Identification Number-The Medicaid identification number is a ten-digit number (e.g., 0123456-001).
- Name of Eligible Recipient
- Date of Birth
- Date of Issuance-Identifies the date the ID card was originally issued.

A-320 ARKids Identification Cards

MS Manual 01/01/14

ARKids identification cards are produced and mailed directly to recipients as described in A-310 above. They also have the same information imprinted on the card. In addition, the ARKids identification card has the "ARKids 1st, Healthy Kids. Healthy Families." logo on the front of the card. A maximum of four cards can be mailed per envelope.

NOTE: For both Medicaid and ARKids identification cards, the recipient should be instructed to keep his or her identification card even after an eligibility period has ended, as the individual may use it again should he or she become eligible again in the future.

A-330 Health Care Independence Program Identification Cards

MS Manual 01/01/14

For those individuals who are enrolled in a Qualified Health Plan through auto assignment or by their own selection, an identification card will be mailed directly to the individual by the insurance carrier. For those individuals who are enrolled in Medicaid through the Health Care Independence Program (MS-C-150), a Medicaid card will be mailed within 5 business days of the individual completing the Health Care Needs Questionnaire.

A-340 Reissuance of Identification Cards

MS Manual 01/01/14

Replacement cards will be authorized through the system. The procedures are the same for SSI and non-SSI recipients.

1. Review recipient's case information in the system to verify that correct information (e.g., name, date of birth, mailing address, etc.) has been updated.

2. Select the ID button on the Budget Summary and then check the "Replace" box by the member(s) who needs the replacement card and then click the Save button.

   If the recipient is SSI eligible, locate the SSI case number in the system. If there is no record of the case, or the SSI recipient is not receiving a check, refer him or her directly to the local SSA Office. If the SSI recipient has been approved for 30 days or less, inform him or her that it is too early to have received a Medicaid card. It takes Social Security 30 days or more from the date of approval to forward the eligibility date through SDX.

   If the SSI case record is located on WASM, but information on the record is incorrect (e.g., wrong address), the caseworker should contact System Support or Client Assistance for correction(s) to the case.

NOTE: DCO will be the point of contact for Health Care Independence Program recipients enrolled in a Qualified Health Plan. Contact information will be printed on the card and on the letter/card carrier attached to the card.

B-100 Eligibility Groups

MS Manual 01/01/14

A Medicaid eligibility group defines the eligibility requirements an individual must meet to be eligible for Medicaid coverage. The eligibility group also defines the benefit package or array of services the individuals in that group will receive.

Effective January 1, 2014, each of Arkansas' Medicaid groups fall under one the following general groupings:

- Families and Individuals
- Aid to the Aged, Blind, and Disabled
- Foster Care & Adoption Assistance
- Emergency Services for Aliens

Within these general groupings are more specific groups defined by specific individual characteristics, such as age, and/or services needed, such as Long Term Services and Supports. In addition, some groups are assigned two or more categories of coverage due to differing benefit packages or federal funding match rates. These are described in more detail in the following sections.

B-200 Families and Individuals Group (MAGI)

MS Manual 01/01/14

Most individuals under age 65 will fall into the Families and Individuals general eligibility grouping. Most of the specific groups under this general grouping use the Modified Adjusted Gross Income or MAGI methodologies to determine financial eligibility for individuals. (See MS E-200 for specific policy regarding the MAGI methodology.) Therefore, this group is commonly called the "MAGI" group. Generally speaking, the MAGI groups cover non-SSI adults and children under age 65 who are not in need of specialized services or benefits related to a disability or blindness or who are not in need of long term care support or services (See MS E-220). A non-SSI individual with a disability or blindness may be covered in a MAGI group if otherwise eligible and not eligible for or covered by Medicare.

NOTE: Two groups (Newborns and Former Foster Care Adults) which are described below do not have a financial test and therefore, the MAGI methodology is not used. However, since these two groups cover non-aged, blind, or disabled adults or children, they are included in the general grouping of Families and Individuals.

Individuals in all groups must meet the General Eligibility Requirements as outlined in MS D-100-540.

The sections that follow describe each of the specific Families and Individuals (MAGI) eligibility groups.

B-210 ARKids First

MS Manual 01/01/14

The ARKids First group provides health insurance coverage for Arkansas children from birth to age 19. There are two categories of coverage – ARKids A and ARKids B.

ARKids A provides coverage to children under age 19 with family income under 142% of the Federal Poverty Level for the applicable household size (See MS E-110). ARKids A provides the full range of Medicaid services. This is a mandatory eligibility group authorized and funded by Title XIX of the Social Security Act (Medicaid).

ARKids B provides coverage to otherwise uninsured children under age 19 with family income equal to or over 142% but under 211% of the FPL for the household size (See MS E-110). ARKids B provides a more limited range of services with limited co-pays for some services.

(See Appendix G) ARKids B was authorized by Arkansas Act 407 of 1997 (the ARKids First Program Act) and was implemented as a Section 1115 Medicaid expansion program effective September 1, 1997. The program is currently funded by the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act.

Because ARKids A and ARKids B have different benefit packages and have different federal funding match rates, it is necessary to designate separate categories of coverage for them.

Please see PUB-040, Arkansas Medicaid, ARKids First & You for a summary of the benefit packages which highlights the differences in the two packages.

B-220 Newborns

MS Manual 01/01/14

This group consists of newborns up to age 1 whose mothers were Medicaid eligible at the time of their births. Newborns in this group are guaranteed Medicaid coverage for the first year of life regardless of income changes that may occur during that first year. Newborns receive the full range of Medicaid services.

Although this group is considered part of the ARKids First group, Newborns also have a separate category of coverage to ensure no change in household circumstances affects their one-year of guaranteed coverage. At age 1, eligibility for ARKids First (A or B) is determined as for any other child (See MS I-230).

B-230 Parents/Caretaker Relatives

MS Manual 01/01/14

This group consists of adults who have related minor children living in the home for whom the adult exercises care and responsibility (MS F-110) and whose household income is below the income limit for this group (See MS E-110).

Both natural or adoptive parents may be living in the home with the child. There is no "deprivation of parental care or support" requirement for the parents to be included in this group.

If an adult meets the criteria for this group, he or she must be assigned to this group even if eligibility exists in another MAGI eligibility group. Therefore, eligibility for this group is determined first before moving to other categories that may have higher income limits.

NOTE: Only adults are included in this group. The children living with these adults are covered in the appropriate ARKids First group.

Adults covered in the group receive the full range of Medicaid benefits.

B-240 Pregnant Women

MS Manual 01/01/14

This group consists of women age 19 and above who are pregnant at the time of application and are not eligible in either the Parent/Caretaker Relative (MS B-230) or Former Foster Care (MS B-260) group. A pregnant woman can apply for Pregnant Women Medicaid up to 3 months after birth of the baby.

There are two categories of coverage within the Pregnant Woman group.

- Those with household income at or below the income limit for Low-Income Pregnant Woman Coverage (MS E-110) receive the full range of Medicaid services.
- Those with income above that limit but under the limit for Pregnant Woman Only (MS E-110) are provided services related to prenatal, delivery and postpartum care, and to other conditions that may complicate pregnancy.

Both levels provide postpartum coverage through the end of the month in which the 60th day from the date of delivery falls.

B-250 Unborn Child (Pregnant Woman)

MS Manual 01/01/14

This group consists of non-citizen pregnant women who do not meet the alienage requirements for Medicaid. This includes pregnant women who are any of the following:

- Lawfully admitted aliens who do not yet meet the 5 year residency requirements;
- Lawfully present in the United States under a Compact of Free Association with the United States (e.g., individuals from the Marshall Islands);
- Undocumented aliens.

The purpose of this group is to provide pre-natal care to the unborn child who is expected to be born in the United States. As this coverage is intended to benefit unborn children who will be

U.S. citizens at birth, the pregnant woman will not qualify for this coverage if she intends to leave the U.S. before the baby is born.

This group is also different from the other Pregnant Women groups in that it receives an enhanced federal match rate under the Children's Health Insurance Program. The CHIP enhanced funding coverage is available only to pregnant women who have no other insurance that covers pregnancy related services.

The non-citizen pregnant woman will receive postpartum coverage. Postpartum coverage is through the end of the month in which the 60th day from the date of delivery falls.

B-260 Former Foster Care Adults

MS Manual 01/01/14

This group consists of adults up to age 26 who aged out of foster care in Arkansas. There is no income or resource test. Other than the general Medicaid eligibility requirements that all Medicaid eligibles must meet (MS D-100), the only requirement for eligibility in this group is that the adult was in foster care in Arkansas, aged out of foster care at age 18-21 depending on the individual circumstances, and is currently under age 26.

Individuals in this group receive the full range of Medicaid benefits.

B-270 Adults Age 19-64 (Health Care Independence Program)

MS Manual 01/01/14

This group consists of adults who are 19 through 64 years of age with household income below 133% (138% with 5% disregard applied) of the applicable federal poverty level (MS E-110) and are not eligible in either the Parent/Caretaker Relative group (MS B-230) or Former Foster Care group (MS B-260). Adults who are blind or who have a disability may be covered in this group unless they are determined eligible for coverage in another group on the basis of the need for long term care services (facility or waiver) or other disability related services.

A woman who is pregnant at the time of application cannot be included in this group until after the postpartum period. She must be enrolled in one of the pregnant women groups or in the parent/caretaker relative group if eligible. However, a woman who becomes pregnant after enrolling in this adult group may remain in the adult group throughout her pregnancy.

Individuals eligible in this group will participate in the Health Care Independence Program authorized by Arkansas Act 1498 of 2013. The Health Care Independence Program provides

Medicaid funding in the form of premium assistance to enable individuals to enroll in private health insurance plans offered through the Federally Facilitated Health Insurance Marketplace (FFM).

EXCEPTION: Individuals eligible for the Health Care Independence Program, who have health care needs that make coverage through the Health Insurance Marketplace impractical, overly complex, or would undermine continuity or effectiveness of care, will not enroll in a private QHP but will remain in Medicaid (Re. MS A-100).

Note: If an individual in this group has a child(ren) under age 18 living in the home, the child(ren) must be covered in Medicaid or have other health insurance coverage.

B-280 Spend Down Medically Needy (U-18 and Pregnant Woman)

MS Manual 01/01/14

The group consists of

- U-18 - Children that are under 18 years of age that are not eligible for ARKids A and B, and
- Pregnant Woman - Women who are pregnant and not eligible for the Full or Limited Medicaid Pregnant Woman categories.

Eligibility in the above spend down groups will be considered if the household income is above the Medically Needy Income Level (MNIL) and resources are within the Medically Needy resource limit. The excess income that is above the MNIL must be obligated or spent for medical services that are three times the MNIL.

B-300 Aid to the Aged, Blind and Disabled (AABD) Eligibility Groups

MS Manual 01/01/14

The AABD Eligibility Groups are categorized below under Long Term Services and Supports, Medicare Savings Program, Workers with Disabilities and Supplemental Security Income (SSI)/SSI related groups. A brief description follows.

B-310 Long Term Services and Supports

MS Manual 01/01/14

The Long Term Services and Supports group provides coverage to eligible individuals in nursing facilities, home and community based waivers and the PACE program. Home and community based waivers programs provide non-institutional long term care services to individuals as an alternative to institutionalization. Individuals eligible for waiver services must be potentially eligible for admission to a nursing facility.

B-311 Nursing Facility

MS Manual 01/01/14

This group consists of individuals who are aged, blind or have disabilities and are living in a Long Term Care Facility.

Nursing Facility coverage is provided to individuals who meet both categorical eligibility and medical necessity requirements. Refer to MS F-150-151. The individual's income cannot exceed three (3) times the SSI payment standard. However, individuals with income over the limit may be eligible if they have established an income trust (Re. MS H-110).

In addition to facility vendor payments, nursing facility eligibles receive the full range of Medicaid benefits and services with the following exception:

EXCEPTION: Individuals in the State Human Development Centers are not eligible for the Prescription Drug Program.

B-312 Assisted Living Facilities

MS Manual 01/01/14

This group consists of individuals in Assisted Living Facilities (ALF) who are aged (age 65 or older), or 21 years of age or over and blind or have a disability as established by SSI/SSA or by the Medical Review Team. Assisted Living Services are provided to eligible individuals to allow them to maintain their independence and dignity while receiving a high level of care and support. ALF coverage is provided to individuals who meet both categorical eligibility and medical necessity requirements. The individual's income cannot exceed three (3) times the SSI payment standard. However, individuals with income over the limit may be eligible if they have established an income trust (Re. MS H-110).

B-313 ElderChoices

MS Manual 01/01/14

This group consists of Individuals aged 65 or over. ElderChoices services may be provided to individuals who meet both categorical and medical necessity requirements including requiring an intermediate level of care designation as determined by Utilization Review. The individual's income cannot exceed three (3) times the SSI payment standard and resources cannot exceed $2000. Recipients of ElderChoices receive the full range of Medicaid benefits and services.

B-314 Alternatives for Adults with Physical Disabilities (AAPD) Waiver Program

MS Manual 01/01/14

This group consists of individuals aged 21 through 64 who have a physical disability according to SSA/SSI guidelines. AAPD services may be provided to individuals who meet both categorical and medical necessity requirements. The individual's income cannot exceed three (3) times the SSI payment standard and resources cannot exceed $2000.00. Recipients in the AAPD program receive the full range of Medicaid benefits and services.

B-315 TEFRA

MS Manual 01/01/14

This group consists of children 18 years of age or younger with disabilities that must meet the medical necessity requirement for institutional placement in an acute care facility, a skilled nursing facility, an ICF/MR facility or Alternative Home placement, or be at risk for future institutional placement. Medical services must be available to provide care to the child in the home, and it must be appropriate to provide such care outside an institution.

The income limit is three (3) time the SSI/SPA. Only the child's income is considered. Parental income is not considered in the eligibility determination, but is considered for the purpose of calculating the month premium. For information regarding TEFRA premiums and calculation, see MS F 170-173. The resource limit is $2000.00. Only the child's resources are considered. Parent resources are disregarded. Recipients of TEFRA Waiver receive the full range of Medicaid benefits and services.

B-316 Autism

MS Manual 01/01/14

This group consists of children ages 18 months through six (6) years who have a diagnosis of autism. In addition to the autism diagnosis, the waiver participant must have a disability determination and meet the ICF/MR level of care. The income limit for the child is three (3) times the SSI/SPA and the resource limit is $2000. Parental income and resources are disregarded. Autism recipients will receive the full range of Medicaid benefits and services in addition to intensive early intervention treatment.

B-317 Division of Developmental Disabilities Services (DDS) Alternative Community Services Waiver Program

MS Manual 01/01/14

This group consists of individuals of any age who have developmental disabilities as determined by the Division of Developmental Disabilities Services (DDS). DDS waiver services are provided to individuals who meet the ICF/MR level of care. The income cannot exceed three (3) times the SSI/SPA. If the waiver applicant is living in the home of his/her parents, the parental income and resources will be disregarded. Any contributions made to the applicant by the parents will be counted as unearned income. In-Kind Support and Maintenance will not be considered as income. Resources cannot exceed $2000.00. A period of ineligibility will be imposed for uncompensated transfers.

B-318 PACE-Program of All Inclusive Care for the Elderly

MS Manual 01/01/14

This group consists of individuals 55 years of age or older who need nursing facility care to live as independently as possible. PACE is a comprehensive health and social services program that provides and coordinates primary, preventive, acute and long term care services that provide focus on helping participants continue to live in the community. In addition to the general eligibility requirements, the individual must require one of the four levels of nursing facility care of skilled, Intermediate I, Intermediate II or Intermediate III. The individual must also meet special medical criteria as defined in MS F-155. The individual's income cannot exceed three times the current SSI SPA. However, individuals with income over the limit may be eligible if they have established an income trust (Re. MS H-110). PACE participants with spouses living in the community are eligible for the division of spousal income and resources. Transfer of resources will apply only if the PACE participant enters a nursing facility. PACE services are provided in PACE Centers, in the home and in inpatient facilities. The PACE program is only available in certain counties in northeast Arkansas. For a list of these counties, see Appendix K.

B-320 Medicare Savings Programs (MSP)

MS Manual 01/01/14

The MSP groups provide Medicare savings by paying the Medicare premium(s) and possibly the Medicare deductibles and coinsurance. Except for ARSeniors, these categories do not provide for the full range of Medicaid services. The groups are described below.

B-321 ARSeniors

MS Manual 01/01/14

This group consists of individuals aged 65 or over whose income is equal to or below 80% of FPL. If the individual is entitled to Medicare he/she must receive Medicare. ARSeniors provides full Medicaid coverage.

B-322 Qualified Medicare Beneficiaries (QMB)

MS Manual 01/01/14

This group consists of individuals who are aged, blind or have a disability and entitled to or conditionally eligible for Medicare Part A. The income limit is 100% of the FPL. QMB pays the Medicare premium, deductibles and coinsurances.

B-323 Specified Low-Income Medicare Beneficiaries (SMB)

MS Manual 01/01/14

This group consists of individuals who are aged, blind or have a disability and entitle to (actually receiving) Medicare Part A. The income limit is between 100% and 120% of the FPL. SMB pays only the Medicare Part B premium.

B-324 Qualifying Individuals 1 (QI-1)

MS Manual 01/01/14

This group consists of individuals who would be eligible for SMB except that their income exceeds the SMB level. QI-1's must have income of at least 120% but less that 135% of the FPL. QI-1 pays only the Medicare Part B premium.

B-325 Qualified Disabled and Working Individuals (QDWI)

MS Manual 01/01/14

This group consists of individuals who are aged, blind or have a disability who lost Medicare Part A entitlement solely due to the individual's earning that reached or exceeded the Substantial Gainful Activity (SGA) amount. QDWI income limit is 200% of the FPL. QDWI's are eligible only for payment of their Medicare Part A-Hospital Insurance premium.

B-326 Medicare Savings Programs - Comparison Chart

MS Manual 01/01/14

The following comparison chart provides a brief overview of the five categories including the coverage provided and eligibility requirements.

	AR Seniors	QMB	SMB	QI-1	QDWI
Benefits MS A-100	Full Range of Medicaid Benefits	Pays Medicare Premium(s), deductible and coinsurance	Pays Part B Premium	Pays Part B Premium	Pays Part A Premium
Categorical MS F-110 thru 120	Aged Only	Aged, Blind or Disabled	Aged, Blind or Disabled	Aged, Blind or Disabled	Aged, Blind or Disabled
Income Limits MS E-110	Equal to or below 80%	100% of the Federal Poverty	Between 100% and	At least 120% but less than	200% of FPL

	AR Seniors	QMB	SMB	QI-1	QDWI
	of FPL	Level (FPL)	120% of FPL	135% of FPL	
Resource Limit MS E-110	Individual $7,080.00 Couple $10,620.00				Individual $4000 Couple $6000
Medicare Requirements MS F-190	Must receive Medicare if entitled to Medicare	Entitled to or conditionally eligible for Medicare Part A	Entitled to (actually receiving) Medicare Part A		Lost Medicare Part A & SSA-DIB benefits due to SGA Entitled to reenroll in Medicare Part A

Note: QMB and SMB programs are not eligible for simultaneous coverage in another eligibility group. If an individual is eligible in a full coverage eligibility group, the individual should be approved in the non-QMB/SMB group.

B-330 Workers with Disabilities

MS Manual 01/01/14

This group consists of individuals at least 16 years of age, but less than 65 years of age, who, except for earned income, would be eligible to receive Supplemental Security Income (SSI). The intent of this group is to allow SSI eligibles to go to work or increase their earnings without losing their eligibility for Medicaid.

Individuals who lose SSI and SSI related Medicaid due to earnings, are potentially eligible for Medicaid under the Workers with Disabilities policy. There is no requirement that an individual must have at one time been an SSI recipient to be eligible for Medicaid under this category. However, if an individual was not an SSI or SSA disability recipient, a disability determination must be made by MRT (MS F 122). Substantial Gainful Activity (SGA) is not considered for the disability determination. In addition, the individual's unearned income must be under the SSI payment amount for one person. Refer to Appendix S.

Recipients of Medicaid in the Workers with Disabilities category will be eligible for the full range of Medicaid services.

B-340 Supplemental Security Income (SSI)/SSI Related Groups

MS Manual 01/01/14

The SSI groups are SSI eligibles or special groups that lost their SSI due to SSA COLA increases, receipt of widow/widowers benefits or an increase in their Disabled Adult Child (DAC) benefits. These groups are described below.

B-341 Supplemental Security Income (SSI) Cash Eligibles

MS Manual 01/01/14

The group consists of individuals who have been determined eligible for SSI benefits by the Social Security Administration (SSA). They are eligible for the full range of Medicaid benefits and services.

B-342 Eligible Due to Disregard of Social Security Cost of Living Adjustment (COLA) Increases (Pickle)

MS Manual 01/01/14

This group consists of individuals who become ineligible for SSI payments due to Social Security cost of living adjustment (COLA) increases. It also includes individuals who lost SSI for ANY reason, if the individual would be SSI eligible today by disregard of all COLA's received on SSA benefits since the loss of SSI. The individual must have previously been entitled to SSA and eligible for SSI concurrently in at least one month after April, 1977. Individuals in this group must be current SSA recipients. They are eligible for the full range of Medicaid benefits and services.

B-343 Medicaid for Widows and Widowers with Disabilities

MS Manual 01/01/14

This group consists of widows and widowers with a disability who became entitled to receive SSA benefits between the ages of 50 and 59, entitled to SSA for December 1983 and lost SSI benefits after January 1984 due to an increase in SSA window's or widower's benefits due to elimination of a benefits reduction factor. The individual must have continuously received widow's/widower's benefits since their SSI benefits were terminated and would be eligible for SSI if the amount of the 1984 reduction factor increase and any subsequent COLA increases were disregarded.

B-344 Widows and Widowers with Disabilities

MS Manual 01/01/14

This group consists of widows and widowers with a disability who were at least 60 on or after April 1, 1988 and not yet 65 years of age on April 1, 1988 and who were former recipients of SSI whose benefits were terminated due to entitlement to SSA widow's/widower's benefits. They must still be a current recipient of widow's/widower's benefits (may also receive concurrent other SSA benefits), not currently eligible for Medicare, would still be eligible for SSI if all SSA benefits were disregarded and otherwise income and resource eligible for Medicaid.

B-345 Medicaid for Widows, Widowers with a Disability and Surviving Divorced Spouses with a Disability (OBRA)

MS Manual 01/01/14

This group consists of widow/widowers with a disability and surviving divorced spouses with a disability who lost their SSI due to receipt of SSA widow/widower or disabled surviving divorced spouse benefits. The individual must currently be receiving SSA widow/widower or disabled surviving divorced spouse benefits, not entitled to Medicare Part A and would still be eligible for SSI if all SSA benefits were disregard as income including resource eligibility. Individuals found eligible under these provisions are entitled to the full range of Medicaid benefits.

B-346 Disabled Adult Children (DAC)

MS Manual 01/01/14

This group consists of individuals who lost their SSI after July 1, 1987 due to SSA Disabled Adult Children (DAC) entitlements or due to increases in their DAC benefits.

An individual who may be eligible for Medicaid in this categorically eligible group is one who:

- Is age 18 or older,
- Was determined to be blind or have a disability before age 22,
- Was receiving SSI based on a disability determination or blindness, and
- Lost SSI on or after July 1, 1987 due to a DAC entitlement or a DAC increase.

Income included will be the current income, less the DAC entitlement or increase that resulted in the loss of SSI. Any other income other than the DAC entitlement or increase will be counted. Resources cannot exceed $2000.

B-400 Foster Care Medicaid

MS Manual 01/01/14

This group consists of children who are in the custody of the State of Arkansas because of removal from a parent or caregiver.

The eligibility criteria for this group are explained in MS Section K.

Children who “age out” of foster care at age 18 or 21 years old, if an agreement has been signed by the child to remain in foster care, will be eligible for the Former Foster Care category of Medicaid (MS B-260).

B-500 Emergency Medicaid Services for Aliens

MS Manual 01/01/14

This group consists of:

- Nonqualified aliens living in the U.S or
- Qualified aliens living in the U.S. for less than 5 years.

Medicaid benefits are available to pay for the cost of emergency services for aliens who do not meet the Medicaid citizenship or alien status requirements or Social Security Number requirements. However, they must meet the financial and categorical eligibility requirements and state residency requirements for the category in which they apply, such as Parent Caretaker Relative, Healthcare Independence, ARKids A or B.

To be eligible for emergency Medicaid, the applicant must have, or must have had within the last 3 months, an emergency medical condition. Labor and delivery is considered an emergency medical condition.

Emergency medical condition is defined as a medical condition, including labor and delivery, manifesting itself by acute symptoms of such severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in at least one of the following:

- Placing the patient’s health in serious jeopardy
- Serious impairment of bodily function
- Serious dysfunction of any bodily part or organ

To qualify as an emergency, the medical condition must be acute. It must have a sudden onset, a sharp rise and last a short time. If the individual’s condition is chronic (ongoing), such as cancer, AIDS, end-stage renal disease, etc., it is not considered acute and does not meet the definition of an emergency. If the chronic condition worsens, it is still not acute and does not qualify for emergency services. Federal policy specifically identifies care and services related to an organ transplant procedure as **not** qualifying under emergency services.

Before eligibility can be determined, the existence of an emergency medical condition must be verified by a physician’s statement that the alien met the conditions shown above. A physician’s statement that the individual will die without medical treatment does not in and of itself, constitute an emergency. The eligibility determination must include a determination of whether the condition is acute or chronic. Verification that medical expenses were incurred for treatment of the condition must also be presented.

Payment for emergency services is limited to the day treatment was initiated and the following period of time in which the necessity for emergency services existed. (e.g. the date of admission through the date of discharge from the hospital). The date the alien first sought treatment is considered the first day of the emergency, regardless of the length of time the condition exists. The period of eligibility will be a fixed retroactive period, with the Medicaid begin and end dates entered in the system.

Emergency services are defined as services provided in a hospital, clinic, office or other facility equipped to furnish the required care after the onset of an emergency medical condition. Labor and delivery services are covered, including normal deliveries.

C-100 Application Process

MS Manual 01/01/14

All individuals who wish to apply for Medicaid benefits will be given the opportunity to do so without undue delay. No application or inquiry will be ignored. The Agency has the responsibility to follow up on any request for medical assistance and to make arrangements for completion of the application.

NOTE: An application can be filed on behalf of a deceased person if the application is filed within the 3 months after the date of death.

Refer to MS C-200 for those eligibility groups that require an alternative application process.

C-105 Distinction between Application and Inquiry

MS Manual 01/01/14

The distinction between an application and an inquiry is as follows:

- An application is either an electronic, telephonic or written and signed request for assistance by an individual or his or her authorized representative.
- An inquiry is a request for information by an individual or his or her authorized representative.

C-110 Application Assistance

MS Manual 01/01/14

The agency must allow an individual or individuals of the applicant's choice to accompany and/or represent the applicant in the application process or a redetermination of eligibility. Such individuals may be a Navigator or an assistor or may be authorized by the applicant to act as an Authorized Representative.

C-111 Navigators, In-Person Assisters and Certified Application Counselors

MS Manual 01/01/14

A Navigator is a person authorized under federal law to assist individuals shopping for and selecting health insurance offered through the Health Insurance Marketplace. The Navigator will provide information regarding health benefit plans or coverage offered through the Marketplace and will facilitate enrollment through the Marketplace.

An In-Person Assister will assist individuals enrolling through the Marketplace by educating people about the new system, helping them understand about their health plan choices and facilitating the selection of a plan that is right for them.

A Certified Application Counselor is a licensed person authorized to assist individuals in enrolling in different marketplace designated organizational settings including healthcare facilities.

It is the duty of Navigators, In-Person Assistors and Certified Application Counselors to assist individuals completing an application for healthcare benefits. They do not meet the definition of an Authorized Representative as outlined in MS C-112 unless the applicant has designated the individual as an Authorized Representative.

C-112 Authorized Representatives

MS Manual 01/01/14

An authorized representative is:

1. An individual or facility designated by the client, in writing, as authorized to request and receive confidential information that would otherwise be disclosed only to that client; or

2. An individual or facility identified by the court when the client is mentally, physically or legally unable to designate a representative; or

3. An individual designated by an inmate of the Department of Corrections, Community Corrections or a local correctional facility for purposes of filing a Medicaid application and complying with Medicaid requirements for determining eligibility; or

4. The Department of Corrections, Community Corrections or a local correctional facility when an inmate who has received medical services that meet the criteria for Medicaid coverage does not designate a representative within three business days following a request to designate a representative or the inmate’s assigned representative does not file a Medicaid application within three business days after appointment as that inmate’s representative.

See MS A-131 for more information regarding when information can be released to an Authorized Representative.

C-115 Emancipated Minors

MS Manual 01/01/14

An emancipated individual under age 18 will be allowed to file an application on his/her own behalf for Medicaid. Judicial and common law emancipation will be recognized.

A judicially emancipated minor is one who has been given the right by a court to manage his own affairs. A common law emancipated minor is one who has been given the right to manage his own affairs by voluntary or implied agreement between parent(s) and child. A common law emancipated minor must be demonstrating that he/she is responsible for the management of his/her own affairs by establishing an independent household or by sharing equally in payment of household expenses if living with parent(s)/family. The emancipation of a minor is revocable if the minor again becomes dependent upon and responsible to his parents or other individuals who have acted or are acting as his parents. This applies to any type of emancipation. Therefore, emancipation status must be determined on the actual current circumstances without regard to what has transpired in the past.

C-120 Submitting an Application

MS Manual 01/01/14

An application may be completed and submitted electronically via Access Arkansas or through the Federally Facilitated Health Insurance Marketplace (FFM). An application may also be completed in writing on an approved DHS application form and submitted to the Agency via mail, fax, email, telephone or in person to a designated DHS Agency.

> NOTE: See Appendix I for a listing of which application forms are needed to apply for a specific coverage category.

An application may be submitted by the individual, the individual's spouse or Authorized Representative, emancipated minor or if the applicant is a minor who is not living with a parent, a caretaker acting responsibly for the minor.

Although an application will be accepted and processed with only the minimal information listed below, the applicant should complete as much information as possible in order to avoid delays in determining eligibility and processing the application.

An application must include at a minimum the following information:

1. Applicant's name,
2. Applicant's address (or other means of contacting the applicant if homeless), and
3. Applicant's signature (written, telephonic or electronic).

When an individual applies for health insurance coverage through the FFM, a Medicaid eligibility determination will be made by the FFM. If the applicant is determined to be eligible for Medicaid, the FFM will notify DHS of eligibility. At that time, the system will automatically enroll the applicant in the appropriate category based on the eligibility determination. The applicant will not be required to submit a separate Medicaid application to DHS in this situation.

C-125 Date of Application

MS Manual 01/01/14

The date of application is the date the application is received by DHS or, if submitted through the FFM, the date the application was received by the FFM. The date of application is critical to the eligibility determination process as it is used to determine the earliest date Medicaid coverage can begin if the applicant is determined eligible. The date of application is the date the application is electronically or telephonically signed by the applicant.

The date of application for non-online applications is the date the application is received and date stamped by the agency.

C-130 Tracking Applications Upon Receipt

MS Manual 01/01/14

An application submitted to DHS for processing must be monitored and tracked to ensure that the application is disposed of in a timely manner. See MS C-135 for timeliness requirements. The system is designed to monitor and track the application process from beginning to end. Therefore, each application received by the Agency must be entered into the system upon receipt to begin the process and to assign an application ID. This is referred to as registering the application.

Applications submitted online will automatically be registered by the system. Applications submitted to DHS via mail, phone, fax, email or in person must be entered into the system and registered by agency staff no later than the close of business of the first workday following receipt of the application.

Applications submitted through the Federally Facilitated Health Insurance Marketplace (FFM) will be tracked and monitored by the FFM. DHS will not receive these applications for processing. Therefore, applications submitted through the FFM will not be registered as an application in the DHS system. However, when an applicant is determined eligible for Medicaid benefits by the FFM, the applicant's electronic account with all appropriate data will be transmitted to the DHS system which will accept all data and enroll the individual in Medicaid.

C-135 Time Limit for Disposition of Application

MS Manual 01/01/14

Medicaid applications must be disposed of within 45 days from the date of application unless a disability determination is required. Applications requiring a disability determination must be disposed of within 90 days from the date of application. When action on an application will be delayed beyond 45 days (or 90 days for disability cases), the applicant will be notified by DCO-700 (or other system generated notice) of the reason for delay and of his or her right to appeal.

C-140 Eligibility Determination

MS Manual 01/01/14

Eligibility for all Medicaid categories will be determined in accordance with MS Section D, General Eligibility Requirements, and MS Section E, Financial Eligibility. Non-financial criteria (Re. MS Section F) will be determined depending on the category of coverage. Eligibility factors will be verified in accordance with MS Section G.

Generally speaking, the system will determine Medicaid eligibility according to a rules based engine utilizing the data entered into the system by the individual, agency staff or a combination of both. Specific eligibility determination process steps are as follows:

1. Once enough information has been entered, the system will screen the applicant's eligibility for Medicaid and if the individual appears eligible, will verify the applicant's data through various data matches.

2. If the applicant's data and data sources are "reasonably compatible" (MS G-151 and MS G-152) and eligibility exists, the system will approve the application, update all information regarding the case, and send a notification of approval to the individual.
3. If eligibility does not exist based on the information entered on the application, the system will deny the application and send a notice to the individual.
4. If additional information is required to process the application due to reasonable compatibility issues or missing data, the system will send a notification to the individual requesting the needed information.
5. An interview with the applicant is not required. The applicant will be contacted only if necessary to obtain necessary information.
6. When all requested information is supplied by the applicant, the caseworker will enter the information into the system which will then determine eligibility.
7. If the application is denied, the system will send a notification of denial and, if appropriate, provide the individual with referral information to the Health Insurance Marketplace to allow the individual to apply for services there.

C-145 Application Disposal

MS Manual 01/01/14

Applications must be disposed of by one of the following actions: approval or denial.

Approval

When all eligibility requirements are determined to be met, the application will be approved and the individual enrolled in the appropriate Medicaid coverage group. An approval notice will be sent to the applicant advising that he or she has been approved for coverage with the effective beginning date of coverage.

Denial

An application will be denied in the following situations:

1. The applicant is determined to be ineligible due to an eligibility requirement not being met;

2. Eligibility cannot be established due to failure of the applicant to provide information necessary to determine eligibility; or

3. The applicant withdraws the application.

When an application is denied, a denial notice will be sent advising the applicant of the denial, reason for denial and the applicant's right to appeal the denial.

C-150 Enrollment

MS Manual 01/01/14

Each individual approved for Medicaid by DHS or the FFM will be enrolled in the appropriate eligibility coverage group. The system will make this determination based on the information entered to the system. Upon enrollment, a Medicaid or ARKids ID card will be issued to each eligible individual if the person does not already have an existing card. The enrollment process for the Healthcare Independence Program requires that once eligibility is determined, the applicant will complete a Medically Frail screening and select a Qualified Health Plan, if appropriate. The eligibility approval notice for the Healthcare Independence Program will provide instructions regarding the next steps needed to complete the enrollment process.

C-200 Alternative Application Processes

MS Manual 01/01/14

The following eligibility groups do not follow the standard application processes as described in C-100:

- Newborn.
- Autism.
- TEFRA.
- ElderChoices/AAPD.
- PACE.
- DDS Alternative Community Services.
- Referral processes for Eligibles Who Lose SSI due to SSA COLA Increases, DAC and Disabled Widow/Widowers and Disabled Surviving Divorced Spouses.

The application process for the above eligibility groups are described below.

C-210 Newborn Application Process

MS Manual 01/01/14

Hospital and physician providers refer children born to Medicaid eligible mothers using the DCO-645, Hospital/Physician/Certified Nurse-Midwife Referral for Newborn Infant Medicaid Coverage. The referring provider is requested to complete the DCO-645 and mail to the DHS County Office of the mother's residence within five (5) days of the child's birth, when possible.

The DCO-645 will serve as verification of the birth date of the child as well as documentation of relationship and citizenship.

Date of application will be the date the DCO-645 is received. If the application is received more than 3 months after the baby's birth, the baby's date of birth will be the application date. If vital information (e.g., DOB or name) in either Part I or Part II of the form is missing, the form will not be registered but will be returned to the provider within five working days from date of receipt, with a note to indicate what missing information is needed. If the mother of the child is not Medicaid eligible and has not made application for Medicaid, Part III of the DCO-645 will be completed and returned to the provider advising that newborn eligibility for the infant cannot be determined at this time. The caseworker will scan the DCO-645 into the eligibility system for future use if the mother applies for Medicaid later. No further action is required of the county in this situation.

If there is a pending Medicaid application for the mother when a DCO-645 is received, the DCO-645 will be held by the county until disposition is made of the mother's PW application, at which time the county will notify the provider by completing Part III of the form and returning it to the provider. The county should inform the provider within 5 days that eligibility for the mother is pending.

If all vital information is on the form when received and it is verified that the mother was Medicaid eligible at time of delivery, the system will place the child in the newborn eligibility group within twenty working days from receipt of the completed DCO-645. The caseworker must then complete Part III of the form and return it to the provider within the twenty-day period.

NOTE: Neither a DCO-645 nor an application form are required forms for initial certification of newborn coverage. A newborn case may be certified without a DCO-645, other formal referral, or application as long as the county has all the necessary information and has determined that the newborn requirements have been met. When newborn coverage is requested, whether or not there is a signed application or DCO-645 referral, information will be entered into the system as an application and processed accordingly.

C-211 Newborn Application Disposal Process

MS Manual 01/01/14

Once a newborn is eligible, the newborn will remain eligible until the last day of the month of the child's first birthday regardless of whether the mother continues to be eligible.

The newborn coverage may be terminated only if the child no longer resides in the State of Arkansas.

If the mother was a certified Medicaid eligible recipient or was later determined Medicaid eligible for the birth month in any category, Medicaid coverage of the child will be provided as follows:

1. Secure information necessary to open a Newborn Medicaid case.
2. The system will place the child in the newborn eligibility group with the DOB as the Medicaid begin date.
3. DCO-700 or system-generated notice will be sent to the person with whom the child will be residing. The person, with whom the child will be residing, will be listed on the DCO-645 under Part II B. The notice will advise the caretaker of the Newborn approval (or

denial, if applicable) and advise the caretaker to report all address changes for the family, and that application may be made for the newborn in another Medicaid eligibility group when the newborn's eligibility has expired under newborn coverage.

C-220 Autism Application Process

MS Manual 01/01/14

The Autism Waiver program is operated by Partners for Inclusive Communities (Partners) under the administrative authority of the Division of Medical Services. The following describes the Autism application process:

If a parent or guardian inquires at the county office about the Autism Waiver, county office personnel will:

1. Provide the Autism Waiver brochure.
2. Inform the inquirer that he or she must contact Partners at the phone number listed on the brochure for more information or to start the application process.
3. If the child doesn't have a pending Medicaid application or an open Medicaid case, explain Medicaid/ARKids requirements and assist the parent or guardian if he or she wishes to apply for Medicaid or ARKids.

When the parent or guardian contacts Partners, Partners will:

1. Explain the program and program requirements.
2. Screen the applicant to determine if he or she meets the program criteria.
3. Send the following forms to the parent or guardian, if the child meets the therapeutic requirements:
    a. DCO-9700, TEFRA and Autism Waiver Application;
    b. If a disability determination is needed , a DCO-108C, Social Report for Children;
    c. DCO-106, Disability Worksheet; and
    d. DHS-4000, Authorization to Disclose Health Information.
4. Advise the parent or guardian to return completed forms to Partners.

Upon receipt of the application and documentation, Partners will:

1. Review the application and documentation to determine if the application should be denied based on Partners' autism diagnosis assessment.
2. Send the application and documentation to the Area TEFRA Processing Unit (ATPU).

3. Complete form DHS-703, Evaluation of Medical Need Criteria if the applicant meets Partners medical criteria and forward it to the Office of Long Term Care (OLTC). OLTC will document the level of care determination on the DHS-704 and return the form to Partners. Partners will forward the completed DHS-704 to the appropriate ATPU.
4. Send notification of ineligibility denial to ATPU via the DHS-3330 if the applicant does not meet medical criteria.

ATPU will:

1. Register all applications received from Partners in the Autism Waiver Service Program.
2. Deny application and send the applicant's parent or guardian a system generated notice of denial, if the applicant is determined not to be eligible based on Partner's medical criteria,
3. Determine financial eligibility, if the child meets the autism criteria.
4. Forward medical records (Forms DCO-106, DCO-108C and DHS-4000) to MRT while determining financial eligibility, if a disability determination is required.
5. Determine financial eligibility and if found not eligible:
    a. Deny the application.
    b. Send the parent or guardian a system generated notice of denial and a DHS-3330 to Partners.
    c. Notify MRT to stop the disability determination if the determination has not been received.
6. Approve the application, if the applicant is medically and financially eligible:
    a. The Medicaid begin date will be the date the application is approved.
    b. Send the parent or guardian a system generated notice of approval and a DHS-3330 to Partners.

C-230 TEFRA Application Process

MS Manual 01/01/14

TEFRA applications (DCO-9700) will be available at local DHS offices or by mail, through hospitals, including Arkansas Children's Hospital, and Federally Qualified Health Centers. Information will be available through the Division of Developmental Disabilities (DDS) Services Coordinators and Providers. Information will also be available on the DHS/DMS website.

The application will be made by the adult responsible for the care of the child and will be processed in the child's county of residence.

TEFRA Waiver applicants should be screened for ARKids eligibility. The ARKids program should be explained to the parents so they can make an informed choice between ARKids and TEFRA. ARKids can generally be approved much more quickly than TEFRA as no disability or medical necessity determination is required. When explaining the two programs, also, advise the parents that respite service is not offered in ARKids, but it is offered in TEFRA.

The DMS-2602, Physician's Assessment of Eligibility, will be given to the individual to be completed by the child's physician. If disability is to be established by MRT, forms DCO-106, DCO-107, DCO-108 and DHS-4000(s), if needed, will also be completed. The TEFRA Waiver Brochure, PUB-405, should also be given to the applicant explaining the medical determination process and the premium process. (Refer to Appendix I.)

C-231 Re-Application When Case Closed Due to Non-Payment of Premiums

MS Manual 01/01/14

When the TEFRA case is closed due to non-payment of premiums, a new application must be made before eligibility can resume. Eligibility will be redetermined at the time the new application is made.

If the case has been closed less than 12 months because of failure to pay premiums, the past due premiums must be paid in full before the child can be re-approved for TEFRA Waiver services.

If a case is closed 12 months or more due to failure to pay premiums, payment of the past due premiums will not be required to reopen the case.

C-232 Eligibility Determination

MS Manual 01/01/14

With the exception of the Appropriateness of Care and Cost Effectiveness requirements, eligibility will be determined by the caseworker in the same manner as AD Long Term Care cases.

A child who would not be eligible or potentially eligible for Medicaid in an institution cannot be considered for TEFRA. If the child's countable income is less than the current LTC income limit and the child's countable resources are less than $2,000.00, he/she will meet the TEFRA income and resource requirements. Parental income and resources will be disregarded when determining eligibility. However, parental income will be considered when calculating the monthly premium amount.

C-233 Disability Determination

MS Manual 01/01/14

To qualify for TEFRA, a child must be considered an individual with a disability according to the SSI regulations that govern children with disabilities. If a child received SSI within one year prior to making TEFRA Waiver application, but was terminated for reasons other than lack of disability, (e.g. parental income or resources), documentation will be obtained for the case record. A disability decision made by SSA on a specific disability is controlling for that disability, until the decision is changed by SSA. The child will be considered an individual with a disability based on the previous SSA disability determination. (Refer to MS F 120-128.)

C-234 Determining Appropriateness of Care and Cost Effectiveness

MS Manual 01/01/14

When the completed DMS-2602 is returned to the county office by the child's physician, the DMS-2602 and DCO-2603 and any medical records that have been submitted will be sent to:

> **DMS**
> **Attention: TEFRA Committee**
> **P.O. Box 1437, Slot S-406**
> **Little Rock, AR 72203**

The county office will scan all copies of the records into the electronic case file. The TEFRA Committee is coordinated by the Office of Long Term Care.

The TEFRA Committee will determine if the applicant meets the Cost Effectiveness and Appropriateness of Care criteria. If these are met, and if the referral is otherwise appropriate, the TEFRA Committee will complete Sections III, IV and V of the DCO-2603. The TEFRA Committee will determine Medical Necessity and will be responsible for returning the DHS-704, DMS-2602 and DCO-2603 to the county office for final approval or denial, pending MRT decision if applicable.

> **NOTE:** An application will not be denied solely for failure of the physician to complete and return the DMS-2602 until an effort has been made to assist the client in obtaining the completed DMS-2602. The caseworker will remind the applicant of the necessity of

the form and of his/her responsibility for obtaining the form. Assistance will be given whenever possible.

C-235 Disposition of Application

MS Manual 01/01/14

The DCO-2603, Summary of Case Eligibility/TEFRA will be reviewed for documentation that each eligibility requirement has been met. If at any point in the eligibility determination the child fails to meet eligibility requirements, the application will be denied.

The begin date for TEFRA Waiver eligibility will be the date of application, unless retroactive coverage is needed. If needed, the eligibility begin date can be as early as three months prior to the date of application, provided all eligibility requirements are met.

A child cannot be approved for retroactive coverage before the onset of his/her disability as he/she would not meet the TEFRA disability or medical necessity requirements prior to the onset of disability. A child who had been residing in an institution would not be eligible for any retroactive coverage while still residing in the institution as TEFRA Waiver coverage is for non-institutionalized children only. For any retroactive coverage needed, it can be assumed that medical necessity, appropriateness of care and cost effectiveness have been met unless there is evidence to the contrary.

C-240 ElderChoices/AAPD Waiver Application Process

MS Manual 01/01/14

A potential Waiver client will make application (DCO-777) at the DHS county office in his/her county of residence for a financial eligibility determination. Refer to Appendix I for other forms to be completed during the application process. Separate applications will be registered when both individuals of a couple apply.

Applicants should be advised that if they accept services from ElderChoices or AAPD Waiver providers while their applications are pending, they will be responsible for paying the provider if the application is subsequently denied.

NOTE: If the applicant's income is under the SSI/SPA, he/she may be referred to SSA to make a SSI application. However, ElderChoices or AAPD Waiver eligibility is not contingent upon SSI eligibility, and the eligibility determination will not be delayed pending a SSI determination.

C-241 ElderChoices/AAPD Waiver Assessment Process

MS Manual 01/01/14

All applicants will be referred to the DHS RN by DHS-3330 for coordination of the medical assessment within 2 days of the date of application. If a physical disability determination is required for an AAPD applicant, the referral will be made on the date the disability determination is received by the agency. The Office of Long Term Care will determine if the applicant meets the Intermediate Level of Care requirements.

The assessment results will be routed by the DAAS Central Office staff to the DHS RN and to the county office via Form DHS-704, Decision for Nursing Home/Waiver Placement.

If an individual meets the Intermediate Level of Care requirements, and if the individual is otherwise eligible, DAAS will work with the client, family, or other caregiver to ensure that the client receives services necessary to meet his/her needs according to the written Plan of Care. (Refer to MS C-247)

The DHS RN is required to make 3 attempts to contact the applicant through telephone contacts and home visits within an established timeframe of receiving the referral from the caseworker. The procedures below describe what happens when the RN fails to make contact:

1. If the DHS RN cannot contact the applicant after several attempts, a DHS-3330 will be sent to the caseworker informing him/her of the failed attempts.

   The caseworker will then send a DCO-700, Notice of Action, to the applicant and a copy to the DHS RN advising that the application will be denied if the applicant does not make contact with the RN within 10 days. The caseworker will provide the name and telephone number of the RN on the notice.

2. After 10 days, the caseworker will check with the DHS RN to see if the applicant made contact. If not, the application will be denied using reason “Other”. The caseworker will send a manual notice of action to the client explaining the reason of the denial and document all information in the narrative.

On pending applications, the caseworker will:

1. Check the Long Term Care Unit (LTCU) Screen within 30 days of application to determine if the assessment has been completed.
2. Contact the DHS RN if the LTCU Screen does not indicate the assessment has been completed.

3. Hold the application pending receipt of the DHS-704 if the DHS-703, DHS Evaluation of Medical Need Criteria has been completed by the DHS RN.

If notified that the application will be denied due to lack of medical information, it is ultimately the responsibility of the applicant to provide the required information.

If the caseworker learns the medical assessment has not been completed by the DHS RN, the caseworker will:

1. Send a DHS-3330 to the DHS RN and indicate "Second Request" for medical assessment, and
2. Fax a copy of the DHS-3330 to DAAS**, 501-682-8155,** ATTN: HCBS Nurse Manager.

On the 35th day, the caseworker will again contact the DHS RN. If the medical assessment has not been completed, the caseworker will contact his/her Program Eligibility Analyst. When possible, DAAS will take the necessary action to complete the medical assessment prior to the 35th day.

When a DHS RN receives a referral on a nursing facility resident who elects ElderChoices or AAPD Waiver:

1. The DHS RN will contact the individual to proceed with the assessment process to develop a Plan of Care.
2. An assessment may not be necessary if the individual was classified as Intermediate Level of Care with the preceding 6 months. The necessity of completing a new assessment will be left to the professional judgment of the DHS RN.
3. If 6 months or more have elapsed since the last determination of Level of Care, or if the DHS RN deems a new assessment to be appropriate, a new assessment will be submitted to the Office of Long Term Care.

C-242 ElderChoices/AAPD Waiver Applications from Nursing Facility Residents

MS Manual 01/01/14

If the county is contacted regarding ElderChoices or AAPD Waiver for a Medicaid certified nursing facility resident who is classified Intermediate Level of Care, the County will send a DHS-3330 to the DHS RN who will initiate an assessment as outlined below.

When the RN proceeds with the assessment process:

1. A DHS-3330 will be sent to the county office, along with page 2 of the Plan of Care showing the recipient's election of Waiver services with signature.

2. The signed election of Waiver services will serve as the application for Waiver services.
3. It is not necessary to complete a DCO-777 or DCO-7781 unless it is time for the annual renewal of the LTC case.
4. The ElderChoices or AAPD Waiver application must be registered.

NOTE: When accepting Page 2 of the Plan of Care as described in this section, the Plan of Care must include the client's signature, the election of community services and the date. The date must be later than the date of nursing home admission. The DHS RN's signature is not required on the Plan of Care when used for this purpose. The name of the DHS RN will be included on the DHS-3330.

If an ElderChoices or AAPD Waiver application is received from a non-Medicaid eligible nursing facility resident:

1. The application must be registered.
2. The application will not be routinely denied because the individual is institutionalized.
3. The caseworker will send a DCO-3330 to the DHS RN who will initiate an assessment as described in MS C-241.

C-243 Residents of Residential Care Facilities

MS Manual 01/01/14

If an individual living in a residential care facility (RCF) applies for Waiver services and has no plans to move out of the RCF, the caseworker will explain to the applicant that, according to current LTC and RCF policy, he or she does not meet the required Level of Care to receive Waiver services, and the application will be denied.

When the applicant gives a date that he or she plans to move out of the RCF and the relocation date is within the next 45 days, the application will be taken and the targeted relocation date will be documented. The caseworker will include the date that the applicant plans to move out of the RCF on the DHS-3330 that will be sent to the DHS RN. The normal application process at MS C-240 will then be followed. Eligibility for a Waiver program cannot begin until the individual has moved out of the RCF and all other eligibility criteria have been met.

At the end of the 45 day period, if the applicant has not relocated, the caseworker will send a 10 day notice advising that the application for Waiver services will be denied if the relocation does not occur within the next 10 days.

C-244 ElderChoices/AAPD Waiver Eligibility Determination

MS Manual 01/01/14

Eligibility determinations for ElderChoices or AAPD Waiver cases will be conducted in the same manner as for AABD long term care cases.

The SSI related income and resource criteria located in section MS Section E will be followed. SSI exclusions are not allowed from gross income in determining eligibility.

When determining an applicant's countable gross income when both spouses apply, each individual will be budgeted separately and his/her income will be compared to the current LTC limit. Only the income of the applicant will be considered for eligibility.

In determining resource eligibility, the current LTC resource limits will apply. A single applicant's resources will be compared to the one-person limit. When there is a married couple and both apply, their combined resources will be compared to the couple's resource limit. If only one individual of a couple applies for ElderChoices or AAPD Waiver, the rules for spousal resources at MS H-200 will apply. The DCO-710 will be used to compute the initial assessment.

C-245 Approval/Denial for New Applicants

MS Manual 01/01/14

The policy and procedures outlined in MS C 246-249 that determines the Waiver eligibility date will apply to applicants entering Waiver programs from both the community and from institutions.

If there is a closed case number on file for the client, this number will be used to open the ElderChoices or AAPD Waiver case.

When certifying an eligible couple, each will be entered into the system using separate case numbers.

The gross income of an eligible individual will be entered in the appropriate fields in the system. The total gross income will also be entered as Protected Maintenance, since Waiver recipients will not contribute to the cost of services.

The county office will notify DAAS of certifications and denials via the DHS-3330 on the date the action is taken. The DHS-3330 may be mailed, emailed, or faxed to the DHS RN or placed in a designated location at the DHS county office for the DHS RN to collect.

Denial reasons include, but are not limited to:

1. Failure to meet the nursing home admission criteria.
2. Withdrawal of the application by the applicant.
3. Ineligibility based on income or resources.
4. Death of the applicant when no Waiver services were provided.

If the caseworker denies the application for any reason, the DHS RN will be notified via a DHS-3330 and the RN will notify providers of service via the AAS-9511.

When denying an ElderChoices or AAPD application because the applicant refuses to receive at least one service, is not in need of a service or the service is not available in their area, denial code “Other” will be used. A manual notice will be sent, notifying the applicant of the denial.

If the ElderChoices or AAPD Waiver application is denied for any reason, and Waiver services were provided during the period of ineligibility, any charges incurred will be the financial responsibility of the applicant.

If the ElderChoices or AAPD application is denied, the client has the right to appeal by filing for a Fair Hearing. If the individual wins the appeal and has no unpaid ElderChoices or AAPD Waiver charges, Medicaid coverage will begin the date the appeal is won. However, the Waiver portion of the case will not be opened until the date the caseworker completes the case. If the individual has unpaid ElderChoices or AAPD Waiver charges, and services were authorized by the DHS RN, eligibility for both Medicaid and Waiver services will begin the date service began. However, under no circumstances will Waiver eligibility begin prior to the date of application on the DCO-777 or before the Provisional Plan of Care is signed by the DHS RN and the applicant.

When the Office of Appeals and Hearings reverses an Agency decision that an individual did not meet medical necessity requirements, a new DHS-704 will not be issued. The final Agency decision will contain the determination of the Intermediate Level of Care. The Medicaid Begin Date will be the date of the hearing officer’s decision and the Eligibility Start Date on the Waiver portion of the case will be the same as the Action Date. As no Level of Care Review Date will be given, the caseworker will enter a date 12 months after the date of the hearing officer’s decision.

NOTE: If Waiver services were provided and the applicant dies prior to approval of the application, Waiver eligibility will begin the date services began and end the date of death if all other eligibility requirements are met.

C-246 Effective Date of Eligibility for ElderChoices/AAPD Waiver

MS Manual 01/01/14

After all eligibility criteria have been established, the effective date of ElderChoices and AAPD Waiver Medicaid eligibility will be the date of approval into the system. The effective date of eligibility cannot be prior to the date of approval of the case. (MS A-200)

> **NOTE:** ElderChoices eligibility beginning before the date the application is approved by the DCO caseworker will be established only when the DHS RN has recommended the applicant for medical approval based on the medical criteria. The Waiver eligibility date will never be established retroactively by the DCO caseworker unless the retroactive eligibility date is provided by the DHS RN. In all other cases, the Waiver eligibility date will be the date the approval is entered into the system.

C-247 Provisional and Comprehensive Plan of Care (ElderChoices Only)

MS Manual 01/01/14

The Provisional Plan of Care will include all Plan of Care information with the exception of the Medicaid number and Comprehensive Plan of Care expiration date. The Provisional Plan of Care will expire 60 days from the date the Plan of Care is signed by the DHS RN and the applicant.

A signed copy of the Provisional Plan of Care will be mailed to each provider included on the Plan of Care. The provider will begin services within an established timeframe and notify the DHS RN via the AAS–9510 that services have started. The DHS RN will track the start of care dates. If at least one Waiver service begins within 30 days of the development of the Provisional Plan of Care and the applicant is otherwise eligible, the Waiver eligibility date will be established retroactively effective the day the Provisional Plan of Care was signed by the DHS RN and the applicant. If no Waiver services begin within 30 days of the development of the Provisional Plan of Care, the effective date of service will be the date the approval is keyed into the system or the day a Waiver service started as verified by the DHS RN.

If an application is denied, a new Provisional Plan of Care must be developed when a subsequent application is made. Regardless of the reason for the denial and regardless of when a new Waiver application is made, a Provisional Plan of Care will only be utilized on a current Waiver application.

Prior to the Provisional Plan of Care expiration date, the DHS RN will mail the Comprehensive Plan of Care to the client and all providers included in the Plan of Care. If the Medicaid application has been approved, the Comprehensive Plan of Care will include the Medicaid recipient's ID number, diagnosis, Waiver eligibility date and the Comprehensive Plan of Care expiration date. The new Plan of Care expiration date will be 365 days from the date the DHS RN and the applicant signed the Plan of Care. Once the application is either approved or denied, a Plan of Care including the Medicaid ID number or an AAS-9511 giving the date of denial will be sent to the providers.

C-248 Optional Participation (ElderChoices Only)

MS Manual 01/01/14

Neither Waiver providers nor Waiver applicants are required to begin or receive services prior to the establishment of Medicaid eligibility. Participation is offered by the DHS RN at the time of assessment. If services are started based on the receipt of a Provisional Plan of Care, it is the responsibility of each provider to explain the process and the financial liability to the applicant and/or family members prior to beginning services. The decision to begin services prior to eligibility must be a joint decision between the provider and the applicant.

NOTE: The provider is required to notify the DHS RN via the AAS-9510 regardless of the participation decision. The information reported by the provider on the AAS-9510 will document which services are being delayed and which services are beginning based on the provisional Plan of Care.

C-249 Approvals for Medicaid Recipients Who Leave LTC

MS Manual 01/01/14

The ElderChoices or AAPD Waiver case may be certified when the county is notified by the nursing facility that the recipient has left the facility if all the following conditions are met:

1. The county has received a DHS-3330 and Plan of Care signed by the recipient or if a Money Follow the Person (MFP) (MS I 540-541) participant, Form DCO-777 may be provided.
2. The system shows an Intermediate Level of Care.
3. The Level of Care was entered into the system in the previous 6 months.
4. There is a future Level of Care review date.

If the Intermediate Level of Care was entered by the county more than 6 months previously, or if the Level of Care Review Date has expired, the Waiver case may not be certified until the county receives a new DHS-704 verifying Intermediate Level of Care status.

To certify the ElderChoices or AAPD Waiver case, close the LTC vendor portion of the case but do NOT close Medicaid. The day after closure of the vendor portion of the case, the Waiver portion of the case may be opened.

To clear the pending application screen when approving Non-SSI recipients, counties will submit an email to ANSWER SYSTEM SUPPORT requesting the register number to be cleared. If the recipient is a MFP participant, the email should include this information.

For SSI recipients, the register number will be cleared by keying the approval reason in ANSWER.

When opening a case in which the Intermediate Level of Care was entered less than six months previously and there is no Level of Care Review Date in the system, show the Level of Care Decision Date and the Eligibility Begin Date as the first day of ElderChoices or AAPD Waiver eligibility. The Level of Care Review Date will be 12 months from the original Level of Care Decision Date.

If there is a future Level of Care Review Date when closing the LTC case, use that Level of Care Review Date when opening the Waiver case, again showing the Level of Care Decision Date and the Eligibility Begin Date as the first day of ElderChoices or AAPD eligibility.

Counties will review the records of recipients who leave facilities for ElderChoices or AAPD Waiver. If it is time for the annual reevaluation, a reevaluation will be done prior to Waiver certification.

No Waiver eligibility date may be established prior to an applicant's discharge date from an institution. Therefore, if a Provisional Plan of Care is developed while an applicant is a resident of a nursing home or an inpatient in an institution, the earliest Waiver eligibility date will be the day the applicant was discharged home.

C-250 Assisted Living Facility (ALF) Application Process

MS Manual 01/01/14

Applications for ALF Waiver will be made on the LTC Application for Assistance, DCO-777 in the county DHS office where the facility is located. Applications can be made by the applicant, designated representative, next of kin or person acting responsibly for the individual. If application is made in the applicant's home county before he/she enters the facility and the applicant enters a facility in another county, the application will be denied in the system. A notice will not be system generated for this denial. A DCO-700 will be completed and mailed by the caseworker, advising the client or representative that the application has been sent to the appropriate county. All documents will be scanned into the electronic case file and then transferred to the county where the facility is located. The transferring county will send an email and task to the County Administrator and Program Eligibility Coordinator in the receiving county when the transfer in ANSWER is complete. A new application will not be needed by the receiving county and the original date of application will be entered when the application is reregistered.

If a period of eligibility has been, or will be, established in a facility in the county of initial application, that county will certify the case for the eligible period before transferring the case to the second county.

The applicant will have 30 days from the date of approval to move into a Medicaid approved Assisted Living Facility. If the individual has not moved into the ALF within the 30 day time period, the application will be denied.

C-251 Registering the ALF Application

MS Manual 01/01/14

Applications will be registered in LTC Aged Individual, LTC Disabled Individual or LTC Blind Individual. ALF Waiver recipients having SSI will retain their SSI Aged Individual, SSI Blind Individual or SSI Disabled Individual case numbers. “AL” will be keyed in the Waiver Field on the WIMA interface when the application is registered. Separate applications will be registered when both members of a couple apply.

C-252 Applications from Nursing Facilities, ElderChoices or AAPD Waiver Recipients

MS Manual 01/01/14

If the county is contacted regarding an ALF application for a Medicaid certified nursing facility resident who is classified Intermediate Level of Care, or an ElderChoices or AAPD Waiver recipient, the caseworker will notify the DHS nurse via the DHS-3330. The DHS nurse will visit the client on site to begin the assessment process to develop a Plan of Care. The county will be notified of the recipient’s election of ALF Waiver services. The signed election of ALF Waiver services will serve as the application for ALF and a new DCO-777 or DCO-7781 need not be completed by the applicant, unless it is time for the annual reevaluation of the LTC or Waiver case.

If a non-Medicaid eligible nursing facility resident wishes to apply for ALF Waiver, the DCO-777, Application for Assistance, must be completed and registered. The caseworker will notify the DHS RN, who will initiate the assessment.

C-253 Assessment Process

MS Manual 01/01/14

All applicants will be referred to the DHS RN by DHS-3330 for coordination of the medical assessment within 2 days of the date of application or the date the physical disability verification is received if a disability determination is required. The RN will visit the client on site to evaluate his or her physical, functional, mental, emotional and social status, as well as, to obtain a medical history. The DHS RN will develop a Plan of Care based on the assessment. The plan must include the medical and other services to be provided, their frequency and the type of provider to furnish the service. The client's choice of service provider must be specified by this time. The DHS RN will ensure that the applicant's degree of incapacity is reflected accurately.

The assessment will be submitted to the Office of Long Term Care for determination of nursing home level of care eligibility. The Decision for Nursing Home Placement Form, DHS-704, will be routed to the DHS RN and the county office.

If an individual meets the Intermediate Level of Care requirements and if the individual is otherwise eligible, DAAS will work with the client, family or other caregiver to ensure that the client receives the services necessary to meet his/her needs according to the Plan of Care.

Waiver services will not be provided where the cost of home and community based care exceeds, on an annualized basis, the cost of Intermediate Level of Care for the recipient in a nursing facility.

The DHS RN is responsible for monitoring for changes in the ALF client's service needs, referring clients for reassessment, if necessary, and reporting any client complaints of violations of rules and regulations to the appropriate authorities for investigation.

C-254 Eligibility Determination

MS Manual 01/01/14

Eligibility determination for ALF Waiver cases will be conducted in the same manner as for AABD Long Term Care cases.

The SSI related income and resource criteria located in MS E 400-530 will be followed. SSI exclusions are not allowed from gross income in determining eligibility.

In determining an ALF applicant's countable gross income when both spouses apply, each individual will be budgeted separately and his/her income compared in his/her budget to the current LTC limit. (Re. Appendix S). For an applicant with an ineligible spouse, only the income of the applicant will be considered for eligibility. When there is a married couple and only one member of the couple applies the rules for spousal impoverishment (Re.MS H 200) regarding income will be applied. An individual with income over the current LTC income limit may establish Medicaid/Waiver eligibility by establishing an Income Trust (Re. MS H 110- 116).

In determining resource eligibility, the current LTC resource limits will apply. A single applicant's resources will be compared to the one-person limit. When there is a married couple and only one member of the couple applies, the rules for spousal impoverishment (Re. MS H 200) regarding resources will be applied.

For information regarding contribution to the cost of care, refer to MS H-480.

C-255 Approvals for New Applicants (Non-LTC)

MS Manual 01/01/14

After all eligibility criteria have been established, the effective date of ALF Waiver eligibility is established by the DHS RN based on the latter of the date of application, date of admission to the assisted living facility or the date the Plan of Care is signed by the DHS RN and the applicant. The DHS RN will provide the Waiver eligibility date to the county via the DHS-3330. Eligibility will not be established prior to the development of the Assisted Living Plan of Care by the DHS RN. Applicants who desire Medicaid coverage for the time before admission to the ALF or before the Plan of Care is signed, must be determined in another category. The same application can be used but a separate application must be registered to determine coverage prior to eligibility for Assisted Living Facility Medicaid.

When certifying an eligible couple, each will be entered into the system using separate case numbers.

The gross income of the eligible individual will be entered in the appropriate fields in the system. The cost of room and board, as well as, the spousal support amount, health insurance premium amount, bank service charges for the income trust account, and other deductions, if applicable, will be entered as Protected Maintenance. The personal allowance will be shown in the PA field.

C-256 Approvals for Medicaid Recipients Who Leave LTC, ElderChoices or AAPD Waiver

MS Manual 01/01/14

If the county receives notice from the DHS RN that the LTC, ElderChoices or AAPD Waiver recipient has elected to enter an ALF and meets the Intermediate Level of Care, the ALF Waiver case can be approved once notice is received that the recipient has left the nursing facility or the EC or AAPD program. A new DHS-704 will be required before the case can be certified if the Intermediate Level of Care was entered by the county more than 6 months previously or if the Level of Care Review Date has expired.

To certify the ALF Waiver case, close the LTC vendor payment or Waiver portion of the case, but do NOT close Medicaid. Two days after the LTC vendor, EC or AAPD portion of the case is closed; the ALF Waiver portion of the case may be opened.

When opening a case in which the Intermediate Level of Care was entered on the LTC vendor portion of the system less than six months previously and there is no Level of Care Review Date in the system, show the Level of Care Decision Date and the Eligibility Begin Date as the first day of ALF eligibility with a Level of Care Review Date 12 months from the original Level of Care Decision Date.

If there is a future Level of Care Review Date when closing the LTC or Waiver case, use that Level of Care Review Date when opening the ALF case, again showing the Level of Care Decision Date and the Eligibility Begin Date as the first day of ALF eligibility. Caseworkers should review the records of recipients who leave LTC facilities or other Waiver programs for the ALF Waiver program. If it is time for the annual reevaluation, the reevaluation should be done prior to ALF certification.

NOTE: If a LTC case was closed then reopened for ALF services and a retroactive adjustment must be made to the LTC case, send a memorandum to the **Office of Long Term Care, MMIS Unit, Slot S406, P.O. Box 1437, Little Rock, 72203**. The memorandum must include the name, case number, month(s) of retroactive changes(s), and the new net income amount(s).

As the providers are different for each Waiver program, the caseworker must notify the DHS RN any time that a Waiver recipient changes from one Waiver program to another, or when the case is closed or transferred.

C-260 PACE Application Process

MS Manual 01/01/14

Prospective PACE recipients can apply for PACE services through their local DHS county offices. Applicants may apply by referral from the PACE provider, by referral from the DHS RN, or without a referral from any source. Regardless of the origin of the inquiry, the prospective recipient must meet the medical and financial eligibility criteria outlined in MS E 400 and F 155. The final determination of eligibility will be communicated to the PACE provider by the DHS RN.

When the initial application is made at the local DHS county office, the caseworker will begin the application process.

The caseworker will determine if the applicant resides in the service area approved for the PACE organization to which the applicant is seeking enrollment. Application for PACE will be made on the DCO-777, LTC Application for Assistance. A DCO-727, Disposal of Assets Disclosure, must be completed for individuals entering a LTC facility. The DCO-710 and DCO-713 will be completed for individuals with ineligible spouses. The DCO-712 will be used only when the individual enters a nursing facility or when an Income Trust is established.

After verifying the applicant resides in the PACE service area, the caseworker will send a DHS-3330, Alternative Community Services Waiver Communications Form to the DHS RN to request completion of a medical assessment. Because PACE eligibility may not begin until the medical assessment has been completed, it is very important to make the referral to the DHS RN as quickly as possible. Unless there are extenuating circumstances that cannot be avoided, the county office will send the DHS-3330 referring the applicant for medical assessment to the DHS RN within 2 days of registering the PACE application.

The financial eligibility process will continue and may be made before or after the medical determination.

If the prospective PACE recipient makes the initial inquiry with the PACE provider, the provider will instruct the applicant to make application at the local DHS county office for a determination of financial eligibility. The local DHS county office will make the proper referral to the DHS RN for the medical assessment.

If the initial inquiry for PACE is made with the DHS RN, the RN will instruct the recipient to make application at the local DHS county office for determination of financial eligibility. The local DHS county office will make the proper referral to the DHS RN for medical assessment.

The DHS RN will complete the in-home medical assessment of the applicant after receiving the DHS-3330. The DHS RN will also verify that the applicant resides in the service area approved for the PACE organization. The DHS RN will then submit the DHS-3330 to the county office indicating that the assessment has been completed.

The DHS RN will submit the DHS-703 to the Office of Long Term Care (OLTC). OLTC will send a DHS-704, Decision for Nursing Home/PACE Placement to DAAS if all necessary information is available. DAAS will then send a copy of the DHS-704 to the DHS RN and the county office.

The DCO caseworker will make the final decision to approve or deny the application when the financial eligibility determination is made.

C-261 PACE Assessment Process for Nursing Facility Residents or ElderChoices, AAPD or Assisted Living Facility Participants

MS Manual 01/01/14

When a DHS RN receives a referral on a nursing facility resident or an active ElderChoices, AAPD, or Assisted Living Waiver participant who elects the PACE program:

1. The DHS RN will contact the individual to proceed with the assessment process.
2. An assessment may not be necessary if the individual was classified as Intermediate Level of Care within the preceding 6 months. The necessity of completing a new assessment will be left to the professional judgment of the DHS RN based on the medical condition and circumstances of the applicant.
3. If 6 months or more have elapsed since the last determination of Level of Care or if the DHS RN deems a new assessment to be appropriate, a new assessment will be submitted to Utilization Review.

C-262 PACE Application Approval

MS Manual 01/01/14

If the application is approved, the caseworker will notify the applicant by system notice. The caseworker will notify the DHS RN on the DHS-3330 of the PACE eligibility date. A participant's enrollment in the PACE program is effective on the first day of the calendar month following the date the PACE organization receives the signed enrollment agreement; but it may not be prior to the date of application at the county office or prior to the date the medical assessment was completed by the DHS RN. The county worker will establish the PACE eligibility date based on the information provided to them by the DHS RN via the DHS-3330. The DHS-3330 must include the date the medical assessment was completed or the county worker will not be able to process the approval. The PACE eligibility date will be established and keyed as the first day of the calendar month following the date of the medical assessment, as indicated on the DHS-3330 from the DHS RN. Once the approval is keyed, the county worker will notify the DHS RN via a DHS-3330, giving the effective date of approval and the Medicaid ID number. The participant will not receive a Medicaid card as benefits will be received through the PACE provider. A PACE applicant may complete an enrollment application prior to the final medical and financial eligibility determination. However, the capitation payments will only be paid if the enrollee is found to be medically and financially eligible for PACE. An ineligible applicant will be responsible for paying any charges for PACE services he or she has received.

A capitated monthly payment will be generated to the PACE organization based on data received from the ANSWER system that indicates the number of individuals having the PACE aid category. There are four different payment rates based on rate category:

1. Pre-65 Medicaid Only-Individuals under age 65 having Medicaid only
2. Pre-65 Dual Eligible-Individuals under age 65 having both Medicare and Medicaid
3. Post-65-Individuals over age 65
4. QMB Only-Individuals eligible for QMB but not currently eligible for PACE Medicaid

The caseworker will key the PACE approval to the ANSWER system. PACE providers will have service areas based on the client's Zip Code. ANSWER will assign the PACE provider to the eligible recipient. The PACE provider information will include a start date, stop date, provider number add date and last change date. The caseworker as well as the DHS RN will assess each individual and determine whether the individual's place of residence and zip code fall within the service area of the PACE organization prior to eligibility determination and keying to ANSWER.

Refer to MS C-263 for procedures for approving Waiver recipients to PACE and PACE participants to a Waiver group.

C-263 Approvals for Waiver Recipients to PACE and PACE Participants to Waiver

MS Manual 01/01/14

When the caseworker determines that a Waiver recipient was found to be medically and financially eligible for PACE, the Waiver case cannot be closed in ANSWER until the day before the PACE eligibility started as the participant's enrollment in the PACE program is effective on the first day of the calendar month (MS C-262). When a PACE participant applies for a Waiver category, the approval for the Waiver category cannot be submitted until two days after the closure.

EXAMPLE 1: Jane Hathaway is an ElderChoices recipient who applied for PACE on 5/29. The DHS RN completed the DHS-3330 providing the PACE eligibility date as 6/15. The caseworker determined Ms. Hathaway to be medically and financially eligible for ElderChoices. The caseworker closes the ElderChoices case effective 6/30 as PACE eligibility cannot begin until 7/01. Approval for PACE cannot be submitted in ANSWER until two days after the closure of the ElderChoices case in order to prevent billing errors.

EXAMPLE 2: Jack Jones is a dissatisfied PACE participant and wishes to disenroll from PACE. He applied for ElderChoices on 6/15. The caseworker established that Mr. Jones is medically and financially eligible for ElderChoices on 7/3. The caseworker submits in ANSWER closure of the PACE case on 7/3. The effective date to begin his ElderChoices will be 7/4 in order for Mr. Jones not to lose any Medicaid coverage. However, approval for ElderChoices must be submitted in ANSWER two days after the PACE closure to prevent billing errors.

C-264 PACE Enrollment

MS Manual 01/01/14

Participant enrollment into the PACE Program is voluntary. The Division of Aging and Adult Services (DAAS) must assess the potential enrollee and concur that the client meets the requirements for nursing facility care prior to enrollment. The DHS-RN must certify that an assessment has been completed.

The PACE provider must explain to the potential enrollee that enrollment in PACE results in disenrollment in any other Medicare or Medicaid plan and that enrollment requires the completion of an intensive assessment that includes a minimum of one home visit and one visit by the potential PACE enrollee to the PACE center.

C-265 PACE Disenrollment

MS Manual 01/01/14

Participants may voluntarily disenroll from the PACE program at any time for any reason.

Participants may be involuntarily disenrolled due to:

1. The participant's failure to pay if he/she has a payment responsibility.
2. The participant's disruptive or threatening behavior.
3. The participant moving out of the PACE service delivery area.
4. The participant no longer meeting the nursing facility Level of Care requirement.
5. The participant' death.
6. The PACE organization cannot provide the required services due to loss of licensure or contracts with outside providers.
7. A PACE program agreement is not renewed.

To involuntarily disenroll a participant, the PACE Organization must obtain the prior review and approval of the Division of Aging and Adult Services with the Department of Human Services. The request to disenroll a participant and documentation to support the request must be sent to the DHS-RN. The DHS-RN will review the request and corresponding documentation and will make a recommendation to the DHS-RN Supervisor and DHS PACE Program Manager regarding whether the PACE Organization should proceed with the involuntary disenrollment. The DHS-RN Supervisor, in consultation with PACE Program Management will make a final determination regarding the appropriateness of the involuntary disenrollment and will notify the PACE Organization and the DHS-RN.

The PACE Organization may appeal an adverse decision to the DAAS.

C-266 PACE Provider Post-Enrollment Assessments

MS Manual 01/01/14

Upon enrollment, it is required that each PACE provider have an interdisciplinary team in place that is responsible for the overall assessment of care needs and subsequent management, supervision and provision of care for PACE participants. The team's membership consists of a primary care physician (PCP), registered nurse, social worker, physical therapist, occupational therapist, recreational therapist/activity coordinator, dietician, PACE center supervisor, home care coordinator, personal care attendant/aid, and a transportation staff/driver.

The interdisciplinary team is responsible for the assessment, treatment planning and care delivery of the PACE participant. PACE regulations establish the following assessment requirements:

1. An initial in-person assessment must be completed by the Primary Care Physician, RN, Social Worker, Physical Therapist and/or Occupational Therapist, Dietician and the Home Care Liaison.
2. At least semi-annually, an in-person assessment and treatment plan must be completed by the Primary Care Physician, RN, Social Worker and Recreational Therapist/Activity Coordinator.
3. An annual in-person assessment and treatment plan must be completed by the Physical Therapist and/or Occupational Therapist, Dietician and Home Care Liaison.

PACE organizations will consolidate discipline specific plans into a single plan of care semi-annually through discussion and consensus of the interdisciplinary team. The consolidated plan will then be discussed and finalized with the PACE participant and his or her significant others. Reassessments and Treatment Plan changes will be completed when the health or psycho-social situation of the client changes.

C-270 DDS Waiver Application Process

MS Manual 01/01/14

The DDS worker will obtain a completed DCO-777 from each applicant or the parent/guardian/representative of the applicant UNLESS the applicant is a current Medicaid recipient residing in an ICF/MR and nursing home facility OR opened in a TEFRA case. Please refer to Appendix I for the required forms to be completed during the application process.

For current Medicaid recipients, who are residing in ICF/MR and Nursing Home facilities, refer to procedures in MS C-273.

When a TEFRA recipient completes ACS-102 Freedom of Choice form requesting DDS waiver services, an additional application is not required as eligibility for Medicaid has been established. Please refer to Appendix I for the required application forms. For further guidance on approving the DDS waiver and closing the TEFRA case, refer to (MS C-272).

For other Medicaid categories (e.g. ARKids, etc.) form DCO-777 will be completed along with all the required forms necessary to process the application for DDS Waiver services.

Upon receipt of completed applications, the DDS Waiver Application Unit (WAU) will register in the appropriate category and determine eligibility.

EXCEPTION: Applications by SSI recipients need not be registered.

A DDS Medicaid Eligibility worker will have 45 days in which to process an application, or 90 days if a disability determination is needed. It will be the responsibility of the DDS Medicaid Eligibility worker to verify and document each eligibility requirement.

Please refer to MS A-200 and MS A-212 for information regarding the Medicaid coverage period and retroactive eligibility.

NOTE: If a Waiver applicant (or recipient) requests an Administrative Hearing at any time, the DDS Medicaid Eligibility worker will be responsible for preparing the Medicaid file, the county statement and will attend the hearing. MS L 100-173).

C-271 Approving the Application

MS Manual 01/01/14

When submitting approval for the Waiver Program the caseworker will register the application in ANSWER. If there is an existing case the caseworker will be required to use the closed budget.

When the Budget Unit characteristic of Waiver-Nursing Home is selected, the ANSWER interface screen will display the number “2999” in the WVNO field to identify clients who have been moved from an ICF/MR facility to enter the Waiver Program. **The ICF/MR case must be closed before the Waiver case is opened, (ICF/MR case must be closed and allowed to edit over 72 hours before the Waiver case is opened). Waiver certification cannot be made on the same day of the ICF/MR closure.**

When the Budget Unit characteristic of Waiver-Community on the WAIV ANSWER interface screen shows the number “2900” on WVNO field, this identifies the client who has been living in the community prior to acceptance in the Waiver Program.

On the WAIV ANSWER interface screen the DDS Waiver recipient’s total gross income will be displayed.

If an applicant is currently open in a Medically Needy case all eligibility factors - including disability, if not previously established - will be determined prior to Waiver certification. The Medically Needy case will be closed or the individual dropped from the case prior to approval for the Waiver services.

If an individual found eligible for the Waiver program is currently certified in a Medically Needy Spend Down case, a Waiver certification will not be made until the Spend Down case has expired.

An open TEFRA child found eligible for the Waiver program will be certified in the appropriate category after closure of the TEFRA case.

C-272 DDS Waiver Applicants Currently Residing in ICF/MR Facilities

MS Manual 01/01/14

Eligibility determinations may be made for applicants who request Waiver services and who are currently residing in an ICF/MR facility, when there is a plan to move them to a community setting. The approval request from DDS Waiver Unit is included in the file. The Waiver Services and Medicaid Income Eligibility files are separate.

If an eligibility determination is made before an applicant is discharged from the ICF/MR facility, the Waiver case cannot be opened before the individual leaves the facility.

For Medicaid eligible DDS Waiver applicants currently residing in ICF/MR Facilities, the following actions must be completed:

1. Upon notification that an individual in an ICF/MR facility is requesting DDS Waiver services, DDS staff (Intake Unit or HDC Admission Coordinator), will meet with the individual's guardian/legal representative and complete ACS-102, Freedom of Choice form. Along with the ACS-102, the DDS Staff will gather the following documentation to complete the Waiver packet:
    a. DHS-400-Release of information
    b. Current intellectual and adaptive assessments with scoring, written report and credentialed signature within Waiver prescribed timeframes
    c. DHS-703-Physician's diagnosis (current within 1 year)
    d. Completed Areas of Need form
    e. Current Social History
2. If the individual and/or his guardian are ready to select a provider, a provider choice form will be completed. DDS staff will also obtain a copy of the DHS-704 (Eligibility) form from the individual's file at the facility.

3. If the individual has not chosen a provider, the Waiver Unit Program Manager will assign a DDS Waiver Specialist to meet with the individual and/or his guardian to provide assistance in choosing a provider from the available choices.
4. Form ACS-102 and the DHS-704 will be submitted by the DDS staff to the DDS Waiver Application Unit (WAU) along with notification of the request for waiver services for further processing and distribution.
5. The WAU will send the ACS-102 and DHS-704 to the DDS Medicaid Income Eligibility Unit (MIEU) for Waiver eligibility determination.
6. Once a determination of eligibility has been made, the DDS MIEU will email form DCO-3330 to the WAU advising eligibility status under the waiver category.
7. Once a choice of provider has been selected, plan of care submitted and approved, and discharge date (determined by the ICF staff in cooperation with the receiving waiver provider) scheduled, the Waiver Application Unit will submit a copy of the DHS-702 to the DDS MIEU requesting the Medicaid case to be approved in waiver category upon date of discharge.
8. The Medicaid Income Eligibility Unit will forward a copy of the DHS-702 in email to the DCO Medicaid caseworker of the applicant (copying County Supervisor and County Administrator) and request he/she close the applicant on the WNHU interface screen.
9. Allow up to 72 hours edit; open on the WAIV interface screen, submit the DHS-3330 to the Waiver Application Unit verifying waiver approval and start date as well as send a DHS-700 or system generated approval notice to the individual or guardian/legal representative advising of approval.

For individuals in a nursing facility, the following procedures will be followed:

1. The DDS Intake Specialist and/or Admission Coordinator will notify and submit the waiver packet to the DDS WAU.
2. The individuals discharging from a nursing facility, the DDS Psychological Examiners will review current and past (if applicable) psychological evaluations to establish the ICF/MR level of care requirement is met.
3. The Psychological Examiner will complete the DHS-704 on eligible/ineligible individuals and submit to WAU.
4. Once the ICF/MR Level of Care has been determined, the WAU will then disperse ACS-102 and DHS-704 to the MIEU for eligibility determination.

5. WAU will submit DHS-702 verifying discharge date and request approval in DDS Waiver group.

If an eligibility determination is made before an applicant is discharged from the ICF/MR facility, the Waiver case cannot be opened before the individual leaves the facility. The 45 (or 90) day time frame for processing applications must be followed.

To certify the DDS waiver case, close the LTC vendor portion of the case, but do NOT close Medicaid. **72 hours after closure of the vendor portion of the case, the Waiver portion of the case may be opened.**

When the client has left the facility, DCO caseworker will close the ICF/MR case in ANSWER with a Nursing Home STOP DATE effective the date the individual left the facility. A MED END date should not be entered in ANSWER. After 72 hours if an individual who left an ICF/MR facility is to live in a community setting, the DDS worker will key the Waiver certification in ANSWER. The WAIVER START DATE cannot overlap, so it will be the day after the client left the ICF/MR facility. The address will be changed in ANSWER. It is not necessary to rekey or change the MED BEGIN DATE; the original date shown on the screen will remain.

C-280 SSA Referral Processes for Specific AABD Groups

MS Manual 01/01/14

SSA has several referral processes that are used to notify DCO when Medicaid may be extended when individuals lose their SSI eligibility. These processes are described in the sections below.

C-281 Eligible Due to Disregard of Social Security COLA Increases (Pickle)

MS Manual 01/01/14

The following procedures will be completed to insure that closed SSI recipients will continue to receive Medicaid.

Central Office Procedure:

Converted Cases

From a special lead file provided by the Social Security Administration, Baltimore, the Central Office will identify individuals losing SSI eligibility due to COLA increases. These individuals will be converted to the AABD No-grant category at the end of each calendar year, with a reevaluation due the following year in January.

At the time Central Office converts the individuals entitled to No-grant categories, they will produce a listing of the converted individuals by county entitled "SSI COLA Cases Converted to No-Grant Categories". This report will run in December of each year and located in Web Reports in the Share Site. The County Office will take appropriate steps if needed.

County Office Responsibilities

Converted Cases

Upon receipt of the county listing of individuals converted to AABD No-grant due to loss of their SSI eligibility, the county office will review each individual on the list which identifies them by name, category, case number, and by the indicator (COLA 20--, enter year converted) to identify their status as a former SSI case converted to AABD No-grant under provisions of the Pickle Amendment.

Each January the county office will mail form DCO-111, Notice of Conversion, to all individuals on the most recent "SSI COLA Cases Converted ..." listing to advise them of their current Medicaid eligibility status.

During the three-month period, January through March each year, the county office will conduct renewals on all converted No-grant cases on the county listing. The purpose of these reviews will be to build an electronic case record, to establish a new renewal date and to determine whether any individuals have been converted to AABD No-grant in error.

C-282 Identification of Stragglers

MS Manual 01/01/14

The Social Security Administration will notify Central Office of any individuals who qualify for continued Medicaid coverage under the Pickle Amendment who were not identified on the lead file transmitted from Baltimore.

As these individuals are identified to the Central Office, a listing will be on the NAS box/DCO Web Reports.

Upon receipt of the listing from the Report, the County Office will contact the identified individuals, advise them of their potential Medicaid eligibility, and arrange for an application interview. Application will be taken on Form DCO-215, and registered in ANSWER in the appropriate AABD budget unit on the Budget Unit Tab.

C-283 Disabled Adult Children (DAC)

MS Manual 01/01/14

The Social Security Administration will notify the Agency of DAC cases through SDX, and County Offices will receive printouts entitled "SSI Recipients Terminated Due to DAC Increases" through system generation. Within 5 working days from receipt of the printouts, the County Office will notify the listed individuals that application will be needed to determine continuing benefits. Application will be made on DCO-777 and registered in the appropriate category.

C-284 Disabled Widows, Widowers, and Disabled Surviving Divorced Spouses

MS Manual 01/01/14

The Social Security Administration will determine which individuals are potentially eligible, based on their disability and marital status, and will refer those individuals to DCO for eligibility determinations under these provisions. Application will be made on DCO-777 and registered in the appropriate category.

C-285 Individuals Who Have Remarried

MS Manual 01/01/14

It is possible that some of the individuals referred by SSA will have remarried and will have a spouse in the home. In that case, the spouse will be considered an ineligible spouse, and the deeming of income rules at MS E-440 will apply in determining eligibility. The resulting net income will be compared to the couple's SSI/SPA for eligibility. Resources will be compared to the couple's resource limit.

In the event SSA refers both members of a married couple for eligibility determination, the SSA income of both individuals will be disregarded, along with the SSI exclusions, before comparing their net income to the SSI/SPA for a couple in the eligibility determination. The couple's resource limit will apply.

C-286 COLA (Pickle), DAC and Widows/Widowers Referral Letter

MS Manual 01/01/14

SSA mails a referral letter directly to the DCO Medicaid Eligibility Unit when an individual may be a candidate for preservation of Medicaid eligibility under the provision of COLA, DAC or Widow/Widowers benefits. The referral letter contains the pertinent demographic and

Medicaid benefit group information. The Medicaid Eligibility Unit then routes the referral letter to the DHS County Office of residence of the claimant.

C-300 Application Forms

MS Manual 01/01/14

Since many of the eligibility groups have specific application forms as well as other required forms necessary to determine eligibility, an application form table has been developed to show what forms are used for each eligibility group. Please refer to MS Appendix I.

D-100 General Eligibility Requirements

MS Manual 01/01/14

All Medicaid applicants must meet the general eligibility requirements listed below:

- Citizenship/Alienage,
- State residency,
- SSN enumeration, and
- Assignment of medical rights.

Each requirement is explained in the following sections.

Refer to the Eligibility Chart in Appendix J for a general overview of the eligibility requirements for each Medicaid group.

D-200 General Citizenship and Alien Status Requirements

MS Manual 01/01/14

Medicaid coverage will only be provided to those individuals verified to be citizens or nationals of the United States or an alien in satisfactory immigration status.

D-201 Declaration of Citizenship or Satisfactory Alien Status

MS Manual 01/01/14

The Immigration Reform and Control Act of 1986 (IRCA) requires that all Medicaid applicants and recipients must declare in writing under penalty of perjury that they are citizens or nationals of the United States, or that they are an alien in satisfactory immigration status.

For individuals declaring to be U.S. citizens or nationals, the declaration will be made at the time of application. If the application was made via the DCO-215, then the declaration will be via the client declaration form printed and signed by the applicant after the citizenship information has been obtained and entered in ANSWER. If the application was made via an application form other than the DCO-215, then the application form itself will serve as the declaration of citizenship.

For applicants declaring to be aliens in satisfactory status, form DCO-9, Declaration of Citizenship or Satisfactory Immigration Status, must be completed regardless of the application form used. If the applicant is unable to sign, the authorized representative's declaration on the application form will be accepted as the declaration of citizenship.

In LTC cases where the recipient or legal guardian has completed an application form, no further action for this requirement is necessary. In instances where an authorized representative other than a legal guardian has signed the application, the applicant should sign the DCO-9, unless he or she is physically or mentally incompetent to do so. If the applicant is unable to sign, the authorized representative's declaration on the application form will be accepted as the declaration of citizenship.

Once an adult has provided the declaration of citizenship or satisfactory immigration status for himself, herself or others, a declaration will not be required again unless the individual loses eligibility. If the individual later applies, a new declaration of citizenship or satisfactory immigration status will be obtained.

D-210 Citizenship

MS Manual 01/01/14

Consider any person born in the United States to be a citizen. People born abroad are considered U.S. citizens when at least one of the parents is a U.S. citizen. Also, consider a person who is a U.S. national the same as a U.S. citizen. A U.S. national is a person who is born in one of the U.S. territories. The U.S. territories include:

- Puerto Rico
- Guam
- The Virgin Islands
- The Northern Mariana Islands
- American Samoa
- The Swain Islands

People who are not citizens or nationals can become citizens through the process of naturalization.

NOTE: Citizens of the Marshal Islands are under a Compact of Free Association with the United States. They are free to travel to and from the U.S. without a visa. They are not U.S. citizens, nor are they under an alien status. If a Marshall Island Woman is pregnant and intends to give birth in the United States, she may apply for "PW Coverage for Unborn Child" (MS B-250). However, other Marshall Island individuals are not eligible for Medicaid except for Emergency Medicaid Services (MS B-500).

Citizenship must be verified for all Medicaid applicants declaring to be U.S. citizens or nationals. Refer to MS G-130 for verification requirements.

D-211 Citizenship of Children Born Outside of the U.S.

MS Manual 01/01/14

A child born abroad to at least one parent who is a U.S. citizen automatically becomes a U.S. citizen at birth if the parent(s) reports the birth to an American Consular Office and registers for a Consular Report of Birth (FS-240). An original FS-240 is furnished to the parent(s) at the time the registration is approved.

The Child Citizenship Act of 2000 allows the automatic acquisition of U.S. citizenship for both biological and adopted children of U.S. citizens who are born abroad and who do not acquire

U.S. citizenship at birth. Under this act, a child born outside of the United States automatically becomes a citizen when the following conditions are met:

- At least one parent is a U.S. citizen whether by birth or naturalization.
- The child is under the age of 18.
- The child is residing in the U.S. in the legal and physical custody of the U.S. citizen parent after having been lawfully admitted into this country as an immigrant for lawful permanent residence.
- If the child has been adopted, the adoption must be final.

If a child's citizenship is questionable, the following documents can be used if needed to verify that the child has acquired U.S. citizenship:

- Certificate of Citizenship (N-560 or N-561).
- Certificate of Naturalization (N-550 or N-570).

If proof of citizenship is needed but documentation is not available, refer the person to INS for a determination of U.S. citizenship.

D-220 Alien Status

MS Manual 01/01/14

This section contains policy relating to eligibility requirements for individuals who are aliens or immigrants. The immigration status of aliens who appear to be eligible for Medicaid must be verified. If the applicant claims alien status, he or she must provide documentation from the Immigration and Naturalization Service (INS) verifying their status. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), P. L. 104-193, enacted August 22, 1996, changed Medicaid eligibility for individuals who are not citizens of the United States. This act divides immigrants into two basic categories:

- "Qualified Aliens" - those legally living in the United States and meeting one of the conditions at MS D-223 or MS D-224.
- "Nonqualified Aliens" - those living in the United States without meeting legal conditions or those admitted legally but not meeting one of the conditions at MS D-223 or MS D-224.

Medicaid eligibility for aliens is determined by whether the alien is qualified or nonqualified and whether the individual meets the other eligibility requirements for Medicaid. In addition to alien status, the individual must meet all eligibility factors for the category for which he/she is applying. Applicants must provide documentation of qualified alien status for each person for whom Medicaid is being requested. Refer to MS G-140 for alien verification requirements. If an alien has a sponsor, the sponsor's income and resources may be deemed available to the alien when determining eligibility (MS E-280).

Qualified aliens who entered the United States before August 22, 1996 are generally eligible for Medicaid, provided they meet other eligibility criteria.

Qualified aliens who entered the United States on or after August 22, 1996, are barred from participation in Medicaid (with the exception of emergency services) for five years from the date of entry. After these individuals have been in the U.S. for five years, their sponsors' income may then be deemed available to them for determining income eligibility for Medicaid with some exceptions. Refer to MS E-280 and MS E-456. Certain groups of qualified aliens are exempt from this five-year bar. Refer to MS D-223 - D-224 for conditions of exemption.

Nonqualified aliens who meet the other Medicaid eligibility requirements are eligible for emergency Medicaid services only. Refer to MS B-500. A nonqualified (undocumented) alien woman who is pregnant may be eligible for Pregnant Woman Unborn Child (MS B-250).

D-221 Alien Categories

MS Manual 01/01/14

Any person who is not a citizen or national of the United States is termed an alien. Definitions for some of the different types of aliens are found below:

- **Non-immigrant** - an alien who seeks temporary entry to the U.S. for a specific purpose. The alien must have permanent residence abroad and qualify for the non-immigrant classification sought. Non-immigrants are not eligible for any medical assistance, including emergency medical assistance, as they do not meet residency requirements. Refer to MS D-230 for examples of non-immigrants.
- **Asylee** - an alien living in the U.S. who is unable or unwilling to return to his/her country of origin, or the last place they lived, or unwilling or unable to seek protection of that country because of persecution or a well-founded fear of persecution. Persecution or the fear of persecution may be based on the alien's race, religion, nationality, social status, or political opinion.
- **Refugee** - an alien living outside his/her country of nationality who is admitted into the U.S. because the individual is unable or unwilling to return to that country (or to the

place they last lived) because of fear of persecution. Fear of persecution may be based on the individual's race, religion, nationality, social status or political opinion.

- **Qualified Alien** - an alien lawfully admitted and lawfully accorded the privilege of residing permanently in the United States. Qualified aliens are ineligible for medical benefits, except emergency medical assistance, for five years from the date of entry to the U.S., unless they are exempt from the five-year bar. Alien groups exempt from the five-year bar are discussed at MS D-224.
- **Non-qualified Alien** - an alien who is living in the U.S. as an illegal alien or a legal alien who does not meet one of the conditions at MS D-223 or MS D-224. Conditions of eligibility for emergency medical services for non-qualified aliens are discussed at MS B-500.

D-222 Public Charge

MS Manual 01/01/14

"Public Charge" has been a part of U.S. immigration law for more than 100 years as grounds for inadmissibility and deportation. Identification by the Immigration and Naturalization Service (INS) as a public charge can be grounds for denying admission into the United States, for denying an application for permanent resident status, and in rare cases for deportation.

In 1999, the Justice Department issued regulations to clarify that receipt of most forms of Medicaid would not result in a public charge finding. To be considered a public charge by the INS, an alien must:

- Have become or be likely to become primarily dependent on the government for survival through receipt of public cash assistance, or
- Be institutionalized at government expense in a long-term care facility.

Institutionalization in a long-term care facility includes residing in a nursing home or mental health institution. Short-term institutionalization for rehabilitation is not considered as public charge.

The receipt of cash assistance or being institutionalized for long-term care does not automatically cause the individual to be considered a public charge. The INS also considers a number of other factors, such as the individual's age, health, financial status, education, and skills. Each determination is made on a case by case basis.

D-223 Aliens Subject to Five-Year Bar

MS Manual 01/01/14

Individuals shown below, who entered the U.S. on or after August 22, 1996, are barred from receiving Medicaid except emergency services for five years. The five-year period begins on the date the individual entered the U.S. with one of the following statuses:

- **Aliens lawfully admitted for permanent residency** who do not have (or cannot be credited with) 40 qualifying quarters of coverage as defined under Title II of the Social Security Act and do not have sufficient earnings through noncovered employment. Noncovered employment is work that does not require payment into Social Security because the work is covered by a retirement plan that ends the requirement to pay into Social Security (Re. MS D -225).
- Aliens **paroled** into the U.S. under section 212(d)(5) of the Immigration and Nationality Act (INA) for a period of at least one year.
- Aliens granted **conditional entry** under section 230(a)(7) of the INA as in effect before April 1, 1980.
- **Battered** aliens under 8 USC 1641(c). For the alien and children to emigrate or remain in the United States, the alien's spouse must file a petition for lawful permanent residence status via INS Form I-130, Petition for Alien Relative. Unless the spouse files this petition, the alien and children have no lawful immigrant status and face being deported. Since the 1994 enactment of the Violence Against Women Act, a battered alien may self-petition for lawful permanent residency via INS Form I-360, Petition for Amerasian, Widow(er) or Special Immigrant, without the cooperation or knowledge of the abuser.

  The battered alien may be eligible for Medicaid if he/she entered the U.S. before August 22, 1996. If the date of entry is on or after August 22, 1996, the battered alien, spouse or child is subject to the five-year bar, except for emergency medical treatment.

  Due to the abusive relationship, battered aliens may not have access to the needed INS documents. Applicants without documentation should be referred to the INS Forms Request Line, **1-800-870-3676**.

D-224 Aliens Exempt from Five-Year Bar

MS Manual 01/01/14

Aliens with the following statuses are potentially eligible for Medicaid from the date the status is obtained:

- **Refugees** admitted under section 207 of the Immigration and Nationality Act (INA).
- Aliens granted **asylum** under section 208 of the INA.
- Aliens whose **deportation or removal is withheld** under section 243(h) or section 241(b)(3) of the INA.
- **Cuban** or **Haitian** entrants under section 501(e) of the Refugee Education Assistance Act of 1980.
- **Amerasian** immigrants.
- **Canadian born American Indians** who have treaty rights to cross the U.S. borders with Canada and Mexico.
- Aliens lawfully admitted for permanent residence who have, or can be credited with, 40 qualifying quarters of coverage as defined under Title II of the Social Security Act, or have sufficient earnings through noncovered employment (Re. MS D-225).
- Aliens lawfully living in the United States on 8/22/96 who were receiving AABD Medicaid at that time may continue to receive Medicaid benefits. This applies only to AABD categories.
- Aliens lawfully living in the United States on 8/22/96 who subsequently become blind or disabled may receive Medicaid benefits in the future.
- Aliens lawfully admitted for permanent residence who are **veterans** honorably discharged for reasons other than alienage, and their spouses, surviving unremarried spouses, and unmarried dependent children. This includes alien spouses, surviving unremarried spouses, and unmarried dependent children of veterans who are U.S. citizens or deceased veterans.
- Aliens lawfully admitted for permanent residence who are **active-duty personnel of the United States Armed Forces** and their spouses, surviving unremarried spouses, and unmarried dependent children. This includes alien spouses, surviving unremarried spouses, and unmarried dependent children of active duty personnel who are U.S. citizens or deceased active duty personnel. Active duty excludes temporary full-time duty for training purposes performed by members of the National Guard or Reserves.

D-225 Establishing Qualifying Quarters

MS Manual 01/01/14

When an alien's eligibility depends on meeting the 40-quarter requirement, the number of quarters with which the individual can be credited must be determined. Individuals can get up to four qualifying quarters of credit each calendar year based on their own earnings. Individuals may also be credited with additional quarters in a calendar year based on the earnings of a parent or spouse.

The chart on Appendix S shows the amounts required to earn one credit beginning with the year 1978. The quarter of coverage amount increases each year with the SSA cost of living increase.

To calculate the number of quarters available for one year, divide the individual's total earnings for the year by the amount needed to get one credit. Amounts remaining that equal less than the amount required for one quarter will not be used. For regular earnings, use the gross amount of earnings. For self-employment, use the amount after allowable self-employment expenses have been deducted.

NOTE: As of January 1, 1997, income from any quarters in which an alien received any type of federal means-tested public assistance during the quarter is not counted. Means-tested public assistance includes TEA, SSI, Medicaid, and SNAP. Emergency Medicaid assistance for aliens is excluded from means-tested public assistance. If means-tested assistance was received, check the alien status in the other program to see if alien status was met for Medicaid eligibility.

Aliens can count their spouse's quarters earned during the marriage in addition to their own quarters to meet the 40-quarter requirement. For example, if each spouse had 20 quarters, the quarters would be added together and both spouses would be credited with having 40 quarters.

Count the spouse's quarters earned during the marriage when the spouse is either a citizen or an alien and any of the following conditions apply:

- The couple is currently married.
- A spouse is deceased and the surviving spouse has not remarried.
- The couple is separated but not divorced.

Aliens can also count the quarters earned by a parent in addition to their own quarters to meet the 40-quarter requirement. In this instance, parent means the natural or adoptive parent or the stepparent. Count the parent's quarters when the parent is either a citizen or an alien and the quarters were earned before the child turned 18, including quarters earned before the child was born. Death of the stepparent does not end the relationship. However, if the parent and stepparent are divorced the stepparent's quarters may not be counted.

Quarters earned by a child may not be counted toward the eligibility of a parent.

D-226 Victims of Trafficking

MS Manual 01/01/14

Public Law 104-193 states that aliens who are certified as victims of trafficking by the Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR) are eligible aliens for Medicaid purposes. Eligibility for victims of trafficking is determined in the same manner as Medicaid for refugees.

Trafficking is defined as all acts involved in the movement of human beings, usually women and children, from one country to another or within national borders for sexual exploitation or forced labor.

Adults who are certified as victims of trafficking receive an ORR certification letter. Children who are victims of trafficking receive an eligibility letter or an interim assistance letter. An interim assistance letter is given to a child who may have been subjected to trafficking to allow the child to be eligible to receive benefits and services for a 90-day period. Certification letters no longer contain an expiration date. A victim of trafficking is eligible to apply for Medicaid starting with the date of certification by ORR. If eligible, Medicaid coverage will be valid for one eight month period. If Medicaid coverage is needed beyond the initial eight months, the initial certification letter will be used to establish continued eligibility.

Follow the usual procedures for determining eligibility for refugees except:

- Accept the original ORR certification letter for adults or the eligibility or interim assistance letter for children under 18 in place of INS documentation.
- Contact the trafficking verification line at **202-401-5510** to confirm the validity of certification letters for adults and **202-205-4582** to confirm the validity of eligibility or interim assistance letters for children and to notify ORR of the assistance for which the individual has applied.

NOTE: Do not contact SAVE concerning victims of trafficking.

If the worker suspects that an applicant may be a victim of trafficking but does not have the required certification or eligibility letter, the worker will contact ORR at the above telephone numbers for verification of a certified letter.

D-230 Non-Citizens Not Eligible for Emergency Services

MS Manual 01/04/14

The INS issues non-immigrant visas to people who indicate that they are seeking entry for a temporary purpose. These non-immigrants do not meet the residency requirements and are not eligible for emergency services. The following groups of people are ineligible:

- Foreign government representatives on official business and their families and servants.
- Visitors for business or pleasure, including exchange visitors.
- Aliens traveling through the U.S.
- Crew members on shore leave.
- Treaty traders and investors and their families.
- Foreign students and their families who are here as dependents and are not otherwise eligible.
- International organization representatives and personnel and their families and servants.
- Temporary workers including agricultural contract workers.
- Members of foreign press, radio, film or other information media and their families.

D-300 State Residency

MS Manual 01/01/14

Residency regulations are intended to assure uniform application of residency rules and to assure that no otherwise eligible individual is denied Medicaid because no State recognizes him as a resident.

D-310 State Residency Determinations

MS Manual 01/04/14

State residency determinations are as follows:

1. An individual placed in an out-of-state institution is a resident of the State making arrangement for placement regardless of the individual's indicated intent or ability to indicate intent;

2. An individual receiving State Supplementation of SSI is a resident of the State making said payments;

3. A non-institutionalized individual is a resident of the State where he is living.

EXCEPTION: An individual aged 18-22 and a full-time student at an Arkansas school, is not a resident of Arkansas if:

a) Neither parent lives in Arkansas,
b) The student is claimed as a tax dependent by someone in a state other than Arkansas, and
c) The student is applying on his or her own behalf.

4. An institutionalized individual who is incapable of indicating intent, is a resident of the State where the institution is located, unless he is proven to be a resident of another State through application of the following determinations:
   a. An institutionalized individual who became incapable of indicating intent before age 21 is a resident of the State of:
      i. His parents or legal guardian, if one has been appointed, at the time of placement; or
      ii. The parent applying on his behalf, if the parents reside in separate States and a legal guardian has not been appointed;

b. If the individual resides in a Medicaid institution and is receiving Medicaid, he is a resident of the State which pays the Medicaid bills.

When more than one State could be an individual's residence, and you cannot determine the jurisdiction of residence based on the above rules, the residence is where the individual is physically located at present.

NOTE: For purposes of State residency – an institution is a Title XIX Long Term Care Facility and an individual is considered to be incapable of indicating intent to reside in the State if:

1. He has an IQ of 49 or less or a mental age of seven (7) or less, based on tests acceptable to the State's Division of Developmental Disabilities Services (DDS); or
2. He is judged legally incompetent; or
3. Medical or other documentation acceptable to the State supports a finding of incapability of indicating intent.

D-320 Prohibited State Residency Determination

MS Manual 01/04/14

Determinations specifically prohibited for State Residency are as follows:

1. An individual will not be denied Medicaid because he has not resided in the State for a specific period;
2. An institutionalized individual, who satisfies the residency rules set forth in this policy, will not be denied Medicaid because he did not establish residence in the State before entering the institution; and
3. An individual will not be denied Medicaid or have his Medicaid terminated because of temporary absence from the State if he intends to return when the purpose of the absence has been accomplished, unless another State has determined that he is a resident there for purposes of Medicaid.

D-330 Interstate Agreements

MS Manual 01/04/14

Medicaid regulations provide for written agreements between States to resolve cases of disputed residency. These agreements may specify criteria for residency other than the aforementioned determinations provided:

1. They do not stipulate criteria which result in loss of residency in both States or criteria which are prohibited by regulation, and

2. They stipulate procedures for providing Medicaid to individuals whose cases are involved in disputed residency.

As the State of Arkansas enters into written agreement with other States to resolve cases of disputed residency, the County Office will be notified. The notification will identify the State(s) and the criteria of the agreement(s).

The County Office will contact the Medicaid Eligibility Unit when either of the following situations occurs:

1. A State, that has not entered into a written agreement with the State of Arkansas, contacts the County Office regarding Arkansas residents receiving care out-of-state, or

2. The County Office has cases involving possible out-of-state residency.

D-340 Medicaid for the Homeless

MS Manual 01/04/14

Public Law 99-509, the Omnibus Reconciliation Act of 1986, prohibits a State from denying any individual Medicaid benefits who does not have a fixed or permanent address, but who resides in the state and is otherwise eligible. If the applicant is considered an Arkansas resident and meets the other requirements for eligibility, the case may be approved using the address of choice for the applicant.

D-350 Juveniles in the Custody of Division of Youth Services (DYS)

MS Manual 01/04/14

Juveniles committed to the custody of the Division of Youth Services may be detained in secure facilities or be placed for treatment in inpatient psychiatric facilities, inpatient medical facilities, residential treatment facilities, emergency shelters, therapeutic group homes or therapeutic foster care.

When juveniles in the custody of the Division of Youth Services are placed in juvenile detention centers and other facilities operated primarily for the detention of children who are determined to be delinquent, they are not eligible for a Medicaid payment.

When juveniles in the custody of the Division of Youth Services are placed for treatment in inpatient psychiatric facilities, inpatient medical facilities, residential treatment facilities, emergency shelters, therapeutic group homes or therapeutic foster care, they are eligible for a Medicaid payment.

The Division of Youth Services (DYS) and the Division of County Operations have entered into an inter-agency agreement which permits DYS to process and approve Medicaid eligibility for ARKids A and B for DYS juveniles who have entered treatment facilities.

D-360 Facility Transfers of Court Ordered Juveniles

MS Manual 01/04/14

Arkansas Code Ann. §9-27-332(b) and 9-27-334(c) state that a facility cannot be specified by name when a juvenile is court ordered to an inpatient psychiatric facility. Therefore, a case will not be closed solely because the court ordered ARKids participant moves from one facility to another.

If the child transfers to another county, the case will remain open and will be transferred to the county where the facility is located. If the child is transferred to an out-of-state facility, the case record will be transferred, if necessary, to the child's home county office.

D-370 Inmates of Public Institutions

MS Manual 01/04/14

An inmate of a public institution is not eligible for Medicaid payment.

EXCEPTION: An inmate in the custody of the Arkansas Department of Corrections, the Department of Community Corrections or a local correctional facility who has been admitted and received treatment at an inpatient facility may be eligible for Medicaid payment provided all eligibility requirements are met. Eligibility will be determined in accordance with MS Sections D, E and F. Only the inmate will be included in the Medicaid household.

D-370 Inmates of Public Institutions

Public institution means an institution that is the responsibility of a government unit or over which a governmental unit exercises administrative control.

"Public Institutions" include:

1. Institutions for the mental diseases which are hospitals, nursing facilities, or other institutions of more than 16 beds that are primarily engaged in providing diagnosis, treatment or care of persons with mental diseases.

2. Institutions for tuberculosis, which are primarily engaged in providing diagnosis, treatment, or care of persons with tuberculosis.

3. Correctional or holding facilities for individuals, who are prisoners, arrested, or detained pending dispositions of charges, or are being held under court order as material witness or juveniles. Correctional facilities include prisons, jails, juvenile detention centers and other facilities operated primarily for the detention of children who are determined to be delinquent. Wilderness camps and boot camps are considered public institutions if a government unit has any degree of administration control.

If an individual in a public institution must be temporarily transferred to a medical treatment or evaluation facility, or if he/she is given temporary furlough, the individual is still considered to be under custody of the penal system and is not eligible for a Medicaid payment (**See above exception)**.

An individual will be considered in a public institution until the indictment against the individual is dismissed, or until he/she is released from custody either as "not guilty" or for some other reason (bail, parole, pardon, suspended sentence, home release program, probation, etc.).

"Public institutions" <u>do not</u> include:

1. Inpatient psychiatric facilities for individuals under age 21 (22, if an inpatient on the 21st birthday) and over age 65.
2. Medical institutions which are organized to provide medical, nursing, and convalescent care, which have the professional staff, equipment and facilities to manage the medical, nursing and other health needs of patients in accordance with accepted standards, and which are authorized under State law to provide medical care. Medical institutions include hospitals and nursing facilities.

3. Intermediate care facilities for those individuals with intellectual disabilities which meet the standards under 42 CFR 483.440 (a) for providing active treatment for such individuals or individuals with related conditions.
4. Child-care institutions which are private, non-private, or public that accommodate no more than twenty five (25) children and are licensed by the State or approved by the State agency responsible for licensing or approval of such institutions.
5. Therapeutic Group Homes, Residential Treatment facilities, Emergency Shelters and Therapeutic Foster Homes which meet facility and staffing requirements of the Minimum Licensing Standards for Child Welfare Agencies published by the Child Welfare Agency Review Board.
6. Publically operated community residences that serve no more than 16 residents are facilities that provide some services beyond food and shelter such as social services, help with personal living activities, or training in socialization and life skills. They cannot be on the grounds of or immediately adjacent to any large institution or multiple purpose complexes such as educational or vocational training institutions, correctional or holding facilities, or hospitals, nursing facilities or intermediate care facilities for individuals with intellectual disabilities.

D-400 Social Security Number Enumeration Requirement

MS Manual 01/01/14

To meet the Social Security enumeration requirement, each eligible person must either:

1. Declare a Social Security number or
2. Apply for a Social Security number if one has not been issued or if one has been issued but is not known.

EXCEPTIONS: A social security number is not required for an individual who:

a. Is not eligible to receive a SSN (e.g. Refugee);
b. Does not have a SSN and may only be issued a SSN for a valid non-work reason (e.g. Emergency Medicaid, Pregnant Women (unborn child);
c. Is eligible in the Newborn Infant Category or
d. Refuses to obtain a SSN because of well-established religious objections. Well-established religious objections mean that the individual:
   1) Is a member of a recognized religious sect or division of the sect; and
   2) Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

Note: Since most newborns are “enumerated at birth”, a pseudo number assigned to the newborn will be updated in the eligibility system when a SSN is received.

1. **Individuals who Declare an SSN**

   To declare an SSN, an individual must state the number. Verification is not required. When an individual declares an SSN, the caseworker will enter the SSN in the eligibility system for verification through the SVES system. (This verification process is described in MS D-200.) The caseworker will not attempt to verify the SSN declared. However, if the household presents documentary evidence such as a social security card, a copy will be scanned into the electronic case record and used, if necessary, to clear any SSN discrepancies.

2. **SSN Application Process (No SSN or SSN Not Known)**

   a. **Aliens and Individuals age 12 or over**

   An alien regardless of age and an individual age 12 or over must apply in person at the local Social Security Administration Office. The caseworker will issue an SS-5, Application for a Social Security Card and a DCO-12, Enumeration Referral, along with the identifying information and pseudo-SSN to the applicant. The caseworker will not forward any evidence to SSA for the applicant unless SSA specifically requests such evidence. A photocopy of the SS-5 and DCO-12 will be retained in the county office until the DCO-12 is returned by SSA showing that a complete SSN application has been received.

An individual who has been issued a number but does not know it can obtain a replacement SSN card by completing an SS-5 and taking or mailing it to SSA. If the DCO-12 is returned by SSA showing that a complete SSN application has not been received, the caseworker will send a DCO-700 advising the applicant that he must submit a complete SSN application to SSA within 10 days or the Medicaid application will be processed without that person's eligibility being considered.

b. <u>Individuals under age 12</u>

Form SSA-2853 (Receipt for Enumeration at Birth) will be accepted as proof of application for an SSN if an application for an SSN was made at the hospital when the baby was born. The caseworker will request the applicant provide the SSA-2853, and scan a copy into the electronic case record. The caseworker can accept this form as proof until the first reevaluation for continued eligibility. At that time, if a card has not been received, or a number is not on the system, the caseworker will complete an SS-5 and DCO-12 to forward to the SSA office, as described below.

For other individuals under age 12 who must apply for an SSN, the caseworker must complete the SS-5 and DCO-12. The caseworker will inform the applicant of what are acceptable types of evidence to verify date of birth, identity and U.S. citizenship as listed on the SS-5 application.

The original copies of evidence along with the SS–5 and DCO-12 will be submitted to the local Social Security Administration Office. A photocopy of the SS–5 and DCO-12 should be retained in the county office until the DCO-12 is returned by the SSA office indicating that a complete SSN application has been received.

If the DCO-12 is returned by SSA indicating that additional information or evidence is required, the caseworker will obtain the additional evidence, if available to the caseworker, and resubmit the entire SSN application and DCO-12. If additional evidence is not available to the caseworker, a DCO-700 will be sent to the applicant requesting the information and advising that if not provided within 10 days, the application will be processed without the person's eligibility being considered.

c. <u>Qualified Aliens not Authorized to Work in the U.S.</u>

SSA will not assign an SSN or a replacement card to an alien who does not have authorization of the Department of Homeland Security to work in the United States unless the alien has a valid non-work reason for needing an SSN. Meeting the eligibility requirements for Medicaid, in a category where an SSN is required of eligibles, would be a valid reason for SSA to authorize an SSN. To assign an SSN in this situation, SSA requires documentation from DCO that the individual meets all eligibility requirements for Medicaid except for an SSN. For these individuals, the caseworker must first determine that the individual meets all points of eligibility except for an SSN. If they are Medicaid eligible, the caseworker should complete the DCO-12, checking on the form that the non-work alien meets all eligibility requirements except for the SSN. The caseworker will issue the DCO-12 and SS-5 to the applicant or responsible party, following the procedures in 2(a) above, regardless of the age of the qualified alien. SSA requires an interview for enumeration of all non-citizens.

NOTE: Counties should only refer eligibles to SSA. Non-eligible, non-work alien parents applying only for their children should not be referred to SSA. They should be given a pseudo-SSN.

d. **Undocumented Alien**

An undocumented alien who is the casehead or included as an ineligible member in an open case will be assigned a pseudo number even if an SSN is provided. This includes an undocumented pregnant woman. More information regarding the procedures for applying for a SSN can be obtained through SSA's website: www.ssa.gov/ssnumber/ or by calling toll free at **1-800-772-1213**, deaf or hard of hearing at **1-800-325-0778** from 7 a.m. to 7 p.m., Monday through Friday for specific questions.

3. **Non-Eligibles Included In the Medicaid Household Size**

Non-eligible minor children, parents and other caretaker relatives, who meet the relationship criteria as outlined in MS F-110, may be included in the determination of Medicaid household size without enumeration. Every effort should be made to secure the SSN of non-eligibles in the Medicaid household, but eligibility cannot be denied or delayed for eligible individuals based on non-enumeration of non-eligibles.

D-500 Mandatory Assignment of Rights to Medical Support/Third Party Liabilities

MS Manual 01/01/14

As a condition of eligibility for Medicaid, recipients are required to assign their rights to Medical Support/Third Party Liability payments to the Department of Human Services. This means that any funds settlements or other payments made by or on behalf of third parties should be paid directly to the Arkansas Medicaid Program. In Arkansas, Third Party Liability payments are automatically assigned by state law.

The Medical Assistance Program is required by Federal and State Regulations to utilize all Third Party sources and to seek reimbursement for services which have been paid by both a Third Party and Medicaid.

Private insurance and Medicaid are complementary. A recipient's Medicaid eligibility, except for an ARKids B recipient, is not affected by having Third Party coverage (Re. MS F-180).

When a recipient has Third Party coverage in addition to Medicaid, which can be used for medical expenses, Third Party coverage must be utilized first. Medicaid will pay up to the Medicaid allowable charge. For example: A Medicaid recipient has insurance which paid 80%, or $80 of a $100 medical bill. The Medicaid allowable charge for the bill was only $60.00. A Medicaid payment was not due since the Medicaid allowable charge was less than the insurance payment. Third Party sources whose payments Medicaid will retrieve include private health insurance, automobile liability insurance where applicable, workmen's compensation, settlements for injuries, etc.

Tri-Care is considered to be a Third Party source. Whenever a Tri-Care beneficiary is also eligible for Medicaid, Tri-Care is in every instance the primary payer. This applies to all classes of Tri-Care beneficiaries, i.e., dependents of active duty members, retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees.

NOTE: The Third Party Liability policy does not apply to individuals enrolled in a private Qualified Health Plan through the Health Care Independence Program, however Assignment of Rights to Medical Support does apply.

D-510 DCO Responsibility

MS Manual 01/04/14

Third Party resources (if any) will be determined by completing the DCO-662 at the time of application and at each reevaluation when Third Party coverage is reported by the applicant/recipient.

Third Party information will be indicated on the TPL tab in the system.

NOTE: For cases involving Tri-Care, the name and Social Security Number of the service member/policyholder must be entered on the DCO-662. The TPL unit has an online system to check eligibility and addresses of insurance companies.

Upon determining that Third Party coverage exists, inform the recipient of the restrictions placed on the coverage by the Medicaid Program, (i.e., recipients are not entitled to any benefits and/or compensation from Third Party sources on services for which Medicaid has made or will make compensation). Instruct recipients who want Medicaid billed for services that they are to assign their TPL resource benefits to the provider before services are rendered.

D-520 Recipient Responsibility

MS Manual 01/04/14

Recipients are not entitled to any benefits and/or compensation from Third Party sources on services for which Medicaid has made or will make compensation. For this reason, recipients are responsible for assigning the TPL resource benefits to the provider before services are rendered if they want Medicaid billed for the services. This includes indemnity policies such as cancer policies, intensive care policies, etc.

If the provider elects not to accept Medicaid on the recipient, the recipient becomes a “private pay” patient and is responsible for the full cost of services rendered. Assignment is not required for non-Medicaid claims.

D-530 Provider Responsibility

MS Manual 01/04/14

If Medicaid has established the probable existence of third party liability at the time the claim is filed, the agency must reject the claim and return it to the provider for determination of the amount of liability.

It is the responsibility of the provider to file a claim for services with Third Party sources and to report the third party and receipt of funds received from the third party when filing a Medicaid claim.

When the amount of liability is determined, Medicaid will pay the claim to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third party's payment.

The provider is to make no claims against a Third Party source for services for which a claim has been submitted to Medicaid.

D-540 Procedure for Failure to Cooperate

MS Manual 01/04/14

Recipients who are not cooperating with the Division of Medical Services Third Party Liability Unit will be subject to termination of Medicaid assistance. The Third Party Liability (TPL) Unit will notify the County Office when a recipient has been determined uncooperative.

When a notice is received from the Third Party Liability Unit that a recipient is not cooperating, the caseworker will:

1. Complete Form DCO-700 to give advance notice to the non-cooperating recipient that his/her Medicaid will be terminated due to failure to cooperate.
2. If no response from recipient, remove the non-cooperating recipient from his eligibility group in the system, effective the appropriate date for the eligibility group in which he/she resides (Re. MS A-200). This may require case closure if the recipient is in a one-person household.

The recipient who has not cooperated with the Third Party Liability Unit will remain ineligible for Medicaid until TPL determines that the recipient is cooperating. The Third Party Liability Unit will notify the County Office when a case or member can be reopened.

E-100 Financial Eligibility

MS Manual 01-01-14

Each individual applying for or receiving Medicaid benefits must have a financial eligibility determination made at application and, if eligible, on an on-going annual basis or when a change affecting eligibility occurs. Financial eligibility consists of an income test and if the category requires, a resource or asset test.

Most Medicaid eligibility groups have an income limit which an individual's countable income must fall under in order to be eligible for coverage in that group. Income limits and the manner in which countable income is determined vary by eligibility groups. The groups to which an income limit does not apply, and therefore no income determination is made, are the following:

- Newborns (MS B-220);
- Former Foster Children (MS B-260);
- Workers with Disabilities (MS B-330).

NOTE: For the Workers with Disabilities category, income is disregarded in the financial eligibility determination, but earned and unearned income will be used to determine cost sharing. See MS B-330.

A resource limit applies to most of the eligibility groups that do not use MAGI methodologies for financial eligibility. For these groups, the value of an individual's countable resources must be determined. There is no resource limit, and therefore no resource determination is made, for the following groups:

- Those using MAGI methodologies (MS E-110);
- Newborns (MS B-220);
- Former Foster Children (MS B-260);
- Workers with Disabilities (MS B-330).

E-110 Income and Resource Limits for MAGI and Non-MAGI Groups

MS Manual 01-01-14

Below are the income and resource limits for all Medicaid groups. When the income limit is based on a percentage of the federal poverty level (FPL), the countable household income will be compared to the FPL for the applicable household size. Refer to Appendices F and S for the specific income level amounts.

E-100 Financial Eligibility

E-110 Income and Resource Limits for MAGI and Non-MAGI Groups

Category	Income Limit	Resource Limit
ARKids A	142% of FPL	No Resource Test
ARKids B	211% of FPL	No Resource Test
Newborns	No Income Test Eligibility is based on mother's Medicaid eligibility at child's birth	No Resource Test
Pregnant Women: Full Medicaid Pregnant Woman Limited Medicaid Pregnant Woman Unborn Child	 1 person: $124.00 2 person: $220.00 3 person: $276.00 4 person: $334.00 5 person: $388.00 See Appendix F for household sizes over 5. 209% of FPL 209% of FPL	 No Resource Test
Parent and Caretaker Relative	1 person: $124.00 2 person: $220.00 3 person: $276.00 4 person: $334.00 5 person: $388.00 See Appendix F for household sizes over 5.	No Resource Test
Healthcare Independence	133% of FPL	No Resource Test
Medically Needy: U-18 Pregnant Woman	 Exceeds the monthly income limit See Appendix N for the monthly income limit	 1 person: $2,000 2 person: $3,000 3 person: $3,100
TEFRA	3 times the SSI Payment Standard Appendix S	$2000
Autism	3 times the SSI Payment Standard Appendix S	$2000
Long-Term Services & Supports: Nursing Facility, DDS, ElderChoices, Assisted Living, AAPD and PACE	3 times the SSI Payment Standard Appendix S	Individual $2000 Couple $3000
Medicare Savings:		

ARSeniors QMB SMB QI-1 QDWI	Equal to or below 80% FPL 100% FPL Between 100% & 120% FPL 120% but less than 135% FPL 200% FPL Appendix F	ARSeniors, QMB, SMB & QI-1: Individual $7,080 Couple $10,620 QDWI: Individual $4000 Couple $6000
Workers with Disabilities	No income test	No resource test
PICKLE	Under the current SSI/SPA level Appendix S	Individual $2000
Disabled Widows & Widowers	Under the current SSI/SPA level Appendix S	Individual $2000
Disabled Adult Child (DAC)	Under the current SSI/SPA level Appendix S	Individual $2000

E-200 Determining Financial Eligibility Under the MAGI Methodology

E-210 What is MAGI

MS Manual 01-01-14

MAGI is a federal income tax term meaning **M**odified **A**djusted **G**ross **I**ncome. For purposes of determining Medicaid eligibility, MAGI is a methodology for determining how income is counted and how household composition and family size are determined. It is based on federal tax rules but it is **not** an amount on a specific line on an individual federal tax return. In addition to being used to determine Medicaid eligibility for certain eligibility groups, the MAGI methodology is also used to determine eligibility for and the amount of Advance Premium Tax Credits (APTC) and cost-sharing reductions available to individuals and families who are eligible to purchase health insurance through the Federally Facilitated Health Insurance Marketplace (FFM).

For tax purposes, the modified adjusted gross income reflects annual income for a specific tax year. For Medicaid purposes, though, current monthly income is used to determine eligibility. This is true even when using MAGI methodologies. See MS E-265 for more detailed information on determining whether income is "current" and for converting income amounts to monthly amounts.

E-220 Families and Individuals (MAGI) Groups

MS Manual 01-01-14

MAGI methodologies are used to determine financial eligibility for the following eligibility groups:

1. Infants and children under age 19-(ARKids A & B);
2. Pregnant women;
3. Parents and caretaker relatives; and
4. Adults age 19 through 64 who do not fall into another adult group (Health Care Independence Program)

E-230 Steps in Determining MAGI Income Eligibility

MS Manual 01-01-14

Below are the steps for determining income eligibility:

1. Determine the Medicaid household composition and size for each individual applying for assistance. See MS E-240-E-251.

   - "Medicaid household" means the household members whose income will be considered when determining eligibility and/or who will be included in the household size. For MAGI determinations, the Medicaid household is determined based on the individual's tax filing status. See MS E-250.
   - The "Medicaid household size" is the number of people who will be counted to determine the appropriate Federal Poverty Level (or other income standard) for the household.

2. Determine countable household income. See MS E-260-E-264.

   - Countable household income is the income of the Medicaid household members that will be counted in determining eligibility.

3. Determine current household income. See MS E-265-E-266.

   - The income used to determine Medicaid eligibility must reflect the income that a Medicaid household member is currently receiving.

4. Compare countable current household income to the appropriate FPL for the household size. See MS E-267.

   - This step will determine each individual's Medicaid eligibility.

The following sections describe each of the steps above in more detail. In addition, the following example scenario is used throughout these sections to illustrate the application of each step to a particular household.

> **Example Scenario:** Bertha is a working grandmother who claims her daughter Audrey, age 20 and a full-time student, and granddaughter Chloe (Audrey's daughter), age 2, as tax dependents. Audrey works a few hours each week and Chloe's father pays child support. The household consists of these three only. All are applying for Medicaid.

E-240 Determining the Medicaid Household For Families and Individuals Groups

MS Manual 01-01-14

Under the MAGI methodology, the Medicaid household composition is based on federal income tax filing status. Household size is the number of individuals counted in the family size for the income standard. When determining the household size, SSI recipients are counted and in addition, a pregnant woman is counted as one (1) person plus the number of children she is expecting. In most situations, the Medicaid household is the same as the tax filing unit of which the individual is a member. The Medicaid household composition determines whose income will be considered in determining eligibility. If the family or individual has not filed a federal tax return for the most recent tax year and does not expect to file one, then the Medicaid household is determined as described in MS E-251.

E-250 Tax Filing Status

MS Manual 01-01-14

To determine an individual's tax filing status or unit, two basic questions must be asked in relation to the individual.

Note: Each person's eligibility for Medicaid is determined individually, even if two or more individuals are living in the same house/home.

1. **Does the individual expect to file taxes?**
2. **Does the individual expect to be claimed as a tax dependent?**

If the answer to both of these questions is "No", then the individual's Medicaid household is determined according to MS E-251 (Non-Tax Filing Households).

If the answer to either of the above questions is "Yes", then additional questions must be asked to determine the individual's Medicaid household as described in the table below.

Question 1. Does the individual expect to file taxes?	
Yes	Continue to Question 1a.
No	Continue to Question 2.
Q. 1a. Does the individual expect to be claimed as a tax dependent by anyone else?	
Yes	Continue to Question 2.

No	Household is: ▪ The taxpayer; ▪ A spouse living with the taxpayer; and ▪ All persons the taxpayer expects to claim as a tax dependent.
Question 2. Does the individual expect to be claimed as a tax dependent?	
Yes	Continue to Question 2a.
No	Household composition is determined according to MS E-251.
Question 2a. Does the individual meet any of the following exceptions?	
• Expects to be claimed as a tax dependent of someone other than a spouse or parent (biological, adoptive, or step-parent) • Is a child under age 19 living with both parents but the parents do not expect to file a joint tax return • Is a child under age 19 who expects to be claimed by a non-custodial parent	
Yes	Household composition is determined according to MS E-251.
No	Household is: ▪ The household of the taxpayer claiming the individual as a tax dependent; and ▪ The individual's spouse if married.

Example Scenario: Household Composition, i.e. Household Members

Example Scenario: Bertha is a working grandmother who claims her daughter Audrey, age 20 and a full-time student, and granddaughter Chloe (Audrey's daughter), age 2, as tax dependents. Audrey works a few hours each week and Chloe's father pays child support. The household consists of these three only. All are applying for Medicaid.

The table below shows how each individual's Medicaid household for the Example Scenario described above is determined based on each individual's tax filing status.

Bertha			
1.	Does Bertha expect to file a tax return?	Yes	Continue to Question 1a.
1a.	Does Bertha expect to be claimed as a tax dependent by anyone else?	No	
Bertha's Medicaid household is: Bertha (applicant and taxpayer) Audrey (tax dependent) Chloe (tax dependent)			
Audrey			

1.	Does Audrey expect to file a tax return?	No	Continue to Question 2.
2.	Does Audrey expect to be claimed as a tax dependent?	Yes	Continue to Question 2a.
2a.	Does Audrey expect to be claimed as a tax dependent of someone other than a spouse or parent (biological, adoptive, or step-parent)?	No	Audrey is being claimed by her mother.
	Is Audrey under age 19 living with both parents but the parents do not expect to file a joint tax return?	No	Audrey is 20 years old living with her mother. Her mother has filed a tax return.
	Is Audrey under age 19 and expecting to be claimed by a non-custodial parent?	No	Audrey is 20 years old and being claimed as a tax dependent by her mother with whom she lives.
Audrey's Medicaid household is: Bertha (taxpayer) Audrey (tax dependent) Chloe (tax dependent)			Since Audrey does not meet any of the exceptions in Question 2a., her Medicaid household is the same as the household of the taxpayer claiming her as a dependent (Bertha).
	Chloe		
1.	Does Chloe expect to file a tax return?	No	Continue to Question 2.
2.	Does Chloe expect to be claimed as a tax dependent?	Yes	Continue to Question 2a.
2a.	Does Chloe expect to be claimed as a tax dependent of someone other than a spouse or parent (biological, adoptive, or step-parent?	Yes	See MS E-251 for how Chloe's household is determined.

Additional Tax Filing Unit Example Scenarios can be found in Appendix E. They include scenarios dealing with single adults, children claimed as a tax dependent by a non-custodial parent, non-filers, etc.

E-251 Non-Tax Filing Households

MS Manual 01-01-14

Medicaid household composition will be determined in accordance with this section in the following situations:

1. The individual has not filed and/or does not expect to file a federal income tax return for the current year AND does not expect to be claimed as a tax dependent for the current year; or
2. The individual meets one of the following tax dependent exceptions:

a. Expects to be claimed as a tax dependent of someone other than a spouse or parent (biological, adoptive, or step-parent);
b. Is a child under age 19 living with both parents but the parents do not expect to file a joint tax return;
c. Is a child under age 19 who expects to be claimed by a non-custodial parent.

When an individual is in one of the situations above:	The Medicaid household includes the following persons who live in the home with the individual: • Spouse • Children (biological, adopted and step children) under the age 19 • Siblings (biological, adopted and step siblings) under age 19. • If the individual is under age 19, his/her parent(s) (biological, adopted and step parents).

Example Scenario: Household Composition for a Non-Tax Filing Household

Since Chloe met one of the exceptions to using tax filing status to determine household composition, her household is determined in accordance with this section (Non-Tax Filing Households) as follows:

Question 2a exception: Chloe is under age 19 and is claimed as a tax dependent by her grandmother, Bertha.	
Chloe's Medicaid household includes the following person or persons who live in the home with her:	
Spouse	None
Children (biological, adopted and step children) under the age 19	None
Parent(s) (biological, adopted and step parents)	Yes (Audrey)
Siblings (biological, adoptive and step siblings) under age 19	None

Chloe's household is: Chloe (applicant)
Audrey (Chloe's parent living in the home with her)

E-260 Determining Countable Income for Families and Individuals Groups

MS Manual 01-01-14

Once the Medicaid household composition has been established for the individual, then each household member's countable income must be determined. Only income of the persons in an individual's Medicaid household is considered when determining financial eligibility. Generally speaking, countable income sources using the MAGI methodology are the same as a tax filing unit's taxable income sources with a few exceptions. The exceptions are:

- Social Security benefits are counted in full;
- Income received as a lump sum is counted as income only in the month received; and
- Any portion of an educational scholarship, award and/or fellowship grant used for living expenses is countable income.

E-261 Income Included for Families and Individuals Groups

MS Manual 01-01-14

The following are some sources of income that are taxed and included in MAGI to determine Medicaid eligibility: (list not inclusive)

1. Earned Income
2. Self-employment income after allowable income-producing costs are deducted. Refer to MS E-266.
3. Social Security income (Title II) – counted in full for Medicaid even though only a portion (or none) may be taxable
4. Lump sum payments in month of receipt only
5. Dividends and interest income
6. Unemployment compensation
7. Alimony
8. Pensions and annuities payments
9. Rental income
10. Lottery and gambling winnings
11. Any portion of educational scholarships, awards, fellowship grants used for living expenses

If an individual received income from a source not listed above and did file a tax return for the tax year in which the income was received, then the general rule to follow is the income will be considered for Medicaid purposes if it was reported as taxable income for that tax year. If the income was excluded for taxes, it will be excluded for Medicaid purposes. If the individual did not file a tax return for the applicable tax year, then a determination must be made as to whether the income would be taxable or not.

E-262 Income Excluded For The Families and Individuals Groups

MS Manual 01-01-14

The following are some sources of income that are excluded as taxable income for federal income tax purposes and therefore are excluded as countable income for Medicaid purposes: (list not inclusive)

1. Child Support
2. Worker's Compensation
3. Veteran's Benefits
4. Educational grants (Basic Education Opportunity Grant (BEOG or PELL, Supplemental Educational Opportunity Grant (SEOG), College Work Study and Supplemental State Income Grant (SSIG))
5. American Indian/Alaska Native
6. Public Assistance Benefits (TEA Cash, SSI)
7. Disaster Relief Payments
8. Gifts
9. Federal Tax Refunds

Refer to MS E-261 to determine if a source of income not listed above can be excluded for Medicaid purposes or whether it must be counted.

E-263 Household Members Whose Income Will Not be Counted for Families and Individuals (MAGI) Groups

MS Manual 01-01-14

The income of the following household members is not considered when determining Medicaid eligibility for any person in the household:

1. Income of a child who is included in the parent's Medicaid household and is not expected to be required to file a tax return.

2. Income of a tax dependent who is not expected to be required to file a tax return and is in the Medicaid household of the person who is claiming him/her as a tax dependent.
3. Income of an SSI recipient who is included in the Medicaid household size.

E-264 Household Members Whose Income Will Be Counted For The Families and Individuals Groups - Example Scenario

MS Manual 01-01-14

Continuing with the Example Scenario of Bertha, Audrey and Chloe, the table below shows how each person's income will be counted for each individual's Medicaid eligibility.

NOTE: Bertha's and Audrey's households are the same, so the income of each member will be considered in the same way for each of their households.

Bertha's and Audrey's Medicaid Household Composition (which determines whose income is counted)

Members	Income Type	Counted
Bertha	Full-time Earnings	Yes
Audrey	Part-time Earnings	No – Audrey is not expected to be required to file a tax return and she is in the household of her parent and a tax dependent of her parent. Therefore, her income is not counted in either Bertha's or her own household.
Chloe	Child Support	No – Chloe is not expected to be required to file a tax return and is Bertha's tax dependent; child support income is not counted.

Chloe's Household

Members	Income Type	Counted
Audrey	Part-time Earnings	Yes – Although Audrey is not required to file a tax return and is claimed as a tax dependent, her income **does** count in this household because she is not the child

		nor tax dependent of any of the other members of this household, i.e., Chloe.
Chloe	Child Support	No – Chloe is Audrey's child; child support income is not counted.

E-265 Determining Current Gross Monthly Income For The Families and Individuals Groups

MS Manual 01-01-14

Current gross monthly income will be used in determining financial eligibility for Medicaid. Current monthly income is the income the individual is expected to have in the month(s) for which eligibility is being determined.

NOTE: There is an exception to using current monthly income in which projected annual income will be used. This is discussed further in MS E-270.

Gross income is the amount paid to the individual before any withholding taxes or other deductions are taken from the income. Income that may have been received in the prior tax year or even the prior month but that is not currently being received or expected to be received in the current or future months will not be counted. If a continuing source of income has increased or decreased since the last tax return or from other information available to the agency, then the current income will be determined and used for eligibility purposes.

NOTE: Income received in a month for which retroactive eligibility is being determined will be considered for the retroactive month even if it is not considered for current or future months.

Once the household members' current income has been established and verified using the 10% reasonable compatibility standard as appropriate (See MS G-151-152), the monthly amount used to determine eligibility will be calculated. Depending on how the current income was established (e.g., tax return income via the Federal Data Services Hub, State Quarterly Wage Data, check stubs, SOLQ, etc.,), the "verified" income amount may have to be reduced or increased to reflect a monthly amount. For example, if the most recent tax return reflects the income still currently available to the individual, then the annual income from the tax return is divided by 12 to arrive at a monthly amount. If the current income was established through the most recent weekly check stubs, the average weekly amount is multiplied by 4.334 to arrive at a monthly amount. Unless the verified amount is already a monthly amount, for example Social

Security benefits, then some conversion to a monthly amount is required. The calculation will be documented in the individual's case file.

The chart below shows how income amounts larger or smaller than monthly amounts can be converted to a monthly amount.

Income Amount is	Convert to Monthly
Annual	Divide by 12
Quarterly	Divide by 3
Weekly	Multiply by 4.334
Bi-weekly	Multiply by 2.167
Semi-Monthly	Multiply by 2
Monthly	No conversion needed
More Often than Weekly	Total all Income Paid/Received in the Month

There may be situations in which an alternative method must be used to arrive at current monthly income. For example, if annual income included a lump sum payment that will not be paid again, then the lump sum payment will be excluded from the rest of the annual income before the conversion to monthly income is made. Self-employment income may also require an alternative method. See MS E-266 for a more detailed discussion on self-employment income.

Example Scenario: Bertha's and Audrey's current monthly income is determined as follows. Since Chloe's income is not considered in any of the three households, there is no need to determine her current income.

Bertha

Bertha works full time as the vice president of The High Rise Corporation. She reported that the annual income amount returned from the Federal Data Services Hub ($96,000) was reflective of her current salary and that she receives the same amount each month. Therefore, the annual income amount can be divided by 12 months to arrive at her current monthly income ($8000).

Audrey

Audrey just started working part time (10 hours per week) at the daycare center where Chloe attends. She earns $7.25 per hour. Her current monthly income is determined as follows: $7.25 x 10 = $72.50 $72.50 x 4.334 = $314.22 ($314.22 x 12 = $3,770.64 annual)

E-266 Self-Employment Income

MS Manual 01-01-14

The monthly amount of self-employment earnings is the best estimate of earned income which will be available to the individual in a month or months. The individual's recent tax data may be used to determine the monthly income. If the most recent tax data is not available or doesn't reflect current income, the individual's income will be determined by other means as determined appropriate by the caseworker, such as sales receipts, business records, etc.

Costs directly related to producing the income are subtracted from the self-employment annual gross before the monthly earnings are included in the budget. See Schedule C in Appendix Q for all allowable costs associated with self-employment income.

After allowable deductions from annual income, the remainder is then divided by 12 to determine the monthly income.

E-267 Comparing Income to Income Standard for Appropriate Household Size

MS Manual 01-01-14

After the Medicaid household composition, size and countable current income have been established, the Medicaid household's countable income will be compared to the household size income standard for the appropriate eligibility group to determine whether an individual is income eligible. Income eligibility will first be determined in the eligibility group the individual falls into with the lowest income standard, e.g., eligibility for a parent would first be determined in the Parent/Caretaker Relative group before a group with a higher income standard.

E-268 The 5% Gross Income Disregard

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E-268 The 5% Gross Income Disregard

Each individual will be allowed a general gross income disregard in the amount of 5% of the Federal Poverty Level for the household size.

The five percent (5%) disregard will be applied only to the Families and Individuals category that has the highest income level in which an individual could be eligible. For example, if an individual is not income eligible without application of the 5% disregard in the lowest income level group (e.g., Parent/Caretaker Relative), the five (5%) disregard will be applied to the higher income group (e.g., Health Care Independence group). However, if the individual is eligible in the higher income group without applying the five percent (5%) disregard, the disregard will not be applied.

When applied, the 5% disregard effectively raises the income limits for the applicable eligibility group by five (5) percentage points. For example, the income limit for the Health Care Independence Program is 133% (MS E-110). To apply the 5% disregard, add 5 to 133 to raise the income limit to 138% of FPL. The eligibility groups with dollar amounts for income limits are not the highest income limit groups for the individuals that fall into them. Therefore, the 5% disregard will never be applied to the dollar amount income limits.

Application of the 5% Disregard in the ARKids First groups

The 5% disregard is applied to the ARKids A income limit only if the child who would otherwise be ineligible without the disregard is covered by a health insurance plan. Since eligibility in ARKids B is not available to a child with health insurance, ARKids A is the eligibility group with the highest income limit available to an insured child and therefore, the 5% disregard can be allowed.

The 5% disregard is not applied to the ARKids A income limit if the child is uninsured and ineligible for ARKids A without application of the disregard. ARKids B is the eligibility group with the highest income limit for uninsured children and therefore, the 5% disregard is applied only if needed to achieve ARKids B eligibility.

E-269 Who Is Eligible-Example Scenario

MS Manual 01-01-14

Continuing the example of Bertha, Audrey and Chloe to show whose income will be counted and who is eligible for Medicaid.

Bertha and Audrey's household are the same which includes Bertha, Audrey & Chloe.

- Bertha earns $8,000.00 per month which equals $96,000 annually.

- Audrey earns $314.22 per month which equals $3,770.64 annually.
- Audrey is the child and tax dependent of Bertha. Audrey is not required to file taxes; therefore, her income doesn't count. Bertha's income is counted.
- Bertha's household size is 3.
- Compare the $8,000.00 monthly income to the 133% + 5% = 138% standard for a household size of 3, $2,245.95.
- Bertha and Audrey are not eligible for Medicaid; therefore, the agency will electronically transfer their account to the FFM for possible eligibility for Advanced Premium Tax Credits and cost sharing reductions.

Chloe's household includes Chloe and her mother, Audrey.

- Audrey earns $314.22 per month which equals $3,770.64 annually.
- Audrey's income will be counted because neither her mother, nor father is included in this household. Chloe's child support income is disregarded.
- Chloe's household size is 2.
- Compare the $314.22 monthly income to the ARKids A standard of 142% for 2, $1,835.35. Note: The 5% disregard was not needed for ARKids A eligibility and therefore was not applied.
- Chloe is eligible for ARKids A.

E-270 When Projected Annual Income is Used for Medicaid Eligibility

MS Manual 01-01-14

When the agency determines an individual is Medicaid ineligible based on current monthly income, the individual's information is electronically sent to the FFM. If the FFM determines the individual is Medicaid eligible because his or her projected annual income is less than 100% of the FPL, the FFM will transfer the individual's account information back to DHS. The agency will then enroll the individual in Medicaid for the remainder of the current calendar year based on the projected annual income.

Example: Jane Doe has recently obtained a higher paying job. Her household size is 2 and her new monthly income is $1,939.00. She submits a DCO-152 Application for healthcare coverage through DHS who determines she is ineligible for Medicaid based on her current monthly income. Her information is sent to the FFM where her eligibility for the ATPC is determined. ATPC eligibility is based on the individual's projected annual income. The FFM determines her projected annual income for the current calendar year to be $14,400. The FFM determines she is ineligible for the ATPC because her annual income for the current year is below the 100% FPL. Therefore, the FFM sends the information back to DHS as Medicaid eligible. The agency will enroll her in Medicaid for the remainder of the current calendar year based on her projected annual income as determined by the FFM.

E-280 Sponsor Affidavits of Support and Deeming

MS Manual 01/01/14

Alien sponsor deeming established by the PRWORA, as amended by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA), P. L. 104-208, and the Balanced Budget Act of 1997 (BBA), P. L. 105-33 will apply for the Medicaid categories that use the MAGI methodology.

Alien sponsor deeming will be applied to those aliens who are Lawfully Admitted Permanent Residents (LAPRs) that have been in the United States for five years..

Aliens who seek admission to the U.S. as LAPRs must establish that they will not become a public charge (Re. MS D-222). Many aliens enter the country by having a sponsor who pledges to support them to establish that they will not become a public charge.

A sponsor is a person who signs an Affidavit of Support agreeing to support an alien as a condition of the alien's admission for permanent residence in the U.S. An alien may have more than one sponsor. There are two versions of the Affidavit of Support:

- *Affidavit of Support*, form I-134 (Now unenforceable.)
- *Affidavit of Support*, form I-864 (Effective December 19, 1997.)

The process of counting the sponsor's income and resources for the sponsored alien is called deeming. Deeming will not apply when the sponsor is:

- An organization such as a church or service club,
- An employer who does not sign an Affidavit of Support, or
- The alien's eligible or ineligible spouse or parent whose income is otherwise considered in determining the alien's Medicaid eligibility.

A sponsored alien and the alien's spouse, if there is one, are responsible for providing information and documentation about the alien's sponsor and the sponsor's spouse. If the alien appears to be eligible for benefits but does not have the Affidavit of Support or does not know if there is a sponsor, instruct the alien to contact the Immigration and Naturalization Service (INS) to obtain a copy of the Affidavit of Support. If the applicant requires assistance, the caseworker may request information from the INS by submitting Forms G-845 and G-845 Supplement.

The INS will certify whether an alien has a sponsor and if so, what kind of affidavit the sponsor signed. Do not deem income or resources from a sponsor that has signed the old version, I-134, Affidavit of Support, or I-361, Affidavit of Financial Support and Intent to Petition for Legal Custody, as these affidavits are not considered enforceable.

Deeming instructions are shown below for individuals applying for Medicaid having an I-864, Affidavit of Support:

- Count all income of the sponsor and sponsor's spouse living in the same household as if they were income and resources of the alien.
- Do not allow deductions from the sponsor's income or resources.
- Count the sponsor's income as the alien's unearned income and use it to determine the alien's eligibility.
- Do not count the sponsor's income when determining eligibility for the alien's eligible children.
- Do not include the sponsor in the alien's household size.

Deeming continues until one of the following conditions is met:

- The sponsored immigrant accrues 40 quarters of work credit.
- The sponsored immigrant becomes a U.S. citizen.
- The sponsored immigrant leaves the U.S. permanently.
- The sponsored immigrant or the sponsor dies.

E-300 Financial Requirements for Spend Down U-18 and Pregnant Woman (PW)

MS Manual 01/01/14

Individuals or families whose income exceeds the income limit for ARKids B and Limited Pregnant Woman will be considered for Spend Down Medically Needy. These individuals may qualify if their excess income (i.e., that above the Medically Needy income limit) is obligated or spent for medical services.

If an individual who is pregnant has income above the Full Medicaid PW income limit, then Limited Medicaid PW eligibility will be determined prior to determining eligibility for Spend Down.

Note: MAGI methodology will not be used for the U-18 and Pregnant Woman spend down. Net income will be determined as outlined in MS E-330.

E-310 Income Determination for Spend Down

MS Manual 01/01/14

Income eligibility for U-18 and Pregnant Woman (PW) Spend Down cases is determined on a quarterly basis. Use actual quarterly income when available. When actual quarterly income is not available, project income for the quarter as follows:

1. Determine average income per pay period (divide actual total income by actual total pay periods). When available use 8 pay stubs if paid weekly, 4 pay stubs if paid bi-weekly or twice a month, or 2 pay stubs if paid monthly.
2. Determine projected income for the remaining month(s) or portion thereof- (multiply average income per pay period by projected number of remaining pay periods).
3. Determine monthly income (total actual and/or projected income for each month).

Net monthly income will be totaled to arrive at quarterly income. The amount of net quarterly income available to the individual/family is measured against the appropriate Medically Needy Income Level (MNIL) (Appendix N) to determine "excess income."

When eligibility cannot be determined for a full quarter, the determination will be made for the balance of the retroactive period (i.e., one or two months). Net income for the shortened period will be measured against the appropriate MNIL (Appendix N) to determine excess income.

U-18 income determination exceptions:

Income Computation - Income computation is as follows:

- The Lump Sum Payment treatment does not apply - a lump sum payment received in the determination period (i.e. in the quarter for SD cases), will be considered as income in the period and, to the extent retained, a resource in the following period.
- The income of an alien sponsor is disregarded (Re. MS E-280 and MS E-440).
- The net earned income (gross earnings minus earned income deduction ($90) and child care) plus unearned income (minus the first $50 of child support paid) is compared to the Medically Needy Income Level to determine income eligibility.

E-320 Eligibility Based on Incurred Medical Expenses (Spend Down)

MS Manual 01/01/14

The eligibility determination based on incurred medical expenses is a two-step process:

1. Incurred medical expenses (i.e., those which were incurred at the time of application) which cannot be covered by Medicaid are deducted from excess income first. When these expenses obligate all excess income, the individual is eligible beginning the first day of the Spend Down quarter being considered. When these expenses do not obligate all excess income, proceed to item #2. A list of these noncovered expenses is specified in MS E-330.
2. When excess income remains following deduction of incurred non-covered expenses, a chronological listing (by date of service) of coverable medical expenses must be prepared to determine Spend Down eligibility. Daily totals of these expenses will be deducted from remaining excess income. When remaining excess income is exceeded by a daily total, the Spend Down date (i.e., beginning date of eligibility) is established. The last excess income that was exceeded by the daily total on the Spend Down date is the applicant's "unmet liability". When excess income remains after deducting all coverable medical expenses, the application will be denied.

NOTE: When the applicant has incurred medical expenses which have been paid or will be paid within a reasonable period of time by a third party resource (i.e., insurance, etc.), refer to Appendix N.

E-330 Incurred Medical Expenses Not Coverable Under Medically Needy Program

MS Manual 01/01/14

Incurred medical expenses which are not coverable under the Medically Needy Program will be deducted in the following order. These expenses may include the expenses of an ineligible individual whose needs cannot be included in the MNIL, but whose expenses are the liability of the eligible individual (e.g. the expenses of a deceased spouse).

1. The cost of Health Insurance premiums, including the Part B Medicare premium, for the Spend Down period for all individuals whose needs are included in the MNIL.
2. The cost of any required copayments and/or deductibles for the Spend Down period for all ineligible individuals whose needs are included in the MNIL. Only the cost of required copayments or deductibles on Medicare Part B (non-assigned) claims for the Spend Down period can be deducted for the eligible individual(s) (See Note B).
3. The cost of remaining incurred medical expenses for the Spend Down period for all ineligible individuals whose needs are included in the MNIL. This includes the expenses of an ineligible spouse and the expenses of the ineligible parent(s). See Note B.
4. The cost of any uncovered incurred medical expenses for the Spend Down period for the eligible individual(s).
5. The cost of any medical expenses which were incurred during the month of application and the three (3) preceding retro months for all individuals whose needs are included in the MNIL.

   Expenses incurred during the month of application and the three (3) preceding retro months must be deducted from excess income unless they have been paid by or are subject to payment by a legally liable third party, such as a health insurance plan. If the expenses have already been paid by the individual, family or legally responsible relative, the deduction will be allowed. This is true regardless of whether the expenses were incurred during the spend down period. Expenses incurred before the spend down period, but within the retro period, paid or unpaid, will be deducted as noncovered expenses. Any expenses incurred before the retro period, that have been paid cannot be deducted.

6. The cost of any unpaid medical expenses which were incurred outside the Spend Down period for all individuals whose needs are included in the MNIL.

Proof of current liability (at the beginning of the Spend Down period) must be provided by the applicant for expenses incurred outside the period or the expenses cannot be used in Spend Down. When the applicant has made arrangements to repay any medical expenses, only the payments due in the Spend Down period can be deducted as noncovered, unless the bill was incurred during the Spend Down period. In that case, the bill may be used in the chronological Spend Down, rather than using the monthly payment amount to be made under the contract. Expenses sold or turned over to collection agencies may be deducted if they are verified to be from a medical source.

When there is no formal agreement to pay noncoverable medical expenses, but regular payments are being made, only those payments made during the Spend Down quarter may be deducted as noncoverable. If payments are being made irregularly or only occasionally, then the entire expense may be deducted as noncoverable.

NOTE A: Incurred medical expenses used to achieve eligibility cannot be used in future Spend Down determinations, with the following exception. When only a portion of an incurred medical expense is used to achieve eligibility, the unused balance is available for use in the future Spend Down determinations if the applicant can prove continued liability.

NOTE B: In households with multiple cases, the medical expenses of an individual may be used in the Spend Down of each case in which he/she is included in the budget, whether the individual is eligible or not in the case. In households where a parent and child are eligibles in separate cases, the medical expenses of the parent and child will be considered as covered expenses in each other's Spend Down determination. If an application is made for the child only and the parent does not qualify for Medicaid, the parent's expenses will be considered as noncovered in the child's Spend Down determination.

E-340 Incurred Medical Expenses Included in Chronological Spend Down

MS Manual 01/01/14

When excess income is not eliminated after deduction of noncovered incurred expenses, it will be necessary to conduct a daily Spend Down (i.e., eliminate remaining excess income through chronological deduction of incurred expenses coverable in the Spend Down quarter). These expenses would be comprised of all services incurred during the Spend Down quarter for individuals potentially eligible for Medically Needy services and apparently coverable under the program (includes the cost of Medicare copayments and/or deductibles) on assigned claims and the cost of any prescribed drug(s) covered by the Medicaid program (name brand drugs must be certified by the physician as medically necessary if lower cost generic equivalent drugs are available).

For maternity expenses, any payments will be deducted on the date of such payments and the balance will be deducted on the date of delivery (if applicable).

NOTE A: Incurred medical expenses used to achieve eligibility cannot be used in future spend down Determinations, except as noted in MS E-330 #5.

NOTE B: Medical expenses paid by a credit card or loan within the spend down period and the client is still liable for the loan may be used in the chronological spend down to reduce excess income. Medical expenses incurred before the spend down period that were paid by a credit card or loan can be used as a non-coverable expense.

E-400 Determining Financial Eligibility for AABD Groups

MS Manual 01/01/14

The methodology in the following sections will be used to determine financial eligibility for Medicare Savings Program (MSP), TEFRA, Autism, PACE and the Long Term Services and Supports Groups. It will also be used to calculate the contribution to care for nursing and assisted living facilities.

E-405 Income

MS Manual 01/01/14

Income is defined as the receipt of assets by an individual in cash or in-kind (Re. MS E-432 #7) during the month. To be considered as income, the assets received must be something of value received by the individual for his own use and benefit in providing the basic requirements of food, clothing, and shelter. Lump sum or one time payments are considered as income for the month of their receipt.

Income may be received in cash (including checks, money orders, etc.) or in-kind (including items such as rent, free food, etc.). The cash value of items received in-kind must be determined. The value of infrequently and irregularly received items such as small gifts of clothing will not be considered as income.

E-410 Income Evaluation

MS Manual 01/01/14

Determination of income eligibility will be based on an applicant/recipient's monthly income. The recipient's gross monthly income will be compared to the monthly income eligibility standard to make this determination. Exclude VA Aid and Attendance and CME/UME in this computation.

Income which is received on a basis other than monthly (annually, semiannually, etc.) will be considered as income for the month of receipt only. (Do not count dividends received from insurance policies as income in eligibility determinations). Amounts carried over into the following month will be considered as resources. Non-monthly income receipts will be treated as follows:

1. Regularly Received Non-monthly Income - When income that will affect eligibility is regularly received by the individual in an established amount and at a set time, the caseworker will begin processing case adjustment in the month prior to the receipt of

the income. The caseworker will notify (via the DCO-700) the recipient or person acting on his behalf of case adjustment at least ten days prior to the month in which the income is to be received. If the increased income will result in only one month of ineligibility, the case may be reinstated effective the first day of the month following the month of ineligibility without taking a new application. Advance notice to the client will state that the case is being suspended for a month and that it will be reinstated the following month without action from the client, provided the client is still resource eligible. To adjust the case for a month of ineligibility, refer to the ANSWER Desk Guide found on SHARE.

If the anticipated income is in an amount great enough that is likely to result in two or more months of ineligibility, the client will be informed in the advance notice that the case will be closed and that a new application will be required to reopen the case.

Anticipated income changes that will not result in case closure may be entered on the WNHU interface no earlier than the month prior to the month of receipt of the income. The vendor payment adjustment will then be made by the caseworker. The recipient or representative should be notified of the increased vendor payment responsibility by DCO-700 at least ten days prior to input of the change.

2. Irregularly Received Non-Monthly Income - When the recipient receives income on an unpredictable basis and in unpredictable amounts, income adjustments and ineligibility resulting from its inclusion in the budget will not be processed until after its receipt. The ten day advance notice of intended action will be given before effecting any case closures or income adjustments. All income adjustments or closures will be made effective the first day of the month in which the income is received. The recipient or person acting on his/her behalf must be fully advised by DCO-700 of the amount of his/her vendor payment responsibility in these cases. Every effort should be made to anticipate non-monthly income receipts so that advance action can be taken.

   As with regularly received non-monthly income, if benefits will be terminated for only one month for receipt of irregular non-monthly income, a new application will not be required and the customer will be so advised. Closures of two or more months will require a new application.

3. SSI/SSA Lump Sum Benefits - SSI lump sum payments will not be counted as income in the month of receipt and will be given a resource exclusion according to the schedule at MS E-523 #6. SSA lump sum payments will be counted as income in the month of receipt, but will be given the appropriate resource exclusion. Interest earned on these excluded funds will be counted as income in the month accrued and as a resource, if retained, in the month(s) following.

When SSA lump sum benefits result in income ineligibility, the case will be suspended in the month of receipt of the lump sum. A new application will not be required to reopen the case in the following month. (Re. MS H-323 for procedures).

4. Interest and Dividend Income - Interest and dividends on checking and savings accounts, certificates of deposit, etc. represent a return on an investment or a loan of money, and are considered unearned income when credited to an account. Interest and dividends are considered credited to an account when a financial institution normally reports the income to the customer. The frequency with which interest is computed is immaterial in determining when the income is received (e.g., a bank may compute interest daily, but credit an account only monthly or quarterly).

Interest and dividends will be considered in both eligibility and net income determinations. An individual will not be allowed to retain interest and dividends for personal needs in addition to the monthly personal needs allowance.

In determining initial eligibility and at subsequent reevaluations, the latest interest/dividend statement (two if paid quarterly, at least three if paid monthly) will be used to determine the countable monthly amount. If small interest/dividend amounts paid monthly or quarterly fluctuate slightly, counties may average and use the average amount until the next scheduled reevaluation, unless an adjustment is necessary sooner due to a reported change. Interest/dividends credited or paid annually will be counted as income in the month of credit or receipt.

The caseworker will provide the customer (or authorized representative) with an explanation regarding the consideration of interest/dividend income in the eligibility and net income determinations. Since the monthly interest/dividend amount will be combined with other income before the $40 monthly allowance for personal needs is considered, the recipient will not receive the full $40 monthly allowance unless he/she withdraws the interest/dividends as paid.

NOTE: Interest income of State Human Development Centers and Benton Services Center customers will be used in determining initial eligibility, but will not be considered in determining net income. All recipient interest income will be reported by these facilities in their semi-annual cost reports, and the full amount will be deducted by Central Office at the time of retrospective cost settlement.

Interest income of customers in 10 bed ICF/MR facilities is counted in BOTH initial and post-eligibility determinations, as semi-annual cost reporting is not done for these facilities.

Gross earned income is counted in determining initial eligibility for ICF/MR residents including residents of State Human Development Centers. In post eligibility determinations earnings less mandated deductions up to an amount equal to the current SSI SPA are disregarded.

E-415 Determination and Verification of Earnings from Employment

MS Manual 01/01/14

The monthly gross amount of any earnings from employment will be determined. Monthly gross income is determined by the actual earnings received (or to be received) during the month of application or reevaluation, whether paid weekly, biweekly, semimonthly, or monthly. In cases where 5 pay periods during the month of application result in ineligibility, the application will not be denied (if otherwise eligible) but will be considered for eligibility in the following month when there will be only 4 pay periods. In ongoing cases where earnings are biweekly, the cases will be flagged to make income adjustments on WNHU during the months when 5 paychecks are to be received.

If the earnings fluctuate, the caseworker will determine, by averaging or other means, an amount which fairly reflects the income actually currently available to the applicant on a monthly basis. The case narrative will clearly reflect the manner in which the income was determined and the justification for considering it a fair reflection of the actual, current income available to the applicant.

Verification of earnings from employment will be by check stubs, pay slips, or collateral contact with the employer. Sufficient verification must be obtained so that the actual income of the employee can be determined. The caseworker will not automatically assume that one check stub accurately reflects earnings for an entire month. The latest month's verification will be required. If a person is paid weekly, then the latest 4 (or 5) consecutive check stubs will be required. If the person is paid every other week or twice a month, then the latest two check stubs will be required, and if paid monthly, then the latest check stub will be required. If the customer does not have the required verification, then verification from the employer will be required.

EXCEPTION: For cases in which the applicant/recipient has just begun employment and a month's verification is not available, the caseworker will compute the income from the best information available. In this instance the case will be flagged for a redetermination of earnings in the following month using full verification procedures.

E-420 Determination and Verification of Earnings from Farm, Business or Self-Employment

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Generally, it is necessary for the self-employed individual to estimate current income based on a projection from the tax return filed for the previous year and from current records kept in the regular course of business.

Because of the fluctuating nature of income receipts and self-employment expenses, current estimates for net income from self-employment will be based on the entire taxable year.

E-421 Determining Amount of Net Earnings from Self-Employment

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The amount of net earnings from self-employment is not always ascertainable from business records. If this is the case, use the first of the following methods that is likely to give the most accurate estimate of current and future net earnings which may be allocated on a monthly basis.

1. When the individual has been carrying on the same trade or business for some time, net earnings from self-employment have been fairly constant from year-to-year, and he/she anticipates no change or gives no satisfactory explanation of why the net earnings for current and future months would be substantially different from what it has been in the past, the estimate of earnings for the current taxable year should be the same as the net profit last year. Monthly income should be determined as one-twelfth of the net profit as shown on the tax return for the preceding year.
2. When the individual is engaged in the same business that he/she had the preceding taxable year and anticipates no change or can give no reason why the net earnings for current and future months would be substantially different from what it has been in the past, determine the ratio between his net profit and gross receipts for the last year (e.g. net profit of $1,200 for $6,000 gross income, or 20%). Determine from his/her records the actual gross receipts for the current taxable year and project for the remainder of the year (e.g. $4,000 in current year's receipts for the first 6 months gives an assumed gross of $8,000 for the entire year). Apply the previously determined gross-net ratio (e.g. 20% of $8,000 is $1,600) and the resulting estimated net profit would be allocated equally into each month of the taxable year. This method would not be suitable for a business which is seasonal or has income peaks at certain times of the year.

3. Have the self-employed individual supply a profit and loss statement or other business records for the taxable year to date so that a net profit can be projected for the year and allocated monthly.
4. Use the individual's best estimate based on his/her business records.
5. Consideration may be given to the individual's explanation as to why he/she believes his/her estimated net earnings for the current year will be substantially different from the information on tax returns for past years or business records for past periods. Some examples of satisfactory explanations include business loss or damage due to fire, flood, burglary, serious illness or disability of the owner, or other such catastrophic event which can be documented. Obtain documentation for the records (newspaper accounts, police reports, medical reports, etc.). With documentation, a lower estimate may be accepted.

After the estimated net income from self-employment has been determined, explain to the individual how it has been determined and the effect it has on eligibility. Advise the individual that he/she may appeal if he/she disputes the estimates, or that he/she may request a change or reapply if new evidence becomes available.

If the allocated amounts of income result in ineligibility, explain to the individual that he/she may reapply if the remaining current year receipts or expenses or a new accounting of net earnings from self-employment result in lower net earnings.

If the individual is eligible for assistance, advise him/her that any substantial variation of net earnings should be reported promptly with appropriate evidence, so that overpayments and underpayments can be prevented. Explain also that he/she must provide a copy of the federal tax return as it becomes available.

When one of the methods under items 3, 4 or 5 has been used to determine net earnings, advise the individual that he/she should maintain monthly records of ongoing receipts and expenditures until the federal tax return is available so that substantial variations of income can be identified and reported immediately to avoid erroneous eligibility.

E-425 Unstated Income

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Unstated income is income not reported or otherwise accounted for, but known to exist because living expenses exceed the income that has been reported.

An applicant, recipient or person whose income is subject to deeming may have unstated income.

The amount of unstated income to be considered as unearned income in determining eligibility is the difference between the declared monthly income and the monthly living expenses.

E-426 When to Develop Unstated Income

MS Manual 01/01/14

When an individual's stated income does not appear adequate to cover living expenses, it will be necessary to develop unstated income, unless there is a reasonable explanation to account for the difference; e.g., savings have been used or bills have not been paid.

If the previous year's income tax return of an individual engaging in self-employment activity shows "0" or only a small amount of net income, living expenses and unstated income must be explored.

E-427 Development of Living Expenses

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When development of living expenses is required due to unstated income, explain to the individual what information will be needed to develop living expenses and why it is needed. Consider the living expenses of each and every member of the self-employed individual's household, and explain that all expenses must be considered. It is essential that a complete disclosure be obtained.

The following guide should be used in developing living expenses:

1. Prepare on a separate narrative sheet(s) a topical breakdown of pertinent monthly living expenses such as:
    a. <u>Shelter or Living Quarters Cost</u> (rents, taxes, mortgage payments, heating expenses, utility expenses, water expenses, sewer expenses, garbage collection expenses, etc.).
    b. Clothing and Upkeep.
    c. <u>Medical Expense Not Reimbursed by Insurance</u> (doctor bills, dentist bills, drugs, health insurance premiums, etc.).
    d. <u>Transportation</u> (car loan payments, insurance premiums, gasoline, tires, oil, mass transportation fares, etc.).

e. Food, Meals and Household Supplies (groceries, cleaning supplies, restaurant meals, etc.).
f. Credit Purchases and Loans (furniture bill payments, finance company payments, etc.).
g. Other (life insurance premiums, legal services, traffic fines, cigarettes, alcoholic beverages, etc.).

2. The reported living expenses will be considered as expenses in the actual time periods in which the expenses were paid by members of the household. Take into account the tendency to overlook expenses. Avoid averaging expenses between different months unless the monthly living expense total would be distorted if they were not averaged. If averaging is used, give an explanation of the reason on the narrative sheet.

3. Add the following statement to the narrative sheet(s) of living expenses: "I agree that this is a fair statement of monthly household living expenses".

4. Obtain the signature of the self-employed individual. If the self-employed individual does not provide the information, obtain the signature of the individual who does, and explain why the self-employed individual cannot or will not sign the statement.

E-428 Determination of Unstated Income

MS Manual 01/01/14

Determination of Unstated Income:

1. Reported Income - Reported income may include net earnings from self-employment and income from other sources, including cash or in-kind income. The amount of reported income for a month is determined by adding to the allocated monthly portion of net income from self-employment, the amount of other monthly income for the self-employed individual and any other individual who is an applicant or whose income is being deemed to the applicant, or who is an ineligible child taken into account because of deeming of income.
   Reported income is the aggregate of unearned and earned income of the following people living together as one household.
   a. Applicant(s)
   b. Individual(s) whose income is deemed to the applicant; and
   c. Ineligible children, if any, who would be taken into account in computing the amount of deemed income where there is a deeming situation.
2. Computation of Unstated Income:

a. Applicant is self-employed - When an applicant or both applicants in a household (in the case of a couple) are self-employed, the computation of unstated unearned income, if any, requires that the amount of reported monthly income be subtracted from the amount of monthly living expenses, and the result, if greater than zero, be added to the amount of total unearned income of the applicant(s). Such income would be treated as other unearned income in the application.

EXAMPLE: The applicant reports earned income consisting of $100 per month net earnings from self-employment. The spouse, also an applicant, reports a pension of $100 per month. Living expenses are developed and total $400 per month. The total family income of $200 is subtracted from the $400 monthly living expenses, leaving $200 that will be counted as unstated unearned income for the couple to be divided as $100.00 for each member of the couple.

b. Individual whose income is deemed is self-employed - When the self-employed individual(s) in a household with an applicant is an ineligible spouse or parent, the computation of unstated unearned income (reported income subtracted from living expenses) increases the amount of unearned income of the self-employed individual. The effect of the unstated unearned income on the applicant depends on the deeming computation. Refer to MS A-214 for SSI Retroactive Medicaid determinations.

3. Providing an Opportunity to Explain - When unstated unearned income is determined, discuss the matter with the individual and provide the individual with an opportunity to explain how living expenses are met. If the stated living expenses include obligations which do not represent actual expenditures (because bills are not being paid), adjust the amount of living expenses after obtaining a second (adjusted) statement of living expenses. If there are loans which account for the money used to pay living expenses, obtain a statement of specifics of the loan(s) and verify the loan transaction(s). Verified proceeds from loans received and used for living expenses can be subtracted from the amount of unstated unearned income left after subtracting reported income from living expenses. The use of resources may also be used to explain how living expenses are met.

4. Notice of Determination - When unstated unearned income is counted, explain on the notice of decision (DCO-700) that an inclusion of unstated income was made based on a comparison of living expenses with reported income because of excess living expenses.

E-430 Sources of Unearned Income

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The following are possible sources of unearned income:

1. Pensions, annuities, insurance benefits, Social Security, Railroad Retirement, and Veterans Benefits (exclude V.A. Aide and Attendance and CME/UME payments. Re. MS E-451), Civil Service, military allotments, Teachers' Retirement, State Retirement, Workmen's Compensation, Miners' Pension, and Black Lung benefits.
2. Payments received for the rental of rooms, apartments, dwelling units, buildings, or land. If paid regularly, taxes, insurance, interest on loans, and the expense of upkeep may be deducted.

NOTE: In Waiver and TEFRA cases, the deductions are not given for eligibility determinations. In nursing facility and ICF/MR cases, the deductions are not given in the initial OR post eligibility determinations, and neither for home nor for non-home rental properties.

3. Interest, dividends, and income from capital investments, insurance policies, etc.
4. Royalty income from oil, gas or other mineral leases.
5. Regular payments from estates, trust funds (Re. MS E-522 #13), or other personal property which cannot be converted into cash because of legal provisions.
6. Child support payments.
7. Regular contributions from organizations, churches, friends, relatives, or social agencies.
8. Income or support and maintenance received in-kind.

E-431 Determination and Verification of Unearned Income

MS Manual 01/01/14

The monthly amount of unearned income must be determined, verified, and included in the budget. Verification will normally be by documentary evidence obtained from the source of the income. Another means of verification may be used if it clearly establishes the source and amount of the income.

In addition, if the applicant or recipient is potentially eligible for any benefit, he/she will be required to apply for it and to accept the benefit if found eligible. Verification of his/her application for such benefits will be included in the case record. Once the applicant has applied for the benefit, his/her application or reevaluation may be completed, if otherwise eligible. If the applicant refuses to apply within 30 days of his application for any benefit for which he may be eligible, the application will be denied (or case closed).

E-432 Types of Unearned Income

MS Manual 01/01/14

1. Social Security Benefits

Social Security benefits are paid upon retirement, disability, or death of a covered wage earner. Retirement benefits are payable at age 62.

Social Security disability benefits are payable at any age. A wife or widow is eligible at age 60, disabled widows at age 50. A wife or widow is eligible at any age if there are minor children of the wage earner living in their home. Children are covered until age 18, or until age 19, if attending school and an individual may receive a child benefit at any age if incapacitated prior to age 21. All unmarried children of a wage earner are covered, even though the wage earner and the mother of the children were later separated or divorced. Illegitimate children may be covered if the wage earner can be established as the parent.

Social Security benefits will be verified by SOLQ, SSA-1610, or by award letters. .

2. Voluntary Reduction of SSA Benefits

The withholding from Title II benefits by SSA for the recovery of SSI overpayments is voluntary on the part of the overpaid SSI recipient. The money withheld from this cross-program adjustment will be considered as available income for the institutionalized individual's contribution toward his cost of care.

Individuals who have agreed to the Title II reduction will not have sufficient income to pay their share of the cost of institutional care. Since the individual remains liable for the cost of institutional care, the county office will inform the individual of the possible adverse consequences of choosing cross-program adjustments while residing in a Title XIX nursing home, and of his right to revoke the agreement.

NOTE: The withholding from Title II benefits by SSA for the recovery of SSA overpayments is not voluntary on the part of the overpaid SSA recipient. The money withheld from this adjustment will not be considered as available income for the institutionalized individual's contribution toward his cost of care.

3. Railroad Retirement Benefits

Railroad Retirement Benefits are paid to individuals and spouses covered under the Railroad Retirement Act. An individual may receive both Railroad Retirement and Social Security, if covered under both programs, and the wife of a Railroad Retirement beneficiary may receive a wife's benefit while drawing Social Security.

Information on Railroad Retirement Benefits may be secured from:

U.S. Railroad Retirement Board
Three Financial Center
900 S. Shackleford, Suite 513
Little Rock, AR 72211

4. Military Allowances or Allotments

If the applicant has a son, daughter, or spouse in the Armed Services, the Service Representative will explore the possibility of obtaining an allotment.

The address of the Army Finance Center is:

Army Finance Support Agency
Indianapolis, Indiana 46492

The address of the Navy Finance Center is:

Navy Finance Center
Federal Office Building
Cleveland, Ohio 44199

The address of the Air Force Finance Center is:

Air Force Finance Center
3800 York Street
Denver, Colorado 80205

5. Veterans Benefits

If the applicant is a veteran, or the wife, widow, child, or other dependent of a veteran, full exploration will be made of potential eligibility for Veterans Benefits. Only the portion of the VA Benefit attributable to the veteran/surviving spouse will be counted as his/her income. The dependent's portion of the VA Benefit will be counted as income to the dependent(s). It will be necessary to determine the portion of the VA Benefit that is attributable to the applicant/recipient. Veterans, widows and other surviving dependents eligible for higher benefit payments under the Veteran's Pension Improvement Act must agree to apply for and accept those benefits. Information on Veterans' Benefits should be requested on Form DCO-52 from:

VA Regional Office
Building 65, Fort Roots
North Little Rock, Arkansas 72205

The caseworker will not attempt to represent veterans or dependents in filing claims. Such persons should be referred to Service Officers of the local American Legion Post, County Offices, Veterans Administration Contact Offices, or:

Veterans' Service Office
American Legion Arkansas Department
1415 West 7th St.
Little Rock, Arkansas 72201

6. Civil Service Benefits

Civil Service Benefits are paid to individuals and to surviving spouses of individuals who retired from civilian government jobs (e.g., Internal Revenue Service, Postal Service, etc.). These benefits include regular retirement and disability retirement.

Information on Civil Service Benefits may be secured from:

U.S. Office of Personnel Management
Retirement Operations Center
Boyers, PA 16017

7. In-Kind Support and Maintenance and Other In-Kind Income

There are two types of unearned in-kind income: in-kind support and maintenance, and other in-kind income.

<u>In-Kind Support and Maintenance</u>
When an individual receives an item of food, clothing, or shelter outright, or when someone else pays for (or makes a payment on) food, clothing, or shelter for the individual, the individual receives in-kind support and maintenance (ISM). Generally, ISM is counted when the individual has use of the food, clothing, or shelter item. Mortgage payments made by a third party on the home where the individual resides will be considered ISM; or an individual living rent free (or making only token payments) in the home of another is considered to be receiving ISM.

Other In-Kind Income

When an individual receives something outright (other than food, clothing, or shelter) which can be sold or converted to cash, the individual receives other in-kind income. Other in-kind income is counted when received. The use of a car is not considered other in-kind income, as it cannot be sold or converted to cash. However, if the individual is given a car outright, it is considered other in-kind income in the month received, unless the car (or other item) would be a partially or totally excluded non-liquid resource if retained into the month following the month of receipt.

a. Someone else's payments to a vendor on behalf of the individual (other than ISM), even if it increases equity value, is not considered unearned in-kind income. However, the equity value is considered in the determination of total resources. For example, car payments for an individual are not other in-kind income, even though the equity value increases; but the equity value may be counted as a resource. Premium payments made for an individual on health insurance, life insurance, credit life, or credit disability insurance are not counted as other in-kind income (There is no equity value increase in these examples). However, the cash surrender value of a life insurance policy may be counted as a resource (Re. MS E-523 #2).

Cash payments which are made directly to an individual are counted in full as unearned income. This would be true even if the cash payment is given to the individual for the purpose of his meeting a basic need.

NOTE: In-kind support and in-kind income are not considered in Nursing Facility, AAPD, ElderChoices, Assisted Living Facility, PACE, DDS, Autism or TEFRA determinations. In-kind support and maintenance are considered in ARSeniors, QMB, SMB and QI-1 determinations.

Valuation of In-kind Income and In-kind Support and Maintenance

The value of other in-kind income is determined by its current market value. The value of in-kind support and maintenance is determined by presumed value. The presumed value of in-kind support and maintenance is based on one third of SSI standard payment amount plus $20.00.

Please refer to Appendix S for presumed values of in-kind support and maintenance.

Individuals receiving in-kind support and maintenance always have the right to rebut the presumed value and must be advised of this right.

To rebut the presumed value:

a. The actual cash value of the in-kind support and/or maintenance must be established. For example, if the individual is receiving free room and board, living in the household of another, determine the actual cost necessary to maintain the household. Include mortgage payments, utilities, real estate taxes, insurance, and food for all members. Expenses should be verified by receipts. Determine the individual's pro rata share by dividing the actual monthly cost by the number of individuals living in the household. This will be the actual cost figure. If the individual purchases his own food, do not include this cost in determining the monthly household expenses.
   If the individual lives rent-free in the home of another or makes only token payments for rent compared to the value received, establish the rental value of the home. This can be established by securing a statement from the owner or through obtaining a verbal estimate from a rental agency. The payment made by the individual in return for in-kind support and maintenance is deducted as stated under step 2.

   If a third party makes payments on behalf of the individual for basic needs items such as rent, consider the actual amount paid as the cash value.
b. Any cash contributed by the individual(s) in return for in-kind support and/or maintenance received is subtracted directly from the established cash value (never the presumed value).
c. If the net amount derived is lower than the presumed value, the presumption is rebutted, and the net figure would be considered as unearned income.
d. If the actual net cash value of in-kind support and maintenance exceeds the presumed value, the presumed value is counted as unearned income.

8. Third Party Payments Excluded as In-Kind Support and Maintenance

Third-party payments that are excluded as in-kind support and maintenance:

a. In-Kind payments made in lieu of cash wages are not considered as in-kind support and maintenance except when paid to agricultural or domestic employees.
   In-kind payments made in lieu of cash wages to other types of employees are considered to be earned income instead of in-kind support and maintenance.

   The value of support and maintenance provided in a nonmedical nonprofit retirement home or similar facility which does not receive full payment from the individual or which receives subsidy payments from a nonprofit organization is not considered as in-kind income of the individual.

b. The value of support and maintenance in such facilities is considered as in-kind support and maintenance for individuals who have acquired rights to life care in the facility by turning over all of their assets to the home or through membership in a fraternal group or union.
   The value of support and maintenance provided in public or private non-profit institutions for educational or vocational training is considered as income of the individual.
c. Support and maintenance provided during a medical confinement and paid to a medical provider by a third party is excluded from income for eligibility determinations. This could be in a hospital or facility.
   Third party payments made directly to a facility as payment for items covered by the facility vendor payment will be considered as income in the computation of the patient's share of the vendor payment. If third party payments are made to cover special charges or additional services and items not covered by the LTC program, they will not be considered as income.
d. The value of support and maintenance provided by a private for profit nonmedical retirement home or similar facility which does not receive third party payments on behalf of an individual is not considered as income of the individual.
   The value of support and maintenance in such facilities is considered if third party payments are being made on behalf of the individual.
e. Occasional in-kind items of little value (not exceeding $20.00 in a month) are excluded when they are received irregularly or infrequently.

E-433 Determining Financial Eligibility for the SSI/COLA Groups

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In determining income eligibility, the SSI related income criteria in the MS E-400-452 section will be used to determine eligibility for the following groups:

PICKLE

All SSA COLA increases received since loss of SSI benefits will be disregarded, including the initial SSA COLA increase which resulted in loss of SSI. (Other types of SSA benefit increases and other changes in income and resources will not be disregarded.) The $20 general exclusion and other SSI exclusions (Re. MS E-450) will also be deducted from current income.

If an ineligible spouse or other family member (e.g. parent of a child with a disability) has income that must be deemed to the applicant, their COLA increases since the applicant lost SSI will also be disregarded. For deeming procedures, refer to MS E-440-447 section.

After all COLA disregards and SSI exclusions have been deducted from current income, the net countable income will be compared to the current SSI SPA. If the individual's income is under the SPA, he/she is eligible for continuing Medicaid benefits.

If the individual has an ineligible spouse, countable income will be determined according to MS E-440-447, allowing COLA disregards, and the net income compared to the couple's SPA.

If eligibility is to be determined for both members of a married couple, total their current income, subtract their combined COLA disregards, a $20 exclusion per couple and other applicable SSI exclusions to arrive at their countable income. This income will be compared to the couple's SSI SPA to determine Medicaid eligibility.

Widows and Widowers with Disabilities (COBRA 1985)

The individual's total amount of SSA income will be entered in the eligibility system on the individual's income tab along with an adjustment for any disregarded amount. Include the total of the 1984 Reduction Factor increase and all COLA's received since January 1984. The $20 general exclusion and any other applicable SSI exclusions will automatically be deducted in the budget summary. Only those individuals with net income under the SSI SPA will be eligible. If there is an ineligible spouse, deem according to MS E-440-447, and compare the resulting income to the couple's SSI SPA.

Widows and Widowers with a Disability (OBRA 1987)

Income eligibility determination will be made by disregarding ALL current SSA income, regardless of type of benefit, when the benefit began, or amount of benefit. Any other income (RR Retirement, VA, private pension, etc.) will be considered in the budget. After the $20 and other applicable SSI Exclusions (Re. MS E-450) are deducted from income, the resulting net income will be compared to the current SSI/SPA (Re. Appendix S). If the income is under the current SSI/SPA, the individual will be eligible for Medicaid.

Medicaid for Widows, Widowers with a Disability and Surviving Divorced Spouses with a Disability (OBRA 1990)

In determining income eligibility, all SSA income currently received by the widow/widower with a disability or surviving divorced spouse with a disability will be disregarded. All other types of countable income will be counted in the budget, as required by the MS E-400 section. The SSI exclusions will be allowed. After all exclusions and disregards from gross income have been made, the net income will be compared to the current SSI/SPA level (Re. Appendix S). If net income is at or below the individual SSI/SPA, the individual will be eligible.

It is possible that some of the individuals referred by SSA will have remarried and will have a spouse in the home. In that case, the spouse will be considered an ineligible spouse, and the deeming of income rules at MS E-440-447 will apply in determining eligibility. The resulting net income will be compared to the couple's SSI/SPA for eligibility. Resources will be compared to the couple's resource limit.

In the event SSA refers both members of a married couple for eligibility determination, the SSA income of both individuals will be disregarded, along with the SSI exclusions, before comparing their net income to the SSI/SPA for a couple in the eligibility determination. The couple's resource limit will apply.

Disabled Adult Child (DAC)

Income eligibility will be computed in the eligibility system. The income to be included in the budget will be the current income, less the DAC entitlement or increase that resulted in loss of SSI. Any income other than the DAC entitlement or increase will be counted. Examples: (1) If applicant previously had $446 SSI and was awarded $466 DAC, count "00" income; (2) if applicant had $400 DAC, $66 SSI and was awarded $66 DAC increase, count $400 DAC; (3) if applicant had $300 DAC, $100 VA, $66 SSI and was awarded $66 DAC increase, count $300 DAC and $100 VA. The $20 general exclusion and other SSI exclusions will also be deducted from current income. Net countable income will be compared to the current SSI SPA limits for eligibility.

E-434 Temporary Disregard of Cost of Living Adjustment (COLA) for Medicare Savings Program

MS Manual 01/01/14

The January SSA Cost of Living Adjustment will be disregarded in determining initial eligibility for Medicare Savings applicants for the period of January 1st through March 31st of each year. Eligibility must then be redetermined for April 1st and beyond, using the new Medicare Savings income limits and the increased SSA amount which includes the January SSA COLA amounts.

E-440 Deeming Procedures

MS Manual 01/01/14

For the Medicare Savings Program categories, when the eligible applicant resides with his or her ineligible spouse or ineligible parents, deeming of income from the ineligible spouse or parent(s) is required.

For the Nursing Facility, AAPD, ElderChoices, Assisted Living Facility, PACE , TEFRA, Autism and DDS categories, deeming is not required.

Note: For deeming procedures for an alien sponsor, refer to MS E-280.

E-441 Deeming of Income from Ineligible Spouse

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Deeming of Income from Ineligible Spouse:

1. Determine the applicant's countable income allowing the SSI exclusions at MS E-450). If countable income is equal to or exceeds the individual SSI Standard Payment Amount (SPA), the applicant is ineligible. If countable income is less than the individual SPA, complete spreadsheet in ANSWER using #2 - #6 below to determine deemed income from the ineligible spouse.

2. Determine the total income of the ineligible spouse by types, earned and unearned less any excluded from deeming (Refer to MS E-446 to determine income excluded from deeming).

3. From the ineligible spouse's income, deduct a living allowance for each ineligible child in the home (i.e., those not receiving TEA cash or SSI as a blind child or child with a disability). Income of the child is used to reduce this allowance unless it is excluded as student earned income; refer to MS E-446 #10 to determine whether any of the student earned income is used to reduce the living allowance. The living allowance is deducted from the unearned income first and any unused balance is then deducted from earned income. Total the remaining income.

4. If the ineligible spouse's remaining income is equal to or less than his living allowance there is no income to be deemed. The applicant is income eligible.

5. If the ineligible spouse's remaining income exceeds his living allowance, total the remaining income by type with the applicant's gross earned and unearned income amounts.

6. Treat the two totals of income, earned and unearned, as you would for an eligible couple.

    a. From the unearned income, the $20.00/mo. general exclusion is automatically deducted when the budget is submitted.
    b. From earned income deduct the $65.00/mo. work expense allowance plus one-half (1/2) the remaining balance;
    c. Total the remaining earned and unearned income to arrive at countable income.

7. Compare the countable income after deeming to the SSI SPA for a couple. If the countable income is less than the couple's SPA, the applicant is eligible. If the countable income is equal to or greater than the couple's SPA, the applicant is ineligible.

NOTE: The following example reflects January 1, 2013 - December 31, 2013 amounts.

EXAMPLE: Deeming of Income from an Ineligible Spouse

An applicant has gross earned income of $585.00/mo. and unearned income of $390.00/mo. His ineligible spouse has gross earned income of $370.00/mo. and unearned income of $380.00 /mo. His ineligible child has no income. Deemed income is determined as follows:

1. From the applicant's earned income deduct the work expense allowance, $65.00 plus one-half (1/2) the remaining balance (i.e. $585.00 - $65.00 = $520.00 divided by 2 = $260.00).

2. From the applicant's unearned income deduct the general exclusion (i.e. $390.00 - $20.00 = $370.00). Add the earned and unearned income amounts ($260.00 + $370.00 = $630.00).

    Since the applicant's total countable income is less than the individual SPA (i.e. $630.00 as compared to $710.00) complete #2 - #7.

3. The ineligible spouse has total income of $370.00 earned income and $380.00 unearned income.

4. From the ineligible spouse's unearned income deduct the living allowance for the ineligible child (i.e. $380.00 - $356.00 = $24.00) Add this amount to the ineligible spouse's earned income ($370.00 earned income + $24.00 = $394.00).

5. The ineligible spouse's remaining income is not less than or equal to her living allowance (i.e. $394.00 as compared to $356.00);

6. Total the ineligible spouse's remaining income (after deeming) with the applicant's gross earned and unearned income (i.e., $370.00 + $585.00 = $955.00 (earned), and $24.00 + $390.00 = $414.00 (unearned);

    a. From the couple's total unearned income deduct the general exclusion (i.e. $414.00 - $20.00 = $394.00);

    b. From the couple's total earned income deduct the $65.00 work expense allowance plus one-half (1/2) the remaining balance (i.e. $955.00 - $65.00 = $890.00 divided by 2 = $445.00)

    c. Add the remaining unearned and earned income to arrive at countable income (i.e., $394.00 + $445.00 = $839.00; and

7. The countable income after deeming is less than the couple SPA (i.e. $839.00 as compared to $1,066.00); therefore, the applicant is eligible.

E-442 Deeming of Income from Ineligible Parent(s) to Child

MS Manual 01/01/14

For purposes of deeming, a stepparent's needs and income will be disregarded.

1. Determine the gross monthly income of the ineligible parents(s) by type, earned and unearned less income excluded from deeming. Refer to MS E-446 to determine income excluded from deeming.

2. From the ineligible parent(s)'s income, deduct a living allowance for each ineligible child in the home (i.e., those not receiving TEA cash or SSI as a blind child or child with a disability). Any income of the child is used to reduce this allowance unless it is excluded as student earned income. Refer to MS E-446 #10 to determine whether any of the student earned income is used to reduce the living allowance. The living allowance is deducted from unearned income first. Any unused balance is then deducted from earned income.

3. After deduction of living allowance(s) from income, the next step in the deeming determination from ineligible parent(s) will be as follows:

    a. From unearned income, deduct the $20.00/mo. general exclusion (carry over any unused balance of the exclusion and deduct from earnings);

    b. From earned income, deduct the $65.00/mo. work expense allowance plus one-half (1/2) the remaining balance;

    c. Total remaining earned and unearned income;

    d. From total remaining income, deduct a living allowance for the ineligible parent(s) equal to the SSI SPA.

    e. Remaining Income (if any) is deemed to the child as unearned income. It is subject to the $20.00/mo. general exclusion in the child's countable income determination.

4. If parental income is deemed to more than one eligible child, prorate the deemed income equally to each child.

Examples: **Deeming of income from parent(s) to a child. (Examples reflect 1/1/13- 12/31/13 figures).**

Example #1 A child has gross unearned income of $35.00/mo. His ineligible parents have gross earned and unearned income of $900.00/mo. and $223.00/mo., respectively. There is one ineligible child.

Deemed income is determined as follows:

1. The ineligible parents have gross monthly unearned income of $900.00 and $223.00, respectively. Proceed to #2.

2. From the ineligible parents' unearned income, deduct the living allowance for the ineligible child (i.e. $223.00 - $356.00 = $0). Since remaining income is earned only, step 3 will be completed.

3. From remaining income;

    a. Deduct $65.00 and ½ the remainder (i.e. $900.00 - $65.00 = $835.00 divided by 2 = $417.50)

b. Deduct the ineligible parents' living allowance to equal to the couple's SSI Standard Payment Amount (i.e. $417.50 - $1,066.00 = 0),

c. $0.00 is deemed to the child as unearned income. This amount would be added to the child's own income for his eligibility determination.

Example #2 A child has gross unearned income of $130.00/mo. His ineligible parents have gross unearned income of $800.00/mo. There is one ineligible child.

Deemed income is determined as follows:

1. The ineligible parents have gross monthly unearned income of $800.00. Proceed to #2.

2. From the ineligible parents income, deduct the living allowance for the ineligible child (i.e., $800.00 - $356.00 = $444.00). Since remaining income is unearned only, step 3 will be completed.

3. From remaining income;

   a. Deduct the general exclusion (i.e., $444.00 – 20.00 = $424.00),

   b. Deduct the ineligible parents' living allowance (i.e., $424.00 – 698.00 = 0),

   c. $00.00 is deemed to the child as unearned income. This amount will be added to the child's own income for his/her eligibility determination.

Example #3 A child has gross unearned income of $35.00/mo. His ineligible parents have gross earned and unearned income of $685.00/mo. and $300.00/mo., respectively. There are no ineligible children.

Deemed income is determined as follows:

1. The ineligible parents have gross monthly earned and unearned income of $685.00 and $300.00, respectively. Proceed to #2.

2. Calculate as follows:

   a. From unearned income deduct the general exclusion (i.e. $300.00 - $20.00 = $280.00).

   b. From earned income, deduct the work expense allowance plus one half (1/2) the remaining balance (i.e. $685.00 - $65.00 = $620.00 divided by 2 = $310.00).

c. Total remaining earned and unearned income (i.e. $310.00 + $280.00 = $590.00).

d. From the total remaining income deduct the ineligible parent's living allowance (i.e. $590.00 - $698.00 = 0).

e. $00.00 is deemed to the child as unearned income. This amount would be added to the child's own income for his eligibility determination.

E-443 Deeming of Income From a Parent Who Would Be Eligible Except for Excess Deemed Income to an Eligible Child

MS Manual 01/01/14

When there is a blind child or child with a disability living in the home with his or her parents and one parent is categorically eligible, the income of the ineligible parent is deemed first to the categorically eligible spouse and then to the eligible child. For this condition to apply, there must be acceptable evidence provided that proves that one parent would qualify as aged, blind or as an individual with a disability except for income). The deemed income to a blind or disabled child under these circumstances is determined as follows:

1. Complete steps 2 through 7 of Spouse to Spouse deeming as indicated at MS E-441. Deeming of Income from the Ineligible Spouse;

2. If the couple's income determined under Spouse to Spouse deeming is equal to or less than the couple's SPA, there is no income deemed to the child;

3. If the couple's income exceeds the couple's SPA, all of the countable income above the SPA is deemed to the child as unearned income. If more than one eligible child is in the home, divide the income equally among each child. The amount deemed to the child as unearned income is subject to the $20.00 per month general exclusion in his/her eligibility determination (Re. MS A-214).

E 444 Deeming of Income to an Eligible Child from Parent/Parents Who Would Be Eligible Except for Excess Income

MS Manual 01/01/14

When there is a blind child or child with a disability living in the home with his or her parent(s) who would be eligible except for excess income, only the income above the parents' SSI/SPA is deemed to the child. For this condition to apply, there must be acceptable evidence provided that proves that one parent would qualify as aged, blind, or as an individual with a disability except for income. Deemed income is determined as follows:

1. Determine the parent/parents' countable income as if no children were involved. Allow the SSI exclusions listed at MS E-450;

2. If the countable income is equal to or less than the SPA, there is no income to deem to the child. If the countable income is greater than the SPA, the amount above the SPA is available for deeming to the child;

3. Reduce the excess income amount by a living allowance for each ineligible child in the home (i.e., those not blind or determined to have a disability). If this reduces excess income to zero, there is no income to deem to the eligible child. If not proceed to #4.

4. If excess income remains after deduction of living allowances, it is deemed to the child as unearned income. If more than one eligible child is in the home, divide the income equally to each child. The amount deemed to the child as unearned income is subject to $20.00 per month general exclusion in his/her eligibility determination (Re. MS A-214).

E-445 Exceptions to Deeming for Alien's Sponsor

MS Manual 01/01/14

Deeming from the alien's sponsor can be suspended for some aliens. The following aliens are not subject to deeming:

- Aliens who do not have sponsors.

- Aliens who have been battered or subject to extreme cruelty in the United States, and their children or parents who have been battered or subject to extreme cruelty. The abuse may be perpetrated by a U.S. citizen or lawful permanent residence spouse, parent, or their family members living in the same household in the U.S. This exception applies for 12 months from the date of determination that the alien has been battered. (Re. MS D-223)

- Aliens who are indigent. An alien with a sponsor who signed form I-864, Affidavit of Support and the alien is unable to obtain food and shelter. If the alien lives with the sponsor, it will be assumed that the sponsor is providing food and shelter and the indigence exception will not be granted, and deeming will apply. If the alien is living apart from the sponsor, consider the alien unable to obtain food and shelter if:

- ✓ The income the alien receives is less than the income limit for the category of Medicaid for which the individual would be eligible.
- ✓ The resources available to the alien are under the resource limit for the Medicaid category for which the alien would be eligible.

- Aliens who can be credited with 40 qualifying quarters or attain citizenship.
- Aliens qualifying for Emergency Medicaid services only. (Re. MS B-500)

E 446 Items (Income) Not Included in Deeming

MS Manual 01/01/14

The items listed below are excluded from income of the ineligible spouse or ineligible parent(s) before determination of deemed income.

1. Assistance or Income based on need: Includes payments by any Federal Agency, State or political subdivision of SSI payments and any income which was taken into account in determining such assistance. Exclusion applies to V.A. Pension but not to V.A. Compensation. Also includes TEA payments and income which was taken into account in determining assistance (including all income of a step-parent in cases which involve a step-parent);
2. Portions of Grants, Scholarships or Fellowships used to pay tuition and fees at an educational institution or the cost of Vocational Technical training which is preparatory for employment;
3. Foster Care Payments received for an ineligible child;
4. SNAP and Department of Agriculture donated foods;
5. Home produce grown for personal consumption;
6. Refund of income taxes, real property taxes, or taxes on food purchased by the family;
7. Income used to comply with terms of court-ordered support and Title IV-D support payments;
8. The value of In-Kind Support and Maintenance provided to ineligible members of the household.

9. Income excluded by other Federal Statute;
10. Earned income of an ineligible child who is a student unless the child makes such income available (contributes) to the family. This income would not be used to offset the living allowance which is deducted from parental income in the deeming process. If a contribution is being made by the student, consider only the amount contributed as available income; and
11. Income necessary for a plan to achieve self-support (i.e., Approved Plan through Rehabilitation Services).

E-447 Deeming from a Non-Qualified Alien Spouse

MS Manual 01/01/14

The income of a non-qualified alien spouse will be deemed to the applicant, but his or her needs will not be included in the needs standard. A citizen or qualified alien spouse's income must be counted in full, with his or her needs included. The income and needs of non-qualified alien children will be disregarded. A citizen or qualified alien child's income and needs may be included if needed.

E-450 Supplemental Security Income Exclusions

MS Manual 01/01/14

When the income limit for AABD Medicaid categories, such as the Medicare Savings categories, SSI/COLA categories, is below the Federal maximum, the below SSI exclusions are allowable for the purpose of determining initial and continuing eligibility.

1. Refund on real property taxes, food taxes or income taxes.
2. Assistance based on need (State Supplementation of SSI, Interim General Assistance).
3. The tuition and fees portion of grants, scholarships, and fellowships.
4. Home produce for personal consumption.
5. Irregular income or infrequent income which:
    a. Cannot be predicted with any regularity;
    b. Is received less than twice per year; and

c. Does not exceed $10.00 per month earned income or $20.00 per month unearned income.

d. Income exceeding these amounts is considered in full.

6. The full amount of foster care payments made to an adult individual or eligible spouse.

7. One third of child support payments as income to a child.

8. The Student Earned Income Exclusion for a working student under the age of 22 who is enrolled in an educational institution attending a course of study preparatory for gainful work. This exclusion will be adjusted annually based on increases in the cost of living index. There may be years when no increases result from the calculation. Please refer to Appendix S for current amount.

9. $20.00 monthly may be excluded from any income not based on need (Per individual or per each couple determination), but

   a. Is not allowed from VA pension or payments made by Bureau of Indian Affairs, and

   b. Is always applied to unearned income first, the balance, if any, is then applied to earned income.

10. $65.00 plus 1/2 of the remainder of monthly earned income.

11. Income to cover work expenses for the blind (FICA, federal withholding, state income tax, transportation, lunches, expenses for a seeing eye dog, etc.)

12. Income to fulfill a self-support plan for blind or disabled recipients. (Approved plan through Rehabilitation Services).

13. Home Energy Assistance and Support and Maintenance Assistance provided by private non-profit organization, state or federal government body, a supplier of home heating oil or gas, or a municipal utility providing home energy.

14. Support and Maintenance and other assistance received as a result of a presidentially declared disaster.

15. Agent Orange Settlement Payments (also excluded from resources).

Exceptions: The above SSI exclusions do not apply to LTC, PACE, Autism, TEFRA and Home and Community Based Waiver (HCBW) cases because the income limit for these categories are at the Federal maximum of three times the SSI payment limit for an individual in his own home.

E-451 Assets Disregarded as Income

MS Manual 01/01/14

The following assets are disregarded as income in their entirety for all AABD categories, including LTC, PACE, TEFRA and Home and Community Based Waiver:

1. Credit disability insurance payments made on home or automobile loans.

2. Personal services performed for the individual (mowing grass, house cleaning, etc.).

3. Funds received from any source for the repair or replacement of lost, damaged or stolen goods (Re. MS E-530 #4 for resource consideration).

4. The sale of a resource (proceeds continue to be a resource) does not constitute income, but does represent a change in form of a resource.

5. Benefits received under other federal programs (Disaster Relief Program, Child Nutrition Act, etc.).

6. Dividends from insurance policies are not counted as income in determining eligibility, but are counted in determining net income for LTC patient liability.

7. VA AID AND ATTENDANCE FOR PERIODS PRIOR TO 6/1/95

   VA Aid and Attendance payments in the full amount (i.e., not reduced to $90) made to an individual to help defray the cost of medical care are excluded from income for eligibility determinations for AABD and AABD-MN (Current and Retroactive).

   For AABD individuals in facilities, the payments will be included as income available to be applied to the cost of care. However, no portion of the payment can be used for protected maintenance of an outside spouse and/or dependent (i.e. payment is for medical care/services).

   Since VA Aid and Attendance payments must be applied to the cost of care in LTC, it will be necessary to review the award letter to determine how the payments are to be applied. When the individual cannot produce the award letter, the VA Regional Office will be contacted for this information (Re. MS E-432 #5).

VA Aid and Attendance payments are made to the individual in the month following the month of eligibility (Ex: Check received in December is entitlement for month of November.) But the payment must be applied to the cost of LTC for the month in which the check is actually received. (Ex: Check received in December is used in December budget). When retroactive lump sum benefits are paid, it will be necessary to determine both the amount of payment and the effective date of entitlement so that payment may be prorated and counted in the budget in the appropriate month.

EXAMPLE: Mr. X received an award letter granting him $165/mo. in VA Aid and Attendance payments with an effective date of entitlement of 10/14/94. On 1/1/95 Mr. X received his initial payment of $423.50.

The payment would be applied to his cost of care, as follows: $165.00 January (full month), $165.00 December (full month) and $93.50 November (partial month, remaining balance would be applied).

VA AID AND ATTENDANCE FOR PERIODS 6/1/95 AND LATER

VA Aid and Attendance payments in the full amount (i.e., not reduced to $90) received and intended as payments for the month of June, 1995, and later months are not only excluded in making initial eligibility determinations, but are also excluded as income to be applied to the vendor payment in a nursing or ICF/MR facility.

8. VA pension benefits reduced to $90 monthly and paid to single veterans with no dependents, or surviving spouses of veterans with no dependents, who are certified Medicaid eligibles in Medicaid facilities.

   The $90 payment is considered Aid and Attendance for eligibility purposes, and the full $90 is allowed as a personal needs allowance in facility cases. Individuals receiving VA compensation are not subject to the $90 reduction and they will not be given a $90 PNA.

9. VA reimbursements for continuing medical expenses (CME) resulting in an increased monthly pension or for unusual medical expenses (UME) resulting in lump sum payments. Effective 7/1/94, these payments are not income in the initial eligibility determination and individuals are not required to apply these payments toward the vendor payment.

10. Any payments, including gifts and inheritances, made to an applicant/ recipient due to the death of another person may be excluded from unearned income to the extent that

the payments are spent on the deceased person's last illness and burial. If an applicant/recipient is unable to make payment of last expenses in the month that the funds are received, the funds will not be considered a countable resource until after one calendar month after the month of receipt (e.g., Funds received on July 15th may be excluded during July and August. If not spent, the funds will be a countable resource September 1st.) Any interest accruing to the unspent funds is countable unearned income in the month accrued.

11. Section 4735 of the Balanced Budget Act of 1997 (Public Law 105-33) states that payments made from any fund established as a result of a class settlement in the case of Susan Walker vs. Bayer Corporation are not considered income in determining Medicaid eligibility. This case involved hemophiliacs who contracted the HIV virus from contaminated blood products. Also, payments made pursuant to a release of all claims in a case that is entered into in lieu of the Walker vs. Bayer class settlement and that is signed by all affected parties on or before the later of December 31, 1997, or 270 days after the date on which the release is first sent to the persons to whom the payment is to be made are not income in determining Medicaid eligibility.

NOTE: Any interest earned by these funds is countable unearned income in the month in which it is added to the account.

E-500 Resources – AABD

MS Manual 01/01/14

Resources are generally defined as those assets, including both real and personal property, which an individual, or couple, possesses. Resources include all liquid assets as well as those assets which are not presently in liquid form. Liquid assets are those assets that can be easily converted to cash such as checking or savings accounts, certificates of deposit or life insurance policies with a cash surrender value.

In order for assets to be considered as resources, property or an interest in property must have a cash value that is available to the individual upon disposition.

Countable resources will be determined on the first day of the month. When resource eligibility exists at the beginning of a month, it continues for the full month. A resource change that occurs during a month in which resource eligibility exists will not be considered for determination of countable resources until the first of the month following the change.

When an individual is ineligible at the beginning of a month due to excess resources, ineligibility due to resources exists for the full month.

> **NOTE:** When an individual is unaware of ownership of an asset, the asset is not counted as a resource. A discovered liquid asset will be counted as income in the month of discovery and as a resource in the months following. Non-liquid assets will be counted as a resource in the month of discovery and thereafter.

Assets which have been received during the month and considered as income may not also be counted with resources during the same month (unless the income received is given away during the month it is received - Re. MS H-147). For example, if an individual had a checking account balance of $1,950 as of June 1, the receipt of a $300.00 SSA check during June would not cause the individual's $2,000 resource limit to be exceeded during June even if the entire check was deposited in the checking account. The individual's resource eligibility would not be affected by the receipt of income during the month. It would only be affected if the income was retained to the extent that it caused the $2,000 limit to be exceeded as of the beginning of July.

SSI lump sum benefits (never counted as income) will be excluded from resource consideration for 9 full months after the month of receipt (Re. MS E-530). SSA lump sum payments also have the 9 month resource exclusion, but will count as income in the month of receipt

(Re. MS E-261). Interest earned on the excluded funds will be counted as income in the month accrued and, if retained, as a resource in the month following.

Each individual must be advised of how countable resources are determined and how resource changes can affect eligibility.

NOTE: An amount up to the amount of benefits paid out by a Qualified Long Term Care Insurance Partnership policy may be used as a resource disregard when determining eligibility for Medicaid (Re. MS H-510).

E-501 Requests for Legal Opinions Regarding Resources

MS Manual 01/01/14

A legal opinion from the Office of Policy and Legal Services (OPLS) will be requested when the caseworker, the Program Eligibility Coordinator, and the Program Eligibility Analysts are unsure of whether a resource should be considered or disregarded.

If the equity value of the questionable resource, when combined with other resources, appears to exceed the resource limit, OPLS will be contacted if:

- Ownership of the resource is questionable, or
- The applicant's right to transfer the resource is questionable.

All such requests for a legal opinion will be submitted through eDoctus to the DCO Office of Program Planning and Development (OPPD) according to the instructions below:

1. The cover memo will outline the issue to be determined and will include any relevant facts. Copies of any documents affecting the property such as deeds, wills and contracts must be attached. If the applicant does not have the necessary documents, he or she will be advised that it is his or her responsibility to obtain them.
2. The caseworker will scan the documents for the legal opinion request in the proper order into the eDoctus library, "County Request for Medicaid Decision." The proper order to scan documents into eDoctus can be found on the OPPD/OPLS legal document review check list. This will trigger an email message to the Program Eligibility Analysts (PEA) for the area that the county office is located in.
3. The PEAs of the specified area will check the "County Request for Medicaid Decision" library on eDoctus to determine if the request originated in one of the counties he/she is responsible for.

4. The appropriate PEA will review the eDoctus documentation based on the guidelines provided by OPPD/OPLS legal document check list to ensure that the documentation is complete, in the proper order and any discrepancies have been corrected. The PEA will select the option of submitting the request to OPPD.
5. OPPD will review and submit the request to OPLS if needed. OPPD will provide an opinion on the requests that do not require an opinion from OPLS.
6. All responses will be forwarded in an email message to the PEA and the caseworker who requested the opinion.
7. The caseworker will index the document in the client's electronic record. The Medicaid Eligibility Unit will scan the opinion into the client's electronic record on eDoctus.

E-502 Excess Resource Determinations

MS Manual 01/01/14

To be eligible for assistance under AABD categories the countable resources of an individual or couple who are aged, blind or have a disability may not exceed certain limitations. Refer to MS E-110 for countable resource limitations.

NOTE: When one spouse enters LTC and the other does not, the spousal rules at MS H-200 apply. When both spouses enter LTC, the couple's standard will apply for the month of entry, but the resources of each will be compared to the individual standard in the month after entry into LTC. For a married couple in Waiver cases, the couple's standard will apply.

E-510 Real Property

MS Manual 01/01/14

Real property is land, including houses or immovable objects attached permanently to land. It also includes burial plots and crypts.

In order for real property to be a resource, it must be convertible to cash. If the individual has the right, authority, or power to liquidate the property or his share or interest in property, it is considered a resource unless otherwise excluded (Re. MS E-516). If a property right cannot be liquidated, it will not be considered a resource.

Certain types of property may have special restrictions, which include the following:

1. Burial Plot - Burial Plots or crypts which are not intended for the use of the applicant/recipient or his immediate family may be a countable resource. If the deed indicates that the contract is irrevocable, the plot or crypt is not a countable resource. If any co-owner refuses to permit sale of the plot or the burial company requires the individual to move from the state in order to sell the plot, it is not a countable resource. Document the file regarding restrictions with a statement from the co-owner or with a copy of the burial contract, whichever is applicable.

   If the deed indicates that the contract is revocable, it is a countable resource. In this case it will be necessary to contact the burial company, etc. (i.e., original seller of the plot) to determine the value of the specific plot. Document the file regarding value with a statement from the burial company, etc.
2. Land Held by a Member of Indian Tribe - Land which is held by an enrolled member of an Indian tribe may be excluded from resources if it cannot be sold or transferred without the permission of other individuals, the tribe, or a Federal Agency. If permission is needed, determine whether it can be obtained.
   - If permission to sell is granted, treat the property as a resource.
   - If permission to sell is not granted, the property is excluded as a resource.

E-511 Evidence of Ownership

MS Manual 01/01/14

The following official records will be utilized in establishing real property ownership:

1. Assessment Notice
2. Recent Tax Bill
3. Current Mortgage Statement
4. Deed
5. Report of Title Search.

Questions of title, ownership, and property interest which cannot be resolved by the county office will be submitted through eDoctus to the Medicaid Eligibility Unit for an opinion from the Office of Policy and Legal Services. (Re. MS E-501)

E-512 Forms of Ownership

MS Manual 01/01/14

The different forms of ownership are listed below:

1. Fee Simple Ownership - When property is held in fee simple, the owner has sole ownership interest. He alone (or his legal guardian if mentally incompetent) may sell or transfer ownership interest without conditions imposed by others.
2. Shared Ownership - Shared ownership means that ownership interest in property is vested with more than one person. There are three basic types of shared ownership.
    a. Joint Tenancy -In joint tenancy, each of two or more joint tenants has an equal interest in the whole property for the duration of the tenancy. On the death of one joint tenants, the survivor becomes sole owner.
    b. Tenancy-in-Common - In tenancy-in-common, two or more persons have an undivided fractional interest in the whole property for the duration of the tenancy. There is no right to survivorship to a tenancy-in-common.
    c. Tenancy-by-the-Entirety - Tenancy-by-the-entirety results when a conveyance is made to a husband and wife. Each member of the couple is considered the owner of the entire estate. After the death of one, the survivor becomes owner of the entire estate. Real estate owned by a married couple by the entirety can be sold only by the consent of both parties. In the case of divorce, former spouses become tenants-in-common of the property, and either person can market his half share, unless conditions in the divorce decree specify otherwise.
3. Life Estates
    a. Life Estates – A life estate conveys to an individual or individuals certain rights in property which expire upon the death of the owner or of another person. The owner of a life estate has the right of possession, the right to use the property, the right to obtain profits from the property and the right to sell his life estate interest. However, the document establishing the life estate may restrain one or more of the individual's rights. The owner of the life estate can only sell his or her life estate, and cannot sell any remainder interest. (Re. MS E-513 #3) See MS H-308 for guidelines regarding the transfer of a life estate.
    b. Remainder Interest – When an individual conveys property to another for life (life estate) and to a second person(s) (remainder man) upon the death of the

life estate holder, both a life estate interest and a remainder interest have been created in the property. Upon death of the life estate holder, the remainder man will own full title. Several individuals may be designated as remainder men who would hold ownership jointly or in common, as specified by will or deed.

4. Ownership Interest in Unprobated Estate

   An individual may have ownership interest in an un-probated estate if he or she is an heir or relative of the deceased, or has acquired rights on the property due to the death of the deceased, in accordance with a will or state intestacy laws.

5. Dower/Curtesy

   State law for dower and curtesy gives a spouse an interest in the other spouse's property. When the deceased leaves no will, dower or curtesy may be claimed. When the deceased leaves a valid will, a widowed spouse can elect to take against the will when he would have a greater right by dower or curtesy than the will provides.

   If there are questions regarding the dower or curtesy interest, the Medicaid Eligibility Unit will be contacted to request a legal opinion, according to procedures established in MS E-501. When requesting an opinion, indicate whether or not there are direct descendants (children, grandchildren, etc.)

6. Rights to Use

   An individual may have ownership of certain property rights such as:

   a. Mineral Rights - A mineral right is an ownership interest in certain natural resources which are usually obtained from the ground such as coal, sulphur, petroleum, sand, natural gas, etc. (MS E-515)

   b. Timber Rights - Timber rights permit an individual to cut and remove freestanding trees from property owned by another. A life tenant also has certain timber rights in keeping with good husbandry.

   c. Easement - An easement is a property right whereby one has the right to use of the land of another for a special purpose.

   d. Leasehold - A leasehold conveys to an individual, at the owner's will and usually for an agreed rent, the control of property for a definite period of time. It does not designate rights of ownership. Leaseholds may be carved out of life estates.

E-513 Determining Value of Ownership Interest

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In determining the equity value (i.e. current market value less encumbrances) of real property, the type of ownership, the number of additional owners, and the individual's actual ownership interest must all be taken into consideration.

6. Fee Simple Ownership (Sole Ownership) - If the individual is the sole owner of property and has the right to dispose of it, the equity value of the property is a countable resource when the property is not an excludable resource.
7. Shared Ownership -If the property is jointly owned by two or more individuals, the equity value of the property is counted to the individual in proportion to his ownership interest.
   a. Joint Tenancy - The property's equity value is divided by the number of owners in proportion to the ownership interest of each to determine the individual's ownership interest. When the individual's ownership interest plus other countable resources exceed the resource limit, determine if the individual is free to sell his interest.

      When consent to sell joint tenancy property can be obtained from the other owner(s), the property will be considered a countable resource.

      When it is established (in writing) that consent to sell joint tenancy property cannot be obtained from the other owner(s), the property will not be considered a countable resource.
   b. Tenancy-in-Common - The property's equity value is divided by the number of owners in proportion to the ownership interest of each to determine the individual's ownership interest. The value of the individual's interest will be considered a countable resource, regardless of the other owners' desire to sell.
   c. Tenancy-by-the-Entirety (Applicable to a married couple)
      1) Married Couple Living Together in the Community - For any month in which a married couple lives together in the community, the total equity value of non-excludable property held by the couple is a countable resource, whether one or both members of the couple apply for assistance. After the month in which one or both enter a facility, each member of the couple is considered individually as a married couple living apart.
      2) Married Couple Living Apart in LTC - When both members of a "living apart" married couple in LTC are applying for or receiving LTC assistance, half of

the equity value of non-excludable property is a countable resource to each individual.

When only one member of a "living apart" married couple in LTC is applying for or receiving LTC assistance, half of the equity value of the tenancy-by-the-entirety property is a resource to that individual unless he alleges that he cannot obtain consent to sell from the spouse.

When the individual indicates that he wishes to sell his share of the property and indicates that he cannot obtain consent to sell from the spouse, request him to obtain a statement to that effect.

If it is established in writing that the spouse refuses to consent to the sale of the tenancy-by-the-entirety property, it cannot be considered a countable resource to the individual who has applied for LTC.

3) Married Couple Living Apart - Only One In LTC - If only one member of a married couple is in LTC, the Spousal Impoverishment rules at MS H-200 will apply in determining the attribution of resources to each spouse. The equity value of non-excludable property will be included in the initial assessment and in the attribution of resources, regardless of the community spouse's consent or refusal to sell.

3. Life Estate or Remainder Interest Held in Non-home Property

Examine the deed which granted the life estate or remainder interest. If there is a restriction which prevents the life estate holder or remainder holder from disposing of his interest, the value of the life estate or remainder interest is not a countable resource.

If there is no restriction to prevent the disposal of the life estate interest or remainder interest, the following steps will be used to determine its resource value.

a. Determine the value of the non-home property (Re. MS E-510).

b. Select the table at Appendix U for life estate or remainder interest as appropriate.

c. Find the line for the life estate holder's age as of the last birthday.

d. Multiply the figure in the life estate column or remainder interest column for that age by the current market value of the property to determine the life estate or remainder interest value. Deduct encumbrances owed by the individual to determine net value.

e. The individual or person acting on his behalf will be given the opportunity to rebut the determined value. When the individual elects not to rebut, the value determined in item d. will be used. When the individual elects to rebut, proceed to item f.

f. To rebut the determined value, the individual or person acting on his behalf must secure an evidentiary statement from a knowledgeable source that the market value of the interest held in the property is less than the value determined in item d. When the value determined by the knowledgeable source is less than the value determined in item d, the rebuttal value will be used. (Refer to Note 2.)

NOTE 1: Life estate and remainder interests which meet the requirements of income producing non-home property qualify for exclusion as a resource (Re. MS E-516).

NOTE 2: The knowledgeable source statement for rebuttal should be for the market value of the life or remainder interest only, not the market value of the property itself.

The market value of property often has little bearing on the market value of a "life estate" interest.

4. Dower/Curtesy
   a. Determine the current market value of the property.
   b. Find the line in the life estate tables (Appendix U) for the individual's age at his or her last birthday.
   c. Multiply the figure beside the individual's age in the life estate table by the current market value of the property.
   d. Divide the resulting amount by 3 to determine the value of the dower or curtesy interest.
5. Ownership Interest Held In Unprobated Estate

   An individual's ownership interest in an unprobated estate is considered to be a resource. When the property cannot be excluded as income producing property and inclusion of it would make the individual's resources exceed the countable resource limitations, ownership must be established.

   If ownership cannot be determined, the facts of the ownership interest will be submitted to the Medicaid Eligibility Unit for review by the Office of Policy and Legal Services to obtain a legal opinion of the individual's ownership share, if any (Re. MS E-501).

When the individual is determined to have an ownership interest in an unprobated estate, it will be necessary to determine its value through contact with a knowledgeable source. Knowledgeable sources include the following, shown in order of priority:

- Real estate brokers;
- Local office of the Farmer's Home Administration (for rural land);
- Local office of Agricultural Stabilization and Conservation Service (for rural land);
- County Extension Services;
- Banks, savings and loan associations;
- Mortgage companies, and similar lending institutions or
- Officials of the local real property tax jurisdiction.

The full details of the individual's share of the ownership interest in the unprobated estate must be given to the knowledgeable source to obtain an accurate estimate of value. If a free estimate of the value cannot be obtained, it will be the individual's or his or her authorized representative's responsibility to obtain the estimate.

The costs of settling the estate including funeral expenses, payment of mortgages and other debts, attorney fees, etc. will be deducted from the value of the whole estate before determining the individual net interest. A knowledgeable source estimate of these costs will also be used in making this determination, if the actual costs are not known.

Document all findings in the electronic case record.

NOTE: If the consent of others who have an interest in an unprobated estate is required in order to sell an individual's interest in the estate, and the other owners refuse to give consent, then the individual's share is not counted as a resource.

6. Rights to Use
   Mineral rights, timber rights, easements or leaseholds may all be countable resources if they have a cash value available to the individual on disposition. However, in many cases, none of the above are saleable and, therefore, would not be a countable resource. Mineral rights can be leased and may be considered a resource. See MS E-515 for guidelines to use to determine the value of an Oil and Gas Lease.

E-514 Determining Equity Value

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Equity value of either a home or non-home real property is determined by deducting outstanding encumbrances (e.g., liens, mortgages, etc.) from the current market value (CMV) of the property. CMV is the amount for which the property can be expected to sell on the open market. The equity value determination of property owned by the individual must be fully documented in the case record.

The individual's allegation of property value is accepted without further verification when the following conditions are met:

- The value would cause total resources to exceed countable resource limitations (Re. MS E-502);
- The individual can dispose of the property; and
- It does not qualify for exclusion.

If these conditions are met, with the exception of alleged value (i.e. the individual is unable to provide an estimate), the caseworker will ask if the property would sell for at least the individual/couple's resource limit, as appropriate. If he alleges that it would, the caseworker will initiate action to deny or close.

When the individual's alleged value does not cause resources to exceed countable resource limitations or result in potential conditional eligibility, determine property value using one of the methods indicated below:

1. Determine the value based on the tax assessment. Multiply the assessed value (AV) by five. The AV used in this determination will be the current assessed value on record at the County Assessor's Office in the county where the property is located. If the individual does not have documentation of the current AV, the caseworker will contact the County Assessor to obtain the current AV. If the value based on the AV results in eligibility, the caseworker will proceed with the determination. If the value based on the AV causes ineligibility, the caseworker will initiate action to deny or close unless the individual wishes to obtain a knowledgeable source estimate to rebut the value. The CMV based on a knowledgeable source estimate will be determined in accordance with #2 below.
2. Determine the CMV based on an estimate from a knowledgeable source. The individual will be asked to obtain the estimate. The estimate must be written, signed, and have

enough information so the source can be identified. It must be specific as to the point in time for which the estimate is effective. Knowledgeable sources include:

a. Real estate brokers;
b. Local office of the Farmer's Home Administration (for rural land);
c. Local office of the Agricultural Stabilization and Conservation Service (for rural land);
d. Banks, savings and loan associations, mortgage companies, and similar lending institutions;
e. County Agricultural Extension Service (for rural land);
f. Local newspaper real estate ads, "multiple listing" publications, etc.

NOTE: When there is a difference between the assessed value and the CMV based on a knowledgeable source estimate, the knowledgeable source estimate will be used.

Although it is the individual's responsibility to obtain an estimate, the caseworker will assist when necessary. If requested, the caseworker will attempt to obtain a free estimate.

If the CMV of non-excludable property (based on the knowledgeable source estimate), when combined with other countable resources, causes ineligibility, the caseworker will initiate action to deny or close. If the CMV allows eligibility, the caseworker will proceed with the determination. The caseworker may request/secure additional knowledgeable source estimates of value when necessary to clear property values. When multiple estimates are secured, the highest estimate will be used.

Net equity in non-home real property is a countable resource unless it is excludable as income producing property. Refer to MS E-516 to determine if the property is excludable.

E-515 Determining the Value of an Oil & Gas Lease

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Mineral rights can be leased and may be considered a resource. A resource determination regarding the value of an oil and gas lease will be conducted at the initial application and each subsequent reevaluation. The following guidelines will be used to determine the value of an oil & gas lease.

1. Homestead Property
   If the oil and gas lease is for the mineral rights of the homestead property and the land contiguous to the home, the value of the lease will be disregarded as a resource for as long as the applicant continues to claim the same homestead.

2. Excess Real Property
   a. If the mineral rights are on excess real property, the value of the land will be taken into account first. If the land value makes the client resource ineligible, refer to MS E-516 to determine if a real property exclusion exists. If no exclusion resulting in resource eligibility exists, the client is ineligible for Medicaid based on the value of the excess real property. There is no need to determine the value of the oil and gas lease.
   b. If the excess real property value does not cause the client to be ineligible, the caseworker will calculate the value of the oil and gas lease by multiplying the most recent year's royalties by 5. The amount of yearly royalties for the previous year can be obtained on the most recent income tax Form 1099, Miscellaneous Income. If the 1099 is not available, the total amount of revenue from the royalty checks received in the previous year will be used to calculate the lease's resource value.
   The value of the land plus the value of the mineral lease will determine the resource value.

Example: Per the 2011 Form 1099, the annual revenue from the royalties on the mineral lease for 2010 was $443.25. Multiply this number by 5. $443.25 X 5 = $2,216.25. This will be the value of the mineral lease.

Example: The client received royalty checks for $57.15, $115.32, and $100.03 for the year 2011. The total of these checks is $272.50. Multiply this number by 5. $272.50 X 5 = $1,362.50. This is the value of the mineral lease.

   c. Refer to MS E-516 a, to determine if the income producing property will meet the $6,000 exclusion.

3. Owns Mineral Rights But Not Real Property
   a) If a client owns the mineral rights for land that he/she does not own, the caseworker will calculate the value of the oil and gas lease by multiplying the most recent year's royalties by 5. The amount of yearly royalties for the previous year can be obtained on the income tax Form 1099, Miscellaneous Income. If the 1099 is not available, the total amount of revenue from the

royalty checks received in the previous year will be used to calculate the lease's resource value.

The value of the mineral lease alone is the resource value.

b) The caseworker will need to refer to MS E-516 to determine if the income producing property will meet the $6,000 exclusion.

Royalty payments from a mineral lease will be considered as unearned income in the month received and as a resource if retained the following month.

E-516 Real Property Exclusions

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The following resource items qualify for special exclusions from resources when specific conditions are met.

8. Home

   The "home" is excluded as the principal place of residence as long as it is occupied by the individual, his spouse, or "dependent relative"; or, if unoccupied, as long as the individual states his intent to return to the home.

   a. The "home" is any shelter in which the individual (or spouse with whom the individual lives) has an ownership interest (e.g., title or life estate), and which is used by the individual (or spouse) as his principal place of residence. The home may be either real or personal property, fixed or mobile, and located on land or water. The home includes all contiguous land, the mineral rights for the land, and the buildings located on such land. Only one home can be considered the principal place of residence and qualify for exclusion.

NOTE: An individual with an equity interest in the home of greater than the home equity limit (Appendix R) is ineligible for nursing facility and Home and Community Based services. This provision applies to the first determination of eligibility as well as future redeterminations. (Re. MS E-517). The limitation on home equity does not apply if the spouse of the individual, the individual's children under the age of 21, or the individual's child who is blind or has a disability is residing in the home.

Farm or other business resources located on the home property (e.g., tractors, trailers, cars, other equipment, inventory, seed, livestock, etc.) cannot be included under the home property exclusion. These resources are considered personal property and will be included with countable resources unless they can qualify for exclusion under #2 of this policy section.

NOTE: Livestock is defined as any animal(s) kept for use or profit. Livestock includes poultry, catfish, minnows, worms, crickets, etc.

b. A "dependent relative" is defined as a son, daughter, grandson, granddaughter, stepson, stepdaughter, in-law, mother, father, stepmother, stepfather, half-sister, half-brother, niece, nephew, grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, stepsister, or cousin who is dependent on the recipient's home for shelter. Dependency may be verified by the recipient's declaration or by contact with collateral sources knowledgeable of the circumstances. Actual documentation of relationship is not required unless relationship is questionable (i.e. doubt has been raised due to contact with collaterals, etc.).

Absence from the Home

Absence from the home does not affect the home exclusion, as long as the individual intends to return to his home. This exclusion may be given to all AABD applicants/recipients who are away from home but intend to return to their home. See below for consideration to be given to an out-of-state home.

Occupied Home

Intent to return is irrelevant if the home is occupied by the spouse or a dependent relative at any time while the applicant or recipient is residing in a medical institution. As long as the spouse or dependent relative resides in the home, it will be excluded.

Unoccupied Home

When an individual enters a facility and leaves his or her home unoccupied, a statement of his/her intent to return to that home will be sufficient to allow exclusion of the home as a countable resource. The statement should include the reason for being away from home and the intent to return.

The statement of intent to return will be accepted without challenge unless it is self-contradictory. For instance, if the individual states his or her intent to return, but also states he will talk to a realtor about listing the home for sale, the intent to return should be questioned. When the statement is contradictory or does not make the intent clear, or the individual's actions are contradictory to his statement, obtain clarification from a secondary source, such as a physician, relative, or other knowledgeable person.

The individual's intent to return home will be documented at 12-month intervals and the home exclusion will continue as long as the individual intends to return.

If at any time it is established that the individual has no intent to return home, the home will no longer be exempted from resource consideration. Putting the home up for sale and having no plans to invest the profits from the sale in another home indicates that the individual does not intend to return home. The individual's equity in the home will be a countable resource effective the first day of the month following the month in which it is determined that the home is no longer the principal place of residence.

NOTE: Statements concerning intent to return, allegation of dependency, and/or principal place of residence may be accepted from individuals who have the authority to act on behalf of the applicant/recipient when the applicant/recipient is incapable of providing the information.

Out-of-State Home

The out-of-state home of an individual who enters the state with the intent to reside permanently or for an indefinite period of time will not be excluded as the principal place of residence unless the home is occupied by a spouse or dependent relative. The out-of-state home cannot be disregarded using an intent to return statement as this conflicts with the individual's allegation regarding state residency.

Transfer of the Home

If an individual transfers his home for less than fair market value while institutionalized, refer to MS H-303 for treatment.

Rental of the Home

If the home is rented while an individual is institutionalized, it may continue to qualify as the principal place of residence and be excluded from resources as long as the individual intends to return. See MS E-420 and MS E-430 for guidelines on how to consider rental income.

The intent to return will be documented at 12-month intervals as long as the individual remains institutionalized.

Replacement of a Home

When an excluded home is sold and the intent is to purchase another home, the proceeds from sale of the original home may be excluded from resources if they are used or obligated to purchase the substitute home by the last day of the third full month following the month of receipt of the funds. If the home is not replaced during this period, then the proceeds will be counted as a resource beginning with the month following the month they were received.

Interest earned on the funds is not excluded, but will be treated as income in the month accrued, and as a resource in the month following.

The home replacement period begins in the month following the month in which the proceeds are received. However, if the funds were received prior to application, the replacement period begins the month of application.

The proceeds of a home sale will be the net payments received after deducting all encumbrances and sale expenses. All of the net proceeds must be used (or legally obligated) by the end of the exclusion period on the costs of the purchase and occupancy of the substitute home. Allowable costs may include the down payment (even if made before sale of the original home), loan fees and points, moving expenses, repairs or replacements to structure or fixtures, and mortgage payments prior to occupancy. The exclusion does not apply to that portion of the proceeds in excess of the funds used on the substitute home, i.e. if all of the proceeds from the sale of a home are not applied to the substitute home, the unused (unapplied) funds will be counted as a resource beginning with the month following the month they were received.

The intent to replace an excluded home must be documented by a signed statement from the individual or his representative. (For home replacement due to disaster, Re. MS E-530.)

Installment Sales Contract in Home Replacement

If an excluded home is sold, the seller has an installment sales contract for payment of the property, and all funds (down payment and periodic payments) are reinvested in the purchase of a replacement home, the CMV of the sales contract may be excluded from resources. In order for the exclusion to apply, the down payment and each installment payment must be applied to the purchase of the replacement home within 3 calendar months of the date each payment is received (i.e., by the end of the last day of the third month after the month in which the proceeds are received).

The portion of any payment which is interest on the principal is counted as unearned income.

If an individual does not use the monies received as payments on the replacement home, the CMV of the sales contract and any payments made will count as resources in the month following the month of receipt of the contract.

If an individual ceases to use the installment payments to purchase the replacement home, any retained payments and the CMV of the contract will be considered countable resources in the month after the month of receipt of the first payment not used as intended within 3 months.

SSI Recipients in a Facility

The Social Security Administration will determine when the home becomes a countable resource for SSI recipients (i.e. those receiving reduced SSI benefits while in a facility). Vendor payments and Medicaid eligibility will continue as long as the individual remains eligible for SSI, unless the individual has made a prohibited resource transfer (which would result in only vendor payment ineligibility) or the county discovers a disqualifying resource unknown to SSA (which would result in ineligibility for both vendor payment and the Medicaid card).

9. Non-Home Income-Producing Property

There are three categories of non-home income producing property which may be excluded from resources.

Any excluded property must be in current use or, if not in use for a reason which the individual cannot control, it must be expected that the usage will be resumed. Resumption of the use must be within 12 months of last use. The 12-month period can be extended for an additional 12 months if nonuse is due to a disabling condition.

a. PROPERTY WITH EQUITY UP TO $6000 EXCLUDED IF PRODUCING A 6 PERCENT ANNUAL RATE OF RETURN

This exclusion applies ONLY to AABD applicants/recipients in facilities, medically needy categories, and QMB/SMB categories who have an interest in mineral or timber rights, rented farmland, rented dwellings, etc., when the income from their property interest is not considered their principal means of livelihood or support and they are not considered to be conducting a trade or business. The exclusion does not apply to SSI recipients or QDWIs.

Up to $6000 equity may be excluded from the property described above if it is producing at least a 6 percent annual return on the amount of equity excluded. Any equity remaining after the exclusion is given will be included with other countable resources. For example, a mobile home on non-home land with total combined equity value of $7000 is being rented for $60 month/$720 year. Six percent of $6000 is $360. Since the annual return ($720) is greater than 6 percent of $6000, $6000 of the equity value of this property may be excluded from resources. The remaining $1000 equity must be counted as a resource.

If an individual has more than one non-home income producing property interest, the total equity value excluded cannot exceed $6000, and the rate of return must equal at least 6 percent of the excluded equity for each activity.

If the property is not excludable because the annual return is less than 6 percent of the excluded equity value, the total equity value of the property is a countable resource.

b. PROPERTY EXCLUDED REGARDLESS OF VALUE OR RATE OF RETURN

When non-home real or personal property is used in a trade or business essential to self-support (including personal property used by an employee for employment), the total equity value of the property may be excluded from resources.

A trade or business is defined as the principal commercial or mercantile self-employment work activity in which one engages regularly and from which one derives his/her principal livelihood. An individual residing in a long term care facility is not ordinarily involved in a business which involves regular work activity that is the primary source of income.

All of the liquid resources used in the operation of a trade or business may also be excluded as property essential to self-support.

Some examples of property used for self-support are land and equipment used for farming; land, a building and equipment used for a dry cleaning establishment; or the land and multiple mobile homes being operated as a mobile home park business. Examples of property used by an employee to maintain employment are tools, safety equipment, uniforms, etc.

The most recent tax return available may be used to verify current use of the property as a trade or business enterprise. If a tax return is not available, other means of verification such as purchase receipts, bank statements, proof of payments, etc., can be used.

The profit/loss shown on an income tax return is irrelevant in determining whether the individual is conducting a trade or business or whether the value of the property will be excluded from resources.

c. PROPERTY WITH UP TO $6000 EXCLUDED REGARDLESS OF RATE OF RETURN

Up to $6000 of the equity of non-home, nonbusiness real or personal property used to produce goods or services essential to daily living may be excluded from resources. There is no rate of return requirement. If the equity value exceeds $6000, only $6000 may be excluded; the remaining equity is a countable resource.

Some examples of the above exclusion are the land used for gardening or for grazing livestock when the product (vegetable or meat) is used only for personal consumption by the applicant/client and his household members. Equipment, such as a tractor or fishing boat, used in the production of food solely for home consumption may also be excluded. However, an automobile or truck may not be excluded under these provisions.

The current market value (obtain from a knowledgeable source) and the value of the individual's equity in the property must be verified in order to determine what portion of the equity value, if any, must be counted as a resource.

Only one $6,000 exclusion may be given under this policy that allows a $6000 exclusion regardless of rate of return.

E-517 Home Equity Limit – Long Term Services and Supports

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The Deficit Reduction Act of 2005 established a home equity limit for individuals applying for Long Term Care Services beginning January 1, 2006. This limit applies only to eligibility for nursing facility vendor payments and Home and Community Based Waiver services. An individual ineligible for nursing facility vendor payments due to the home equity limit may still receive other Medicaid covered services.

EXCEPTIONS: The home equity limit does not apply to:

1. Individuals who applied and were determined eligible prior to January 1, 2006 and who have had no break in LTC eligibility since January 1, 2006.
2. Individuals whose spouse, children under the age of 21, or child who is blind or has a disability is residing in the home.

The Center for Medicare/Medicaid services in the federal Department of Health & Human Services annually reviews and revises the amount of the home equity limit. Changes to the amount go into effect on January 1 of the applicable year. Refer to Appendix R for the current year's home equity amount.

Home equity will be determined at application for those applying on or after January 1, 2006. Equity value in the home will be determined in the same manner as for non-home real property. (See MS E-510) If the home is held in any form of shared ownership, only the applicant's fractional interest will be considered. (See MS E-512) The LTC application must be approved for Medicaid if all eligibility requirements other than the home equity limit have been met. The individual will not be eligible for a vendor payment until the equity in the home is below the current maximum but may receive other Medicaid services with the exception of Waiver services.

Request for Undue Hardship Waiver

An individual who is denied eligibility due to excess home equity may request an Undue Hardship Waiver. An example of a situation in which an undue hardship may exist is if the individual makes an allegation that the home equity should not be counted because of a legal impediment to selling or transferring the home. (Re. MS H-710)

E-518 Reverse Mortgage or Home Equity Loan

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An individual may obtain a home equity loan or a reverse mortgage to reduce the total equity interest that he/she has in the home in order to qualify for Medicaid payment for facility care or Home and Community based services. A reverse mortgage is a type of loan that establishes a maximum Line of Credit that the homeowner is allowed to borrow using the home as collateral.

Any funds that the individual receives from the reverse mortgage or home equity loan are disregarded in the month received as proceeds from a loan. Any funds received from a reverse mortgage or home equity loan are counted as a resource if retained after the month of receipt.

NOTE: If the proceeds from a reverse mortgage or home equity loan are transferred during the month of receipt and the individual does not receive fair market value in return, the transfer will be considered an uncompensated transfer and a penalty period will be determined.

E-518 Reverse Mortgage or Home Equity Loan

If on the first of the month an individual has retained a payment from a home equity loan for an amount greater than the resource limit, he/she would be ineligible to receive Medicaid until the resources are reduced to meet the resource eligibility limit. If the individual gives this money away, this would be considered an uncompensated transfer and a penalty period will be determined.

EXAMPLE: Mr. Smith is applying for LTC. He is otherwise eligible except he has equity in his home in the amount of $537,000 which exceeds the $536,000 home equity limit. He converts $1,000 of the home equity to cash. Mr. Smith reports no other resources. His home equity is now within the accepted limits and if his resources are below $2,000, he is now eligible for vendor payment or Home and Community based services.

EXAMPLE: Mrs. Jones, a LTC applicant, has equity in her home of $550,000. She obtains a home equity loan of $25,000 thereby reducing her equity to $525,000. She now meets the home equity limit but is ineligible due to countable resources of $25,000 if she retains the loan proceeds in the month after she receives them.

If an individual has arranged a private reverse mortgage with an adult child instead of with a commercial lender, verification that the loan is "bona fide" will be required prior to the approval of a reduction in home equity value. If the applicant cannot prove that the loan is bona fide, then the loan cannot be used to reduce the equity value of the home.

In order to be considered a bona fide loan, each of the following requirements must be met:

- A bona fide loan is a contract that must be enforceable.
- The loan agreement must be in effect at the time that the cash proceeds are provided to the borrower. Money given to an individual with no obligation to repay cannot become a loan at a later date.
- A loan is an advance from a lender that the borrower must repay with or without interest and that must be acknowledged by both the lender and the borrower for a bona fide loan to exist.
- The loan must include a plan or schedule for repayment and must document the borrower's express intent to repay the loan by pledging either real or personal property for anticipated future income.
- The plan or schedule of repayment must be feasible. In determining the plan's feasibility, consider the amount of the loan and the borrower's income, resources and living expenses, as well as, other factors that may influence the repayment of the loan.

The individual applying for medical assistance will be required to provide a copy of the loan note which must include the following:

1. Verification of the loan balance,
2. The payment schedule, and
3. Verification of actual payments.

If the applicant cannot prove that the loan is bona fide, the caseworker will not use the loan to reduce the equity value of the home.

NOTE: Any costs paid out of the loan proceeds to enable the individual to obtain the reverse mortgage can be used to reduce the equity provided that the costs become part of the outstanding debt. If the individual pays the costs out-of-pocket, the equity value cannot be reduced by that amount.

EXAMPLE: An administrative cost of $3,000 is charged by the financial institution as part of obtaining a reverse mortgage for $85,000. If the client adds this amount to the balance of the outstanding loan, the total amount of the loan becomes $88,000. The total $88,000 can be used to reduce the client's home equity amount. If the client pays the $3,000 out-of-pocket, the additional $3,000 cannot be used to reduce the equity amount.

E-520 Personal Property

MS Manual 01/01/14

Personal property is property other than real property, consisting primarily of liquid assets.

Personal property which is accessible to the individual, or of which the individual is free to dispose, is a countable resource unless it meets the criteria for exclusion as specified under MS E-516.

E-521 Forms of Ownership

MS Manual 01/01/14

Generally, ownership of personal property can be in the same form as that of real property (Re. MS E-512).

E-522 Determining Value of Personal Property

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Listed below are various types of commonly held assets which are countable resources. The listing also describes how their resource value is determined.

Verification of countable resources is required unless the client's declaration of the resource value would cause total countable resources to exceed the countable resource limit.

1. Cash - Cash consists of money which is on hand in the form of currency or coins. Foreign currency or coins are cash to the extent that they can be exchanged for United States issue. (Coin collections, however, are not considered to be cash, even though they are a resource. Their value is based on collector's value which is determined by contact with a knowledgeable source.)

   Cash on hand includes amounts that the individual has on his person, amounts that he has at home, and amounts being held for him elsewhere.

   The total amount of cash on hand (excluding amounts which were received during the month and counted as income) is a countable resource. The individual's allegation of actual cash on hand is accepted as verification.

2. Checking or Savings Accounts - Assets of an individually held checking or savings account (including patient funds accounts managed by a facility for an individual) will be considered a resource to the individual when he has unrestricted access to the account. The resources of a jointly held account are presumed to be fully available to an eligible individual when he is the only party to the account eligible for assistance. However, when all parties to a jointly held account are receiving or have applied for assistance under the same program, the resources of the account are presumed to be divided equally among the eligibles who have access to the account.

   An otherwise eligible individual, who is a joint account holder with unrestricted access to the account, will be offered an opportunity to rebut the presumption. To rebut the presumption of full or partial ownership, the individual must provide all of the following evidence within 30 days:

   a. A written statement by the individual giving his allegation regarding ownership of the funds for the applicable period, the reason for establishing the joint account, who made deposits to and withdrawals from the account, how withdrawals were spent, etc.;

   b. Corroborating written statements from the other account holders; and

c. Proof of the change in the account designation removing the individual's name from the account (if he has no ownership), or restricting his access to the funds in the account.

The caseworker will provide assistance in obtaining the evidence only when the individual is unable to do so.

If the co-holder of a joint account is incapacitated or a minor, it will not be necessary to obtain a corroborating statement from that individual. When this occurs, obtain a corroborating statement from a third party who has knowledge of the circumstances surrounding the establishment of the joint account. If there is no third party, make the rebuttal determination without a corroborating statement. The caseworker will document in the electronic case record an explanation as to why no corroborating statement was obtained.

A successful rebuttal will result in a finding that supports the individual's allegation regarding ownership of the funds (if any).

If the individual elects not to rebut the presumption, obtain a written statement from the individual which documents his election.

If the individual elects not to rebut, does not provide a rebuttal within the allotted time, or does not provide all of the required evidence, the presumed ownership interest will be used in his eligibility determination. When the individual is a joint account holder with an ineligible individual, any interest payments or deposits made to the account will be considered unearned income in his eligibility determination unless the deposit meets the income disregards listed in MS E-450. When the individual is a joint account holder with an eligible individual, any interest payments will be divided equally among the holders but deposits by one will not be considered income to the other.

If the individual submits all required evidence within the allotted time, determine his ownership interest (if any) and document the findings in the electronic case record. The actual ownership interest determined by the rebuttal will be used in the eligibility determination. When the individual has successfully rebutted ownership of all or a portion of the funds in a joint account, deposits made by the other holder(s) will not be counted as income and interest payments will be counted in proportion to his or her ownership interest, if any.

If the value of a joint account will cause the individual to be ineligible because he or she is the only account member eligible for Medicaid, he or she must be advised of the reason for his ineligibility. Any questions that the individual may have regarding the effect of specific actions that he or she may take concerning the account will be answered.

Verification of a checking account balance is made by examining the checkbook record and the bank statement covering the month before application or reevaluation, or written contact with the financial institution. Checks written and forwarded or delivered for payment prior to the first of a month but not cleared by the first day of the month will be deducted from the account balance.

Verification of a savings account balance is made by examining the passbook and/or bank statement or by written contact with the financial institution.

Verification of a patient fund account balance will be secured by contact with the facility.

If there is any question as to the accuracy of the passbook or checkbook record, secure a DHS-81, Consent for Release of Information, and request a written verification from the financial institution.

3. Certificates of Deposit - Certificates of deposit or time deposits are contracts between an individual and financial institutions whereby the individual deposits funds for a specified period of time in the form of a certificate of deposit, savings certificate, etc. In return, the financial institution agrees to pay the individual a higher interest rate than the maximum permissible passbook rate.

   To be considered a resource, funds invested in the CD or time deposit must be available to the individual. Generally, funds in a time deposit can be withdrawn prior to maturity of the certificate with penalties for early withdrawal. The resource value of a CD or time deposit is the net amount that would be received after imposition of penalties for early withdrawal.

   If after examining the certificate it cannot be determined whether the funds can be withdrawn, or if the resource value cannot be determined, contact the financial institution where the funds are deposited. The electronic case file will be documented as to the resource value of time deposits and the method used to determine value.

4. Promissory Notes - A promissory note is a written unconditional promise signed by a person who promises to pay a specified sum of money at a specified time or on demand to a person, company, corporation, or institution on the note.

   The caseworker will evaluate whether the individual has transferred resources for less than fair market value when an individual transfers a resource and receives a promissory note, loan, or mortgage as compensation. If the transfer of resources was for less than fair market value, the caseworker will refer to MS H-308 for guidance regarding determining a penalty period. If fair market value was received for the transfer, the caseworker must consider whether the note, loan, or mortgage is a countable resource.

If an applicant transfers resources while providing the appearance of a loan and documenting the transfer as a promissory note, the funds will continue to be considered as a resource unless all of the following conditions are met:

- The repayment plan is actuarially sound and feasible,
- The repayment plan provides for equal payment amounts during the term of the loan with no deferral or balloon payments, and
- The repayment plan prohibits cancellation of the balance upon death of the lender.

Promissory notes may be discounted and sold, unless the terms of the note prevent it. If the terms of the note prevent its sale, it is not considered to be a resource.

Discounting refers to the interest deducted in advance by one who buys, or lends money on a bill or exchange or promissory note. For example, a bank may be willing to pay $450 for a $500 promissory note which is due in one year’s time.

When the individual owns a promissory note which he could sell or discount, it is considered to be a resource in the amount for which it could be sold or discounted.

If by examination of the promissory note, it cannot be determined whether the promissory note is saleable, or its value cannot be determined, contact with a local bank or lending institution will be necessary. The bank may wish to examine the note before making a determination. When this is required, the individual or person acting on his behalf should personally submit the note to the bank for examination. When the note is determined not to be saleable until maturity, its value is not a countable resource until that time.

The cash payments received on a nonsalable promissory note are counted in full as unearned income.

The cash payments received on a saleable promissory note, which is considered to be a resource, are treated as follows: (1) payment which represents payment on principal is considered as a resource; (2) payment which represents payment on interest is considered to be unearned income. An amortization schedule may be necessary to determine interest income.

Documentation in the electronic case record will be made to indicate a note's resource value and how it was determined.

5. Mortgage - A mortgage is a pledge of a particular property to a creditor as security for the payment of a debt (or the performance of some other obligation) within a prescribed time period.

   Generally, a mortgage can be sold or discounted like a promissory note.

   Determination of the value and salability of a mortgage is made in the same manner used for promissory notes.

6. Stock - Shares of stock represent ownership in a corporation. Stock value is determined by the closing price at the time of application or redetermination.

   Individuals who own stock must provide either the stock certificate for verification of ownership or a copy of the most recent account statement, if the stock is held by a securities firm.

   Verification of stock value may be made by consulting one of the following free web sites:

   - www.nyse.com (New York Stock Exchange)
   - www.nasdaq.com

   The financial section of a newspaper for stock that is listed on either the New York or American Stock Exchange may also be used to obtain a stock's value. Closing price is used. For stock not listed on either exchange that is traded "over the counter", the "bid" price for the stock is used to determine market value. If "bid" prices for "over the counter" stock are not listed in the newspaper, contact will be made with a local securities firm to verify value. Documentation of ownership and value will be entered in the case narrative.

7. Stock in Close Corporation - Stock held in a corporation wholly owned by one or more board members requires complete development to determine resource value.

   The value of stock in a close corporation which has elected not to trade its stock publicly is determined by subtracting the liabilities of the corporation from its assets and dividing the resulting net assets by the number of stock shares outstanding.

   Net assets of the corporation must be determined by examination of the corporate tax return for the most recent taxable year. The individual who owns stock in a close corporation must provide information necessary to determine its resource value.

8. Stock in Alaskan Native Corporation - Shares of stock held in an Alaskan Native regional or village corporation are excluded from resources.
9. Mutual Fund Shares - A mutual fund is a company that buys and sells securities and other property with funds obtained from its shareholders.

   Value determinations for mutual fund shares follows the procedure used in determining the value of stock.
10. Municipal, Corporate, and Government Bonds - A bond is a written agreement to pay a sum of money at a future specified date. Even though a bond must be held until its specified date of maturity to be redeemed for its stated value, it is saleable and transferable.

    A “municipal bond” is the obligation of a state or a locality (county, city, town, village, or special purpose authority like a school district). “Corporate bonds” are obligations of private corporations, and “government bonds” denote a transferable obligation backed by an agency of the federal government.

    Current market value is generally determined as it would be for stock. It is frequently necessary to contact a local securities dealer to establish the market value of a bond. Documentation of the value determined will be recorded in the case narrative.
11. U.S. Savings Bonds - A U.S. Savings Bond is an obligation of the federal government which is nontransferable. A U.S. Savings Bond can only be sold back to the government.

    U.S. Savings Bonds are usually registered in the name of the owner(s) shown on the front of the bond, and may be redeemed by the owner by completion of a form on the back. If bond ownership is shared, each person’s share as a resource is equal even though any one of the owner’s listed on the bond may dispose of it.

    The value of a U.S. Savings Bond depends on the amount of time elapsed since issuance. There is a table of value on the reverse of many bonds; however, due to interest rate changes which may have occurred since issuance, it may not be accurate. Value determinations should be secured by contact with a bank.

    Documentation of the value determination will be entered in the case narrative.
12. Prepaid Burial Contract - A prepaid burial contract is an agreement in which an individual prepays his burial expenses and the seller agrees to furnish the burial.

    Prepaid burial contracts may or may not be considered as countable resources for determinations of Medicaid eligibility, depending on the terms of the individual contract and depending on the legal authority of the seller to issue prepaid contracts (Re. MS E-523 for treatment of burial funds).

13. Trusts - A trust is a right of property held by one party (the Trustee) for the benefit of another (the beneficiary). The trustee holds the legal title of property for the beneficiary. The term “trust” includes any legal instrument or device that is similar to a trust, and may include annuities.

    Generally, an appointed trustee cannot use funds within the trust for his own benefit, and it is therefore not a resource to him.

    If an individual is not legally competent and a trust is established for the individual by a guardian or legal representative (including a parent for a child), using the individual’s resources, the trust will be treated as having been established by the individual, since he could not do it for himself.

    Two considerations to be given to trusts, when an individual has established a trust and/or when an individual is beneficiary of a trust, are:

    a. Whether or not the trust is a countable resource to the Medicaid applicant/recipient, and
    b. Whether or not a period of ineligibility will be imposed on a nursing facility or Waiver Medicaid applicant/recipient due to the transfer of resources into a trust.

    The resources of a trust may or may not be countable to a Medicaid applicant/ recipient depending upon who established the trust, who is beneficiary of the trust, whether the trust is revocable or irrevocable, when the trust was established, etc.

    Trusts established by will are generally not considered to be trusts established for the purpose of making an individual eligible for Medicaid. However, an individual who is beneficiary to a trust established by a will may be ineligible for Medicaid if the trust resources are considered available and countable as income and/or resources to the individual.

    Applicant/recipients who apply for nursing facility services or Waiver services and who have established a trust may be subject to a period of ineligibility as a result of the transfer of resources into a trust. Refer to MS H-304 for additional information regarding the transfer of resources to a trust.

    In all cases, when an caseworker in a county office becomes aware of a trust, when established by a Medicaid applicant/recipient or by someone acting on behalf of the applicant/recipient, or when the applicant/ recipient is a beneficiary or potential beneficiary of a trust, the trust document along with all other pertinent data and a cover memorandum should be sent to the Medicaid Eligibility Unit with a request for review by the Office of Policy and Legal Services. See MS E-501 for the process to submit an electronic request for an OPLS opinion.

14. Annuities - An annuity is a financial tool used to obtain an income amount paid at specific intervals for a fixed period of time, often for the individual's lifetime, in return for a premium paid either in installments or in a single payment. An individual applying for either Nursing Facility Care or Home and Community Based Services must follow these guidelines regarding annuities:
    1. The individual must disclose a description of any interest the individual or community spouse has in an annuity regardless of whether the annuity is irrevocable or is treated as a resource.
    2. The State of Arkansas must be named as the preferred remainder beneficiary of an annuity unless there is a Community Spouse and/or a minor child or a child with a disability. If there is a Community Spouse and/or a minor child or a child with a disability, Arkansas may be named in the next position after these individuals. If Arkansas is not named as the remainder beneficiary in one of these positions, the purchase of the annuity is treated as a disposal of resources for less than fair market value.
    3. The annuity must provide for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.

    With the exception of the annuities listed in the note below and pre-paid burial contract annuities, a complete copy of an annuity will be forwarded to OPPD for submission to the Office of Policy and Legal Services (OPLS). Based on OPLS' opinion, OPPD will inform the caseworker whether the annuity is to be treated as a resource, as income or as a disposal of resources for less than fair market value.

NOTE: The caseworker will determine the value of APERS (Arkansas Public Employees Retirement System), ATRS (Arkansas Teachers Retirement System), OPM (Office of Personnel Management) and Railroad Retirement pension annuities. These pension annuities provide a scheduled amount of payment that will be income in the month received and a resource if retained in the following month.

Prepaid Burial Plan Annuities (Refer to E-523)

An annuity purchased to fund a pre-paid burial contract will not be a countable resource when the guidelines at MS E-523 #5(b) are met. When the caseworker can determine a pre-paid burial annuity meets these conditions, the annuity does not need to be sent to OPPD for an opinion.

However, if there are questions or issues that cannot be handled at the county level, submit the request to the OPPD Medicaid Eligibility Unit for an opinion.

E-523 Personal Property Exclusions

MS Manual 01/01/14

Listed below are resource items that qualify for special exclusion from resources when specific conditions are met. Resource items which do not meet conditions for exclusion will be included with countable resources. When an excludable resource item has a value in excess of the exclusion limitation, the excess value will be included with countable resources.

1. Automobile

   The term "automobile", as used here, applies to any vehicle which is used to provide necessary transportation, such as passenger cars, trucks, boats, and special vehicles (e.g., motorcycles, snowmobiles, animals, animal-drawn vehicles, etc.).

   Only one automobile can be excluded for an individual or a member of his household under the general exclusion. An automobile is specifically excluded if:

   a. Its current market value (CMV) does not exceed $4500; or

   b. Its current market value exceeds $4500, but;

      1) It is used to obtain medical treatment for a specific or regular medical problem, or

      2) It is necessary for employment, or

      3) It is specially equipped for use by a handicapped individual, or

      4) It is necessary because of climate, terrain, distance, or similar factors to provide necessary transportation to perform essential daily activities.

   If the value of the automobile exceeds $4500 and it is not excludable based on its use, the value in excess of $4500 will be included with countable resources.

   NOTE: If an individual in a facility has a spouse living in the community, they will be allowed one vehicle, regardless of value.

   When the above general exclusion has been given to an automobile, a second automobile can be excluded only if it is essential to the means of self-support of an individual or couple. If a second vehicle is normally used in the operation of a trade or business and if the first excluded vehicle cannot also fulfill the self-support function, then the second vehicle may be excluded from counting toward the resource limitation.

The equity value of all nonexcludable automobiles will be included with countable resources.

Determination of Current Market Value - The determination of value for foreign and domestic passenger cars will be based on use of the "average wholesale value" listed in the NADA Official Used Car Guide, for listed automobiles. The determination of value for trucks, passenger cars, and other vehicles not listed in the NADA Official Used Car Guide will be based on the county personal property tax assessed value (20% rate) multiplied times 5, or contact with a knowledgeable source (e.g., auto dealers, truck dealers, auto insurance companies, etc.).

The NADA Official Used Car Guide is distributed by the Agency twice a year. When using the NADA Official Used Car Guide, use the edition current for the point in time determination. Determine the average trade-in or wholesale value for the auto as listed in the NADA Official Used Car Guide. If the value of the auto is not material to the eligibility determination (i.e., it is excluded or its countable resource value does not affect eligibility when combined with other countable resources), no further determination of exact value is necessary. If, however, the value of the auto is material (affects eligibility), further determination is necessary because the average wholesale value for all domestic cars includes air conditioning and sometimes other options and, if the applicant/recipient's auto does not have the standard options, their wholesale value is deductible. The option valuations are listed with each model in the NADA Official Used Car Guide.

Normally, vehicles too old to be listed in the NADA Official Used Car Guide can be assumed to be worth under $4500. However, the value of an automobile of obvious value such as a Jaguar, Mercedes-Benz, Rolls Royce, Cadillac, Lincoln, Corvette, antique auto, or customized auto will be determined even when it is too old to be listed in the NADA Official Used Car Guide. These may be verified by use of the tax assessment method or by contact with a knowledgeable source.

When contacting a knowledgeable source, an estimate of the wholesale value will be requested. In all value determinations, it is essential to obtain a complete and accurate description of the vehicle being evaluated. Document the case narrative as to determined values and the means used to make the value determinations (including the name and address of dealers used in knowledgeable source contact)

<u>Application of General Exclusion</u> - If the value of an auto is not more than $4500, it is excludable without further determination. If the value exceeds $4500, it is necessary to determine whether it can be given exclusion on the basis of obtaining medical treatment, of being used as transportation in connection with work, of being specially equipped for use by a handicapped member of the household, or of being required to perform essential daily activities due to climate, terrain, or of distance, etc.

a) <u>Exclusion based on use to obtain medical treatment</u> - In the case of an obvious illness or handicap, assume that the automobile is used to obtain specific or regular medical treatment. Document in the electronic narrative as to the nature of the illness or handicap and the exclusion of the automobile. If there is no obvious illness or handicap, verify frequency of use of the auto by obtaining medical appointment cards, evidence of past treatment (bills for services, physician fees, prescription drugs, etc.), or contact with treatment sources. It must be established that the automobile is used at least 4 times per year to obtain medical treatment or prescription drugs. Document the electronic narrative as to the exclusion and evidence used. This exclusion is made whether the use is for the applicant/recipient or a member of the immediate family living in the household.

b) <u>Exclusion based on use in connection with employment</u> - An automobile used by the applicant/recipient, spouse, or other member of the immediate family living in the household as transportation to and from work is excluded regardless of value. The development of income from work activity of a spouse or person whose income is deemed is sufficient to document the exclusion. If the auto is used by another member of the household, a signed statement from that person is acceptable evidence. Narrate the exclusionary status and reason in the case record.

c) <u>Exclusion of an auto specially equipped for a handicapped individual</u> - An automobile specially equipped for use by a handicapped individual in the household (either as a passenger or as an operator) is excluded, regardless of value. Accept the individual’s statement explaining the nature of the modification to the vehicle as verification. Narrate the exclusion in the case record.

d) Exclusion based on climate, terrain, etc. that requires transportation to perform essential daily activities - If climate, terrain, distance, or similar factors requires a vehicle to perform essential daily activities, the vehicle may be totally excluded, even if its value is over $4500. The reason for exclusion should be narrated in the case record.

If the value of the automobile exceeds $4500 and it is not excludable based on its use, consider excess value above $4500 as a countable resource. Do not deduct encumbrances.

Generally, only one automobile is excludable. If the second auto does not qualify for exclusion (i.e. essential for self support), its equity value (current market value less encumbrances) is considered to be a countable resource. No more than two autos can be excluded. If any additional autos are owned, their equity value is considered to be a countable resource.

If a family has two or more automobiles and only one is excludable based on its value/use, the exclusion will be given to the automobile with the highest equity value.

Applicant Disagrees with Determined Value - If the applicant disagrees with the value determined for a non-excluded automobile which is material to the case (affects eligibility), he will be afforded the opportunity to provide two knowledgeable source statements to establish a different value. These appraisals will be at the applicant's own expense. It should be explained to the applicant that the agency is not bound to honor the appraisals. However, the agency will recheck any provided appraisals for accuracy and, if they are accurate, establish a value based on the appraisals.

2. Life Insurance Policies

   a. An individual is allowed to own policies with a combined face value of $1500 or less without consideration of cash surrender value (CSV).

   b. Only policies that have CSV are considered against the $1500 limit. These include Whole Life, Straight Life, Endowment, Limited Payment Life, etc.

   c. Policies without CSV are not counted as resources.

When the combined face value of policies with CSV owned by the individual is equal to or less than $1500, there is no resource to be considered. However, the face value must be considered in determining excluded burial funds.

When the combined face value of policies with CSV owned by the individual exceeds $1500, the CSV of the policies must be determined and counted as a resource. If the individual alleges that the insurance policies are intended to cover burial expenses, the CSV of such policies may be designated as a burial fund.

Most Whole Life policies come with a CSV chart which can be used to determine value. If the CSV cannot be determined from a chart provided with the policy or other available evidence, secure a DHS-81 from the client, and contact the insurance company to determine value. Any outstanding loans made against a policy's CSV will be deducted.

3. Household Goods and Personal Effects

   a. $2000 exclusion (normally the value is assumed to be less than $2000); or

   b. If the individual alleges that a single item is worth $500 or more, verify the value of the item and assume remaining items to be valued at $1000.

   If the individual does not allege a single item to be worth more than $500, no further action is necessary.

   If the individual alleges that a single item such as an antique is worth more than $500, the value of the item must be verified through a knowledgeable source-in this case an antique dealer. A description of the property's age, type, and condition should be given to the dealer. If it is verified that the property is worth more than $500, the actual value of the item is added to the value of the remaining household goods and personal effects ($1000), and any amount above the $2000 limit is considered as a countable resource.

4. Income Producing Non-home Property (Personal Property)

   For the consideration of personal property used in conjunction with a trade or business, with employment, or with production of goods or services essential to daily activities, refer to MS E-516.

5. Burial Spaces and Funds

   a. Burial Spaces

   The term "burial space", as used here, applies to conventional burial plots, gravesites, crypts, mausoleums, urns, vaults, caskets, and other repositories which are customarily and traditionally used for the remains of deceased persons. Additionally, the term also includes necessary and reasonable improvements upon such burial spaces including headstones, markers, plaques, and arrangements for opening and closing the gravesite for burial of the deceased.

   The value of burial spaces for the individual, his spouse or any member of the individual's immediate family will be excluded from resources. The term "immediate family", as used here, applies to the individual's children (minor and adult), including adopted children and stepchildren, his brothers, sisters, parents (natural or adoptive), and the spouse of those individuals. Dependency or living in the same household are not factors.

If a burial space item is included in a contract or policy which accrues interest, the interest retained is excluded from both income and resources as it increases the value of the excluded burial space. This exclusion is in addition to the burial fund exclusions specified in item "b" below.

If a burial contract or policy (item "b" below) separately identifies a burial space from the other items in the contract or policy, the amount for the burial space may be allowed in addition to the $1500 burial fund exclusion. For example, an individual has a $2700 burial contract which lists $900 for the casket and $400 for the gravesite. A total of $1300 may be excluded from resources under the burial space exclusion. The remaining $1400 will be applied to the $1500 burial fund exclusion.

b. Burial Funds and Other Burial Arrangements

Burial funds are defined as revocable or irrevocable burial contracts, burial trusts, other burial arrangements, cash accounts, or other financial instruments (documents which have a definite cash value) clearly designated for burial expenses. Property other than listed above will not be considered "burial funds."

The individual and his spouse can have an exclusion of $1500 each of funds specifically set aside for their burial arrangements. This exclusion is in addition to the burial space exclusion.

It is required that burial funds be kept in an account separate from other non-excluded funds. Burial funds and other funds may not be commingled in the same account.

Interest earned on excluded burial funds are excluded from income and resources, if left to accumulate and become a part of the burial fund.

If burial funds are commingled with other non-burial funds, all of the funds will be counted as a resource, and no exclusion of burial funds will be allowed. When an applicant agrees to (and does) separate his commingled funds, eligibility may begin effective the date of entry into a facility, provided the individual's total countable resources did not exceed $3500 ($2000 resources, $1500 cash for burial) on the first day of the month of entry and he is otherwise eligible.

If any excluded funds, or accumulated interest, set aside for burial expenses are used for a purpose other than the burial arrangements of the individual or his spouse for whom the funds were set aside, the amount used will be considered unearned income in the month in which it was accessed, and a resource (to the extent retained) in the following month.

The most common type of burial funds and burial arrangements are shown below, and must be considered in the order given in their application to the $1,500 burial exclusion.

1) Life Insurance Policies, other than those specifically designated for burial (See Item #3) - The total face value of all insurance policies on the life of an individual owned by the individual (or spouse) will reduce the $1500 burial exclusion if the cash surrender value of those policies was excluded in determining eligibility. If the total face value of policies considered here is $1500, no further exclusions are allowed.

NOTE: Life insurance policies with no cash surrender value will be totally disregarded as both resources and burial funds.

2) Irrevocable Contracts - Burial Association policies (membership through a funeral home) and some prepaid burial contracts (including those funded by deferred annuity and insurance policies) are considered irrevocable and are not treated as a resource, regardless of the value. Groups that issue prepaid burial contracts must have a permit to sell from the Arkansas Insurance Department, and the contract must be written on an approved Arkansas Insurance Department form. Irrevocable trusts that have been established by the applicant/client or representative which are payable only upon death to a specified funeral home for burial of the client shall not be considered an irrevocable contract under this section unless the funeral home designated under the arrangement is licensed by the Arkansas Insurance Department to sell prepaid burial contracts.

   All prepaid burial contracts, including those funded through annuities and life insurance policies which are irrevocably assigned to a funeral home, must include an itemized list of specified services and merchandise to be provided by the funeral home at the death of the individual. Each item on the list must show a value of the service or merchandise. The total value of the itemized services and merchandise must equal the cash payment made to purchase the arrangement. If a partial payment has been applied to the prepaid burial plan by attaching insurance or cash payments, the prepaid plan may be worth more than the annuity. Any amounts itemized as “miscellaneous” or other unspecified services will not qualify for exclusion. Such amounts will be included with the amount paid for unspecified services and merchandise, and the total will be subject to a transfer of resources penalty (see 5d below). The total amount paid for the plan through insurance, annuities or cash payments must not be greater than the cost of the prepaid funeral plan. If the value of the annuity or the total amount paid is greater than the cost of the prepaid funeral plan, the difference is an uncompensated transfer.

NOTE: If there is an uncompensated transfer, check the date of the funeral plan and annuity. If the date is outside the look back period, disregard the transfer.

The local funeral home may be able to advise the county if a contract is irrevocable, if the county cannot make this determination by reading the policy. Irrevocable contracts will be counted toward the $1500 burial exclusion.

If face values of insurance policies in Item (1) are less than $1500, then the value(s) of irrevocable contracts in Item (2) will be applied toward the $1500 exclusion. If a combination of insurance (with face value less than $1500) and irrevocable contracts equals $1500 or more, no further burial exclusions will be allowed, and any combined amount in excess of $1500 will be totally disregarded.

When the caseworker can determine a pre-paid burial annuity meets these conditions, the annuity does not need to be sent to the OPPD Medicaid Eligibility Unit for an opinion. However, if there are questions or issues that cannot be handled at the county level, submit the request to the OPPD Medicaid Eligibility Unit for an opinion.

3) Revocable Contracts

a) Some Prepaid Burial Contracts may be revocable and, if the $1500 burial exclusion limit has been reached by the preceding funds in Item #1 or #2, the value of the revocable contract will be treated as a resource. If the limit has not been reached, the value of the revocable contract will be used to reduce the $1500 exclusion, with any amount over $1500 considered a resource.

b) An insured burial contract is a burial arrangement covered by a life insurance policy. These policies are normally considered revocable. If the $1500 burial exclusion limit has been reached by the preceding funds, the total cash surrender value of the burial insurance policy will be treated as a resource. If the limit has not been reached, the cash surrender value will be used to reduce the $1500 exclusion, with any cash surrender value over $1500 considered a resource.

4) Cash, Checking, Savings Accounts, or Other Funds - If these funds are specifically designated as burial funds (by the client's written statement in case record), they may be used to reduce the $1500 burial exclusion. If the $1500 limit has been reached by funds in Items (1), (2), and (3), then the cash funds in Item (4) will be considered as a resource. If the limit has not been reached, then the cash funds may be used to reduce the $1500 exclusion, with any amount remaining to be treated as a resource. The cash surrender value of life insurance policies, if designated for burial, may also be used to reduce the $1500 exclusion.

5) Contracts or Policies Purchased/Owned by Others- Some contracts or policies are purchased and owned by individuals who are not the applicant/client, but they designate the applicant/client, as beneficiary. These contracts/policies are not considered a resource to the applicant/client; however

   Irrevocable contracts/policies owned by other individuals will count against the $1500 exclusion, but

   Revocable contracts/policies owned by other individuals will not count in the $1500 exclusion.

   The above rule does not apply when the purchaser/owner declares the contract/policy was purchased with the applicant/client funds.

   Ownership can usually be determined by reading the policy/ contract. If the buyer's name shown is not the applicant/client, then the policy/contract is owned by someone other than the applicant/client.

c. Out-of-State Burial Arrangements

   Some burial arrangements with out-of-state funeral homes may be excluded from resources. If it is verified that the arrangement is irrevocable, the value of the arrangement will not be countable. If questionable, submit a request for an opinion to the **Medicaid Eligibility Unit**. (Re. MS E-501)

d. Transfer of Resources Penalty Applicable to Irrevocable Burial Funds

   RULE FOR APPLICATIONS APPROVED 11/1/95 AND LATER

   Transfer of Funds to Funeral Homes - If the value of the merchandise and services itemized in a prepaid irrevocable funeral plan is equal to the payment made for the plan (or to the value of the life insurance or annuity irrevocably assigned to the funeral home as payment for the plan), it can be assumed that the individual has purchased a funeral for fair market value. If the value of the itemized merchandise and services is less than the payment, a period of ineligibility will be imposed for an uncompensated transfer. For example, if an individual pays $15,000 to a funeral director but the contract specifies only $5000 worth of merchandise and services, there is a $10,000 uncompensated transfer for which a period of ineligibility will be imposed.

Transfer of Funds to a Trust, Certificate of Deposit or Other Instrument Designated for Burial If an individual has a revocable trust, certificate of deposit or other instrument and the fund is designated only for burial, any amount over the $1500 burial fund limit is a countable resource. If the fund is irrevocable, the amount over $1500 is also a countable resource. (Re. MS H-304) If the trust, CD, etc., is irrevocably assigned to a funeral home, a penalty for transfer of resources will be applied unless there is an agreement with the funeral home (which must be licensed by the Arkansas Insurance Department to sell prepaid burial contracts) to provide specified services and merchandise equal in value to the fund.

6. Any SSI or SSA retroactive payments that were due for one (1) or more prior months will be excluded from countable resources for nine (9) months. This rule is applicable to an eligible individual, an ineligible spouse, and/or any other persons whose resources are subject to deeming. (Interest accruing to the lump sum funds is not excludable).

   Once the money is spent, the exclusion does not apply to countable resources that were purchased with the money, even if the 9 months have not expired.

7. Section 4735 of the Balanced Budget Act of 1997 (Public Law 105-33) states that payments made from any fund established as a result of a class settlement in the case of Susan Walker vs. Bayer Corporation are excluded from countable resources. This case involved hemophiliacs who contracted the HIV virus from contaminated blood products. Also excluded from countable resources are payments made pursuant to a release of all claims in a case that is entered into in lieu of the Walker vs. Bayer class settlement and that is signed by all affected parties on or before the later of December 31, 1997, or 270 days after the date on which the release is first sent to the persons to whom the payment is to be made.

   NOTE: Interest earned by these lump sum funds and allowed to accrue is not excluded from countable resources.

E-530 Treatment of Resource Changes

MS Manual 01/01/14

Treatment of Resource Changes:

1. Increase in Value of Existing Resource

   The increase in value of an existing resource (such as a value increase in stock) is not considered to be income when it occurs. Value increases in resources are included with resources the month following the increase.

2. Receipt of New Resource

   The receipt of a new resource such as a cash gift is considered to be income for the month of receipt and, if retained, as a resource in the month following receipt.

3. Conversion of Resource

   Conversion of a resource from one form to another (cash to property or vice versa, etc.) can affect resource eligibility in the month following the change. For example, the conversion of an excludable automobile to non-excludable resources by sale or trade could cause the countable resource limitation to be exceeded the month following the change.

4. Repair/Replacement of Lost, Damaged or Stolen Resources

   Cash or in-kind payments received from any source for repair or replacement of lost, damaged or stolen resources are not counted as income, and are not considered countable resources until the month after 9 full months from the date of receipt. Any interest that accrues to these funds is also excluded from income and resource consideration for the 9 month period. The cash payments and interest should be maintained separate from other liquid resources. Cash received for personal injury or other purposes is not excluded from income and resources.

   If the excluded cash is used to purchase a nonexcludable resource during the 9 month period, the resource will be evaluated according to the applicable resource rules.

   When circumstances prevent the repair/replacement of the resource during the 9 month exclusion, a reasonable extension not to exceed 9 additional months may be granted, provided:

   a. It can be documented that a reasonable effort to repair/replace was made (at least 2 providers should be contacted for documentation), and
   b. The individual still intends to repair/replace the resource.

Change of intent to repair/replace is irrelevant during the 9 month exclusion but, if during an extension of the exclusion the individual's intent to repair/replace is changed, the funds and all of the accrued interest will become fully countable as a resource on the first day of the month following the month of changed intent.

When the exclusion period (and extension, if applicable) has expired and the individual has not repaired/replaced the resource, the cash funds and interest will be a countable resource the first day of the month following the month of expiration.

If the payment has been in-kind support and maintenance (e.g., an individual has been furnished shelter because his home was destroyed by fire and the individual decides not to replace the home), the in-kind support will be considered income in the month following the end of the 9 month period or, if an extension was granted, in the month following the month of changed intent.

5. Proceeds of Loan

   Proceeds of a loan which is subject to repayment are not income to the individual; however, unused loan proceeds accrued into the month following their receipt become a countable resource.

6. Proceeds from Sale of Resource

   Proceeds from the sale of a resource are not income to the individual. Proceeds from the sale of a resource are countable for resource determination the month following their receipt if retained by the individual.

7. Reverse Mortgages & Home Equity Loans

   Any funds that the individual receives from the reverse mortgage or home equity loan are disregarded in the month received as proceeds from a loan. The funds received from a reverse mortgage or home equity loan are counted as a resource if retained after the month of receipt. (See MS E-518)

F-100 Non-Financial Eligibility Requirements

MS Manual 01/01/14

Non-financial eligibility requirements are those eligibility requirements not related to income or resources. The requirements in this section may or may not be an eligibility factor for all eligibility groups. The non-financial requirements include:

- Age and Relationship
- Blindness and Disability
- Child Support Cooperation
- Categorical Relatedness
- Medical Care Requirements

F-110 Age and Relationship

MS Manual 01/01/14

Most Medicaid eligibility groups have an age range in which the individual must fall in order to become eligible for coverage in that particular group. Some groups also require a relationship and living with a specified relative requirement. In these groups, a child must be living with a relative who is within the following degrees on relationship to the child:

1. A blood or adoptive relative who is within the fifth degree of kinship. Such relatives by degree of kinship are as follows:

   1st degree – Parent

   2nd degree – Grandparent, sibling

   3rd degree – Great-grandparent, uncle, aunt, nephew, niece

   4th degree – Great-great grandparent, great –uncle, great-aunt, first cousin

   5th degree – Great-great-great grandparent, great-great uncle, great-great aunt, first cousin once removed (i.e., the children of one's first cousin)

   NOTE: Half-relationships will be considered the same as full relationships.

2. Stepfather, stepmother, stepbrother, stepsister

3. Spouses of any persons named in the above groups. Such relatives may be considered within the scope of this provision though the marriage is terminated by death or divorce.

   Relationship and living with the specified relative apply, unless the individual has been removed from the custody of his or her parents or other relative by court order, has been court ordered to an institution, has been emancipated, has reached age 18 or legal custody has been given to someone else. (For ARKids, See MS C-115, E-240 for procedures on who can apply in these situations.)

The particular age and/or relationship requirements for each eligibility group are listed in MS Section B.

F-120 Blindness and Disability

MS Manual 01/01/14

Some eligibility groups require an individual to be either blind or have a disability. The particular blindness and disability requirement for each eligibility group is listed in Appendix J. Blindness is defined as having central visual acuity of 20/200 or less in the better eye (with correction) or a limited visual field of 20 degrees or less in the better eye. Disability is defined as having a physical or intellectual disability which prevents the individual from doing any substantial gainful work (for a child under age 18, the disability should be of comparable severity), and which meets the following criteria:

1. Has lasted or is expected to last for a continuous period of at least 12 months, or

2. Is expected to result in death.

Blindness and Disability must be established by one of the following means:

1. Receipt of SSI (AB or AD), or receipt of a letter of entitlement to SSI with begin date of entitlement, when the individual has not received the first SSI payment;

2. Receipt of Social Security based on disability, or receipt of a letter of entitlement to Social Security based on disability, showing a begin date of entitlement, when the individual has not received the first SSA payment;

3. Receipt (or anticipation) of SSI or Social Security Disability based on a disability benefit continuation, when an individual has requested continuation within 10 days of SSA determination that a physical or intellectual disability has ceased, has not existed, or is no longer disabling,

4. Nonreceipt of SSI cash benefits for reasons other than disability, but verification of an established disability that is current and continuing; e.g. TEFRA child; or

5. Receipt of the DCO-109, Report of Medical Review Team decision, when blindness or disability has been determined by the Medical Review Team.

The type of documentation used will be indexed in the recipient's electronic record.

Disability will either be established by Social Security Administration (SSA) or the Medical Review Team (MRT). The following disability guidelines will apply to all Medicaid applicants where disability is an eligibility factor and disability has not been determined. A disability decision made by SSA on a specific disability is controlling for that disability until the decision is changed by SSA. When DCO makes a disability determination, a later contrary SSA determination will supersede the state determination. If SSA has made a decision that a person is not disabled, that decision is binding on DCO for one year with exceptions noted in MS F-122.

F-121 Social Security Administration

MS Manual 01/01/14

Because SSA decisions are controlling, any new evidence or allegations relating to previous SSA determinations must be presented to SSA for reconsideration within 60 days of the SSA denial notice. If the decision has not been appealed within 60 days, the individual may still request a reopening of the decision within one year.

Therefore, the Agency must refer to SSA all applicants who allege new information or evidence which affects previous SSA determinations of "not disabled" for reconsideration or reopening of a determination, except in cases specified in MS F-122. When the conditions in MS F-122 are met, counties will be required to make an eligibility determination for Medicaid.

Counties may also refer to SSA, for SSI application, those individuals whose income and resources are below SSI limits, because it would be to their advantage to receive both cash assistance and Medicaid.

F-122 Medical Review Team (MRT)

MS Manual 01/01/14

When an individual applies for Medicaid and meets one or more of the conditions below, the DCO-106, Disability Worksheet; DCO-107, Confidential Report of Medical Examination of Patient; and/or DHS-4000, Authorization to Disclose Health Information and DCO-108, Medical Review Team Social Report, along with copies of the Social Security Disability or SSI denial letter (if applicable and available) will be submitted to MRT (Re. MS F-124), provided it appears that the other eligibility factors are met.

MRT will determine disability if any one of the following conditions exists:

1. The individual has NOT applied for Social Security Disability or SSI;
2. The individual has been found NOT eligible for Social Security Disability or SSI for reasons other than disability (e.g., income);
3. The individual has applied for Social Security Disability or SSI, and SSA has NOT made a determination;
4. The individual alleges a NEW disabling condition which is different from (or in addition to) the condition considered by SSA in its previous determinations;
5. More than 12 months have elapsed since the most recent Social Security Disability or SSI denial decision, and the individual alleges that the condition upon which SSA made the decision is worse or has changed, and he or she has not reapplied; or
6. Less than 12 months have elapsed since the most recent Social Security Disability or SSI denial, and the individual alleges that the condition upon which SSA made the decision has changed or deteriorated, AND;
    a. He or she has asked SSA for a reconsideration or reopening of its previous determination and SSA has refused to consider the new allegations,

       OR

    b. The individual no longer meets the non-disability Social Security Disability or SSI requirements (e.g., income).

Applicants who do not meet a criterion specified above will be denied without further development. The DCO-106 will be used to document the applicant's statements/allegations regarding his disability status.

F-123 Dual Applications

MS Manual 01/01/14

When an individual applies for both Medicaid and Social Security Disability or SSI, and the application with SSA is still pending, the county should initiate an MRT determination of disability if the individual appears to meet all other eligibility requirements. The agency will have 90 days from the date of the Medicaid application to make this determination. While an MRT decision is pending, the caseworker should check the Social Security Disability or SSI status of the applicant 30 days after the Medicaid application has been made, and again at certification, if found eligible by MRT. If MRT finds that the individual meets the disability requirements and SSA has not yet made a decision, the caseworker may approve the case for Medicaid. To verify that no SSA decision has been made, SOLQ screens will be checked, if appropriate, and the individual or authorized representative will be contacted by mail or telephone prior to approval.

Additional case action is indicated as follows:

If application for Social Security Disability is approved first:

- Notify MRT
- Approve Medicaid application (if all other requirements have been met).

If application for SSI is approved first:

- Notify MRT
- Deny Medicaid application, except for LTC, which may be approved for facility payment on WNHU (if all other requirements have been met).

If SSA determines the applicant is NOT disabled:

- Notify MRT
- Deny Medicaid application.

If the caseworker approves a case based on an MRT disability decision and later learns the individual has been denied by SSA, the Medicaid case will be closed after appropriate notice, unless the recipient appeals the closure. If the appeal is made within the 10-day time frame, the Medicaid case will remain open pending the outcome of the DHS appeals process. In no case will the Medicaid case remain open pending the outcome of the SSA appeals process if the recipient has appealed the SSA decision.

If an approved Medicaid recipient is approved for SSI, the system will automatically convert the Medicaid case to an SSI category and no further action will be required of DCO except to notify MRT that no future reexamination is required, if appropriate.

If the caseworker denies an application based on a MRT decision and later learns that SSA has approved the disability, the original application will be re-registered regardless of the time frame as Medicaid claims will be paid if the provider files claims timely, refer to MS A-190. Process the application with the original application date provided all other eligibility criteria were met for this time period.

F-124 Procedures for Verification of Blindness and Disability by MRT

MS Manual 01/01/14

The following procedures will be followed for verification of blindness or disability through the Medical Review Team:

1. For Blindness:
    a. The caseworker will give the applicant or his representative a DCO-701, Report on Eye Examination, for completion by the ophthalmologist or optometrist who is to conduct the eye examination. In addition, a Business Reply Mail envelope will be provided for return of the DCO-701 after completion.
    b. Upon receipt of the completed DCO-701, the caseworker will check it to assure that all items of identifying information are completed. If necessary, the caseworker will complete the name, address, race, sex, and date of birth blanks on the form before forwarding to MRT. In addition to checking the DCO-701 for completeness, the caseworker will complete the DCO-108 and attach it to the DCO-701 and forward it to MRT. A notation of the date that the forms are forwarded to MRT will be made in the electronic record.
2. For Disability:
    a. Determine if the individual is engaged in a substantial gainful activity (SGA), following the guidelines at MS F-128.

       If the individual is found to be engaged in SGA, deny the application, using action reason “denied due to employment”. Do not send the application to MRT.
    b. If the applicant has been a patient in a private or state hospital, a VA hospital, or the University of Arkansas for Medical Sciences within the past year (the past five years for the Arkansas State Hospital), complete form DHS-4000. The

Medical Review Team will request medical information from these institutions. A separate form DHS-4000 must be completed for each institution.

c. If the applicant has not been hospitalized within the past year and does not regularly see a physician, form DCO-107 must be completed. If the applicant has been hospitalized within the past year, form DCO-107 may also be completed if the applicant chooses to supply medical information in addition to that which can be obtained from the institution by form DHS-4000. If an applicant goes to a physician regularly, in lieu of another physical examination, form DHS-4000 may be used to obtain copies of the records from the physician (no DCO-107 needed).

   The caseworker will complete Part 1 of Form DCO-107 when the form is needed. The applicant must sign and date the form in Part 2. The form will then be given to the applicant to take to the medical practitioner of his or her choice. A business reply mail envelope will be provided with the DCO-107. The medical practitioner will complete Part 3 of the form and return the form to the county office.

   If an applicant states he or she does not have the funds for payment of a physician's examination, the applicant should be informed that MRT can arrange and pay for an examination. If the applicant wishes MRT to do this, the caseworker should report this on the DCO-108.

d. Complete Forms DCO-106 and DCO-108. These must be completed for all cases submitted to the Medical Review Team.

e. Submit the following completed items to the Medical Review Team:

   i. DCO-108,
   ii. DCO-106,
   iii. DCO-107,
   iv. DCO-4000, and
   v. Any other medical information which the applicant wishes to provide or which is available in the individual's electronic record.

F-125 MRT Decision

MS Manual 01/01/14

The Medical Review Team (MRT) will report the decision regarding physical or mental incapacity to the county office on Form DCO-109.

If MRT finds that the medical information is not adequate to make a decision, further medical/psychiatric/psychological examinations may be recommended by MRT at the expense of the Agency.

Arrangements for such evaluations will be made by MRT only. When medical and social evidence has been resubmitted on questioned cases, the Medical Review Team will make a decision as to disability and notify the county office on Form DCO-109. This decision of MRT will be final, subject to the regular appeal process, unless a later decision by SSA finds the individual not disabled.

F-126 Reapplication that Requires a Disability Determination

MS Manual 01/01/14

If a reapplication is filed and the case has been closed within the past five years for reasons other than disability and the last DCO-109 stated, "Reexamination not necessary" or the date for reexamination has not yet been reached; new medical and social information will not be submitted to MRT. If the case has been closed for more than five years, new medical and social information must be submitted. In all cases of reapplication, a DCO-106 will be completed to determine the applicant's SSA disability status.

F-127 MRT-Reexamination of Disability

MS Manual 01/01/14

Reexamination of disability will be required by MRT when:

1. Medical and social information indicates that an individual may recover in a year or more and/or be rehabilitated to the point where he could meet substantial gainful employment.
2. The county office requests reexamination at any time for the aforementioned reasons.
3. Reexamination is indicated on the DCO-109.

It is the responsibility of the county office to initiate the re-exam by submitting current medical and social information (DCO-106, DCO-108A, and DCO-107 and/or DHS-4000) to MRT. The caseworker will contact the individual in a timely manner that will allow all necessary medical and social information to reach MRT by the first of the month of reexamination. When the reexamination decision is not received in the county office by the end of the month in which the reexamination was required, the case will remain open pending receipt of the MRT decision.

F-128 Substantial Gainful Activity (SGA)

MS Manual 01/01/14

Substantial gainful activity (SGA) is defined as the performance of significant physical and/or mental work activities for pay or profit, or work activities generally performed for pay or profit.

Countable monthly earnings are obtained by deducting any employer subsidy and any impairment related work expense (not payroll deductions) from the gross income (gross income includes payment in-kind for the performance of work in lieu of cash). Then, if earnings are irregular, they will be averaged over the period of months being considered to obtain countable monthly earnings.

Employer subsidy is the payment of wages that is more than the value of the actual services performed.

If the work is sheltered or if there is marked discrepancy between the amount of pay and the value of services, there exists the strong possibility of a subsidy that requires development of specific evidence.

Sheltered Employment is work performed by individuals with disabilities in a protected environment under an institutional program; nonsheltered employment is any work performed by individuals in an unprotected environment.

Impairment Related Work Expenses are items or services needed in order to maintain employment, such as attendant services, prostheses, or other devices. Drugs and medical services are not deductible unless it can be shown they are necessary to control the disability to enable the individual to work. Deductible expenses must be paid for by the individual, and cannot be reimbursable from any source. Legitimate expenses may include installation, repair, or maintenance. The payments may be deducted in one month or prorated over 12 months.

The expenses must be considered “reasonable,” i.e., not more than Medicare would allow or than would ordinarily be charged in the individual’s community.

The following SGA Earnings Guidelines provide the basis for evaluating whether an individual is engaged in SGA:

1. Countable Earnings of Less Than $300 Per Month - When average countable monthly earnings are less than $300 per month, an assumption may be made that the work is not SGA. This assumption may be made for both sheltered and nonsheltered

employment; specific evidence does not need to be developed for either sheltered or nonsheltered employment.

2. Countable Earnings of $300 to $1040 Per Month - When average countable monthly earnings from nonsheltered employment fall within the $300 to $1040 per month range, an assumption may be made that the work is not SGA unless:

   a. The work is comparable to that of unimpaired individuals engaged in similar occupations as their means of livelihood; or

   b. The work, although significantly less than that done by unimpaired individuals, is reasonably worth over $1040 per month according to pay scales in the community.

   When "a." or "b." occurs in a nonsheltered employment situation (or if gross earnings include a subsidy), current medical and social information will be submitted to MRT.

   When average countable monthly earnings from sheltered employment fall within the $300 to $1040 per month range, the work is not ordinarily SGA. However, if earnings include a subsidy, current medical and social information will be submitted to MRT.

3. Countable Earnings of More Than $1040 Per Month - When average countable monthly earnings are more than $1040 per month, an assumption may be made that the work is SGA unless impairment causes the individual to quit work or reduce employment within a short time (6 months or less) under circumstances that would justify the employment being termed an unsuccessful work attempt. Specific evidence must be developed for both sheltered and nonsheltered employment.

   When there is no subsidy involved in gross pay and when there is no marked discrepancy between the amount of pay and the value of the services, an assumption will be made that pay from employment is fully earned. Action will be taken to deny the application or close the case as the individual does not meet the criteria for disability (Re. MS F-120). Advance notice will be given on the DCO-700.

NOTE: If an applicant with a disability reports earnings of more than $1040 per month, the caseworker may deny the application due to employment without making a referral to MRT unless application is for Workers with Disabilities. If an applicant who is blind reports earnings of more than $1740 per month, the caseworker may deny the application due to employment without making a referral to MRT.

F-130 Child Support Enforcement Services

MS Manual 01/01/14

The Office of Child Support Enforcement (OCSE) is mandated to provide services to all Medicaid-only persons/families who have assigned to the State their rights to medical support. Each applicant or recipient must cooperate with OCSE in establishing legal paternity and obtaining medical support for each child who has a parent absent from the home. (See exception below.)

OCSE must provide all appropriate services to Medicaid-only applicants/recipients without the OCSE application or fee. The OCSE agency is required to petition for medical support when health insurance is available to the absent parent at a reasonable cost. OCSE will also collect child support payments from the absent parent unless OCSE is notified by the recipient in writing that this service is not needed. Child support payments collected on behalf of Medicaid-only families are received and distributed to the custodial parent through the Central Office Child Support Clearinghouse. However, no recovery cost will be collected.

1. Referrals

   An OCSE referral will be made at initial approval for children when a parent is receiving Medicaid or when the parent voluntarily request a referral to be made. Refer to Exception and Note below.

   Act 1091 of 1995 amended by Act 1296 of 1997 requires that both parents sign an affidavit acknowledging paternity or obtain a court order before the father's name will be added to the birth certificate.

NOTE: If the father's name is included on the birth certificate of a child born 4/10/95 or later, paternity has already been established. As paternity establishment is the only service the Office of Child Support Enforcement can offer to a family when both parents are in the home, there is no need to make a referral in these instances.

EXCEPTION: Individuals in the Limited Medicaid Pregnant Woman eligibility group will not be required to cooperate with the OCSE on Medicaid certified children until after their postpartum period has ended.

NOTE: For ARKids cases, cooperation with OCSE is voluntary. The only time referral to OCSE is necessary is when a parent is eligible in another Medicaid eligibility group in which cooperation with OCSE is mandatory in that group. When a parent is not receiving Medicaid or is in an exempt category (i.e., Limited Medicaid Pregnant Woman), cooperation with OCSE will be strictly voluntary.

A parent is considered to be absent for Medicaid purposes when the absence is due to divorce, separation, incarceration, institutionalization, participation in a Rehabilitation Service Program away from home or military service, regardless of support, maintenance, physical care, guidance or frequency of contact.

When a referral for Newborn Coverage is received by the county, the caseworker will determine if there is an absent parent and obtain enough information to complete the referral in the system. Approval of the newborn in the 20-day period allowed for approval will not be delayed due to lack of absent parent information or due to non-cooperation by the newborn's mother.

If a child is removed from the custody of his or her parent(s) by court order {fault is assigned to the parent(s) due to abuse or neglect}, refer the parent(s) to the Office of Child Support Enforcement (OCSE). If the child is voluntarily placed in the facility (even if later a court order is established for the state to assume custody), or removed by court order with no fault assigned to parent(s) {e.g., the child is abusive}, only refer a parent if they were absent from the home at the time of placement. Custodial parents {parents present in the home at the time of placement} will only be referred to OCSE if the child was court ordered and the court assigns fault to the parent(s).

Absent parents of all foster children will be referred to OCSE by the Division of Children and Family Services worker.

2. <u>Guidelines</u>

The caseworker will explain the Assignment of Medical Support found on the Medicaid application and will explain the OCSE requirements if an in office interview is conducted.

The Absent Parent Information will be added to the system for each Medicaid eligible child who has an absent parent or when legal paternity must be established. Upon receipt of the referral, OCSE will initiate steps to contact the custodial and noncustodial parents.

A DCO-90, Notice Concerning Good Cause for Refusal to Cooperate, will also be completed at each in office application interview. If Good Cause is claimed, the system will be updated.

When Medicaid eligibility has ended, OCSE will notify the custodial parent that support services will continue. The custodial parent must advise OCSE in writing if they do not want these services to continue.

3. Refusal to Cooperate-Sanction

The County Office will be notified via an electronic interface when an individual fails to cooperate with the OCSE in establishing paternity and medical support. A task is assigned in the system for the caseworker to review and apply the sanction, if appropriate. A 10-day notice is not required. An adequate notice will be sent. If the custodial parent goes into the OCSE office after the sanction has been applied with all the information requested, OCSE will send a form FIN-39, Notice of Cooperation, to the county office requesting to lift the sanction. Cooperation in establishing child support payments is not a requirement for Medicaid-only cases.

For Medicaid, a child's benefits cannot be denied or terminated due to the refusal of a parent or another legally responsible person to assign rights or cooperate with OCSE in establishing paternity or obtaining medical support.

The needs of an adult relative who refuses to cooperate with OCSE will continue to be included in the need standard along with the child, but Medicaid for this individual will end after the appropriate notice period has expired. The status of the individual will be Active and the Medicaid coverage would have an end date. It is not necessary to obtain a protective payee for the child when the adult relative has refused to cooperate.

As the needs of an adult relative are never included in the need standard with an eligible child in Aid to the Blind or Disabled Medicaid categories, the failure of an adult relative to cooperate with OCSE will have no effect on the child's Medicaid eligibility.

F-140 Medical Care Requirements

MS Manual 01/01/14

For facility care, the individual must meet the categorical eligibility and medical necessity requirements. Refer to MS F-150 and F-151.

For Home and Community Based Waivers, TEFRA, Autism, DDS and PACE, the individual must meet the medical necessity, appropriateness of care and cost effectiveness requirements. Refer to MS F-151, MS F-152 and MS F-153.

F-150 Establishing Categorical Eligibility

MS Manual 01/01/14

Current recipients of SSI and Foster Children, for whom the Agency has legal responsibility, automatically meet the categorical eligibility requirement.

However, if, during the processing of an LTC application, any question regarding the categorical eligibility of these individuals should arise, the question will be resolved with either Agency or SSA personnel before proceeding further with the application. The question and resolution should be documented in the electronic record.

If the eligibility of an SSI recipient is questionable, a statement will be obtained from SSA (preferably written) to document its awareness and treatment of the eligibility factor. If there appears to be a policy conflict between DCO and SSA, the DCO Medicaid Eligibility Unit (MEU) will be contacted by email to clear the discrepancy. Refer to Manual Transmittals for email addresses for the MEU.

Categorical eligibility for individuals other than SSI or Foster Children will be determined according to SSI-related AABD facility eligibility criteria as follows:

1. Institutional Status - It must be verified that the individual has been institutionalized for 30 consecutive calendar days (an exception to the 30 days is made when death occurs prior to 30 days). Refer to MS F-152. The period of 30 days is defined as being from 12:01 a.m. of the day of admission to 12:00 midnight of the 30th day following admission.

EXAMPLE: An individual enters a facility anytime on July 18th. The 30 day count begins at 12:01 a.m. of the morning of July 18th, and ends at midnight of August 16th. Hospitalization will count toward meeting the institutional status requirement if the individual enters a facility on the date of discharge from the hospital. This includes hospitalization at Arkansas State Hospital in Little Rock. It also applies to individuals who enter an Arkansas institution directly from an out-of-state institution.

2. Categorical Relatedness - In order to meet the requirement of categorical relatedness, the individual must meet one of the following:

   Aged - Age 65 or older (Re. MS F-110 and MS G-160); or

Blind - Central visual acuity of 20/200 or less in the better eye (with correction) or a limited visual field of 20 degrees or less in the better eye (Re. MS F-120); or

Disabled - Physical or mental impairment which prevents the individual from doing any substantial gainful work (for a child under age 18, an impairment of comparable severity), and which meets the following criteria:

- Has lasted or is expected to last for a continuous period of at least 12 months, or
- Is expected to result in death (Re. MS F-120 and MS F-124).

F-151 Medical Necessity

MS Manual 01/01/14

Before nursing facility, waiver services or PACE can be authorized, it must be determined that the patient's condition warrants facility care or waiver services. Medical necessity decisions are made based on the information submitted on the DCO-703. The decision will be reported to the County Office on the DCO-704.

Medical necessity decisions for:

- Nursing facility applicants and recipients are made by the Office of Long Term Care (OLTC);
- Home and Community Based waiver and PACE applicants and recipients are made by the Division of Aging and Adult Services (DAAS);
- DDS applicants and recipients are made by the Division of Developmental Disabilities Services;
- TEFRA applicants and recipients are made by the TEFRA Committee, and
- Autism applicants and recipients are made by OLTC, Utilization Review.

Applicants for nursing facility admission with indicators or diagnoses of mental retardation or mental illness must be evaluated under Pre-Admission Screening and Annual Resident Review (PASARR) requirements for determination of appropriate placement prior to entering a nursing facility. Persons requiring pre-admission evaluations for mental retardation or mental illness shall not be eligible for Medicaid reimbursement of nursing facility services prior to the date that a determination is made (the PASARR effective date on the DCO-704), unless emergency admission has been prior authorized by the Office of Long Term Care PASARR Coordinator or Utilization Control Committee.

ICF/MR applicants are exempt from PASARR evaluation, but they are not eligible for services prior to the decision date on the DCO-704.

F-152 DCO Institutional Status

MS Manual 01/01/14

Evidence of institutional status includes any written document, record, etc. from a hospital and/or nursing facility which verifies that the individual was in the hospital and/or nursing facility for 30 consecutive calendar days (Re. MS F-150).

When an individual cannot meet the institutional status requirement, the application will be denied, unless the individual dies before meeting the 30 day requirement. In that case, certification may be made for the actual days spent in the facility.

When an individual has met the institutional status requirement of 30 consecutive days, eligibility for facility services will be effective the date of entry into the facility if all other eligibility requirements are met, unless the individual is in an ICF/MR or was subject to PASARR (Re. MS H-440).

NOTE: The institutional status requirement does not apply to individuals who were certified for SSI, U-18, or Foster Care (Cat. 91 or 92) in the month of facility entry.

Individuals who become ineligible for SSI, U-18, or Foster Care (Cat. 91 or 92) following the month of LTCF entry, will have their categorical eligibility determined according to SSI-related AABD facility eligibility criteria, with the exception of the institutional status requirement. Refer to MS F-150.

F-153 Appropriateness of Care

MS Manual 01/01/14

For waiver services (HCBW, DDS, TEFRA and Autism) and PACE, the necessary medical services must be available to provide care to the individual in the home and it must be appropriate to provide such care outside an institution.

F-154 Cost Effectiveness

MS Manual 01/01/14

The average cost of services provided to individuals in the community must be less than the cost of services for those individuals if they were in an institution.

For AAPD, ElderChoices, PACE and Assisted Living, this determination will be made by DAAS. If at any time DAAS determines that cost effectiveness is not met, the caseworker will be notified by DHS-3330 and the case will be closed after the appropriate notice is sent to the individual.

For TEFRA, the TEFRA Committee is responsible for monitoring cost effectiveness. When it is determined that the cost of home care exceeds the cost of institutional care, the TEFRA Committee will notify the caseworker of the change and the case will be closed after appropriate notice is sent to the individual.

For DDS, the Division of Developmental Disabilities Services is responsible for monitoring cost effectiveness.

For Autism, the Division of Medical Services is responsible for monitoring cost effectiveness.

F-155 Medical Criteria

MS Manual 01/01/14

Individuals requiring services in AAPD, ElderChoices or ALF must be classified as requiring an Intermediate (I-A, II-B, III-C) Level of Care as determined by the Office of Long Term Care (OLTC). Individuals classified as Skilled Care patients are not eligible for AAPD, ElderChoices or ALF.

Individuals requiring services in a nursing facility or PACE must be classified as requiring a Skilled, Intermediate I-A, Intermediate II-B or Intermediate III- C Level of Care as determined by the Office of Long Term Care.

No individual who is otherwise eligible for Waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition or disqualifying episodic change of medical condition which is temporary and expected to last no more than twenty-one (21) days. However, that individual shall not receive Waiver services or benefits when subject to a condition or change of condition which would render the individual ineligible if expected to last more than twenty-one (21) days.

If an individual has a serious mental illness or has mental retardation, the individual will not be eligible. However, the diagnosis of severe mental illness or mental retardation will not bar eligibility for individuals having medical needs unrelated to the diagnosis of serious mental illness or mental retardation and meeting all other eligibility criteria.

Individuals requiring services in DDS must be classified as requiring an ICF/MR level of care.

AAPD, ElderChoices, Assisted Living and PACE

To be determined an individual with a functional disability; an individual must meet at least one of the following three criteria, as determined by a licensed medical professional:

1. The individual is unable to perform either of the following:

    a. At least one (1) of the three (3) activities of daily living (ADL) of transferring/locomotion, eating or toileting without extensive assistance from or total dependence upon another person;

    b. At least two (2) of the three (3) activities of daily living (ADL) of transferring/locomotion, eating or toileting without limited assistance from another person; or

2. Medical assessment results in a score of three or more on Cognitive Performance Scale; or

3. Medical assessment results in Changes in Health, End–Stage Disease and Symptoms and Signs (CHESS) score of three or more.

DDS

To be determined an individual with a developmental disability, DDS will administer a comprehensive Diagnosis and Evaluation.

DDS determines ICF/MR eligibility on a schedule according to the individual's age:

1. For individuals aged 0-5, both IQ and Adaptive Functioning Level will be tested every year;
2. For minors age 5-21 or 18 years with certificate of high school completion, current IQ and adaptive functioning will be tested within 3 years of the date of referral; and
3. For adults age 22 and older, the IQ score obtained at age 22 years or over and an adaptive behavior assessment current within 5 years from date of referral will be used.

DDS will develop an individualized plan of care which will be reviewed within six (6) months of the initial assessment and, again, prior to 12 months from admission to the program. Thereafter, DDS Plan of Care reviews will be completed annually.

F-160 Primary Care Physician Requirements

MS Manual 01/01/14

A Medicaid case can be approved before a Primary Care Physician (PCP) is selected; however, the PCP must be selected before most services can be accessed.

F-161 Primary Care Physician Managed Care Program

MS Manual 01/01/14

ConnectCare is the Arkansas Medicaid Primary Care Case Management (PCCM) system. In ConnectCare, a Medicaid recipient chooses a physician or single-entity provider, such as Area Health Education Centers (AHEC), Federally Qualified Health Centers (FQHC), or family practice and internal medicine clinics at the University of Arkansas Medical Sciences campus, who is responsible for the management of the recipient's total care.

Each Medicaid recipient must choose a primary care physician (PCP) except those who:

- Have Medicare as their primary insurance,
- Receive services from DDS Children's Services ,
- Are in nursing or ICF/MR facilities,
- Are Medically Needy Spend Down only,
- Have retroactive eligibility only, or
- Are temporarily absent from the state.

Generally, a recipient must receive medical services from only the PCP or from the medical provider referred to by the PCP. There are some services which are excluded from the Primary Care Case Management (PCCM) system. A recipient can receive these services without a referral from the PCP. Refer to Form DCO-2613, Notice to Medicaid Applicants/Recipients, for a list of these excluded services.

F-162 Recipient Responsibilities

MS Manual 01/01/14

A PCP must be chosen for each family member who is a recipient. Each member may have a different physician.

The Medicaid recipient can choose a PCP:

- By calling the ConnectCare help line at 1-800-275-1131 (TDD: 1-800-285-1131),
- By visiting the website at www.seeyourdoc.org,
- At the doctor's office, or
- At the local DHS County Office.

The recipient must choose a physician who provides services in the recipient's county of residence, in a county which adjoins the county of residence, or in a county which adjoins the adjoining county. A recipient who lives in a county which borders another state may choose a physician in the bordering state.

If a recipient chooses to see a health care provider other than the primary care physician, or other than a provider to whom the primary care physician has made a referral, the recipient will be responsible for payment for any services received.

F-163 County Office Responsibilities

MS Manual 01/01/14

The caseworker will provide and review Form DCO-2613, Notice to Medicaid Applicants/Beneficiaries, with the applicant if in the office. If requested by the applicant, the caseworker will assist in completing Form DMS-2609 or DCO-2609-County, Primary Care Physician Selection and Change Form, for each non-excluded family member. First, second, and third choice of physicians should be listed for each family member.

When a PCP is selected by the individual, the caseworker uses the web-based program at http://207.169.228.130/ or a telephonic voice response system at 1-800-80-1512 to enroll the individual. If the individual's first choice has a full caseload, the worker will try the second choice and if necessary, the third choice. If all physicians selected by the individual have a full caseload, a notice will be mailed to the individual to select three more physicians. A new 2609 must be completed.

NOTE: Counties may use either Form DMS-2609 or DCO-2609-County. However, if an individual requests a form for enrollment at a physician's office, a DMS-2609 will be provided. The DCO-2609-County is for county use only.

Form 2609 will be scanned into the electronic record and the original will be mailed or given to the individual, if requested.

Each County Office will maintain a current listing of all participating physicians in the geographical area. All individuals will be given access to the listing when making physician selections. Counties will receive updates to the listings on a monthly basis.

F-164 Changes in Primary Care Physicians

MS Manual 01/01/14

A change in a recipient's primary care physician can be made in the following circumstances:

1. A physician moves from the county, closes his office, or withdraws from the program.
2. A recipient moves from the county.
3. A recipient finds his relationship with the physician unacceptable. If there is an allegation of substandard care, the recipient may report it to the Utilization Review Section, Division of Medical Services (**501-682-8340**). In this situation, no change in physician will be made until the County Office is authorized to do so by the Utilization Review Section.
4. A physician finds his relationship with the recipient unacceptable; the recipient is abusive to the physician; or the recipient fails to comply with medical instructions.

A recipient, including a SSI recipient, can change his/her primary care physician by:

- Calling the ConnectCare help line at 1-800-275-1131, (TDD:1-800-285-1131),
- Visiting the website at www.seeyourdoc.org, or
- Contacting the local DHS County Office.

F-170 TEFRA Premium

MS Manual 01/01/14

TEFRA households with annual income after allowable expenses above 150% of the Federal Poverty Level for their household size will be required to pay monthly premiums as described in the sections below.

F-171 Determining Monthly Premiums

MS Manual 01/01/14

The amount of the premium will be determined based on the custodial parent(s) total gross income as reported on the applicable Federal Income Tax Return (e.g., line 22 of the 2011 version of form 1040 or line 15 of the 1040A) less the following deductions:

- Six hundred dollars ($600) per child, biological or adopted including the waiver child, who lives in the home of the waiver child and is listed as a dependent child on the applicable Federal Income Tax Return of the parents.

- Excess medical and dental expenses as itemized on Schedule A of the Federal Income Tax Return of the parents. (e.g., line 4 on the 2011 version of Schedule A).

EXAMPLE 1: Family consists of 5 people-mom, dad, waiver child, and 2 minor siblings, living in the home. Total income on last year's Federal Income Tax Return showed $65,417.48. Excess medical and dental on Schedule A showed $9,463.25. All children in the home were included on the return.

- $65,417.48-$1,800.00 ($600x3)-$9,463.25=$54,154.23

Compare the adjusted income to Chart 1 in Appendix P. The income is above the limit. Go to Chart 2. The premium range for the adjusted income is from $52.00 to $78.00.

EXAMPLE 2: Same family with less income reported.

- $46,500.00-$1,800.00 ($600.00x3)-$9,463.25=$38,336.75

Comparing income in Chart 1 in Appendix P, the annual income is below $40,515. Therefore, no premium is required.

If the custodial parent alleges that household income has decreased significantly since filing the Federal Income Tax Return, additional verification can be submitted to determine current income.

NOTE: A stepparent living in the home will be considered a custodial parent and his or her income will be included when determining the premium amount.

See Appendix P for the amount of premiums to be paid. The maximum annual premium amount to be paid by any family is $5,500. Families having more than one child receiving TEFRA Waiver benefits will pay only one premium for all covered children. There will be no increase in premium amount for additional Waiver children.

The caseworker will key the income and household size along with the names of the TEFRA children living in the home to the TEFRA Web application found on the toolbar in ANSWER. The system will figure the premium amount due for the household.

F-172 Adjustment of Premiums

MS Manual 01/01/14

Premiums will begin in the month after eligibility is approved. The premium will be charged on a monthly basis and will not be pro-rated. Income will be reviewed annually for calculation of the premium, when there is a change that will make a difference of more than 10% in annual household income or a change in the number of family members. An adjustment can be made to the premium during the year if a significant change is reported in excess of 10% of the expected annual income or if there is a change in the household size. Verification of the income change must be provided. Income that fluctuates due to seasonal employment will not affect the monthly premium. The premium can only be adjusted a maximum of once every six months.

F-173 Payment of Premiums

MS Manual 01/01/14

Payments must be made through monthly bank drafts or quarterly payments in advance. For new recipients, premiums will be applied beginning with the month after the month of approval.

The TEFRA Premium Unit will collect the TEFRA Medicaid premium payments and send the premium invoices to TEFRA households. When a TEFRA case is approved, the TEFRA Premium Unit will send a TEFRA Premium Payment Selection Form to the recipient giving the option of authorizing an automatic bank draft or making quarterly payments in advance. Regardless of payment choice, everyone will be required to pay for the first two months' premiums by check. The check must be sent in with the Payment Selection Form. The draft or quarterly payment will begin with the third month after the month of approval.

For those individuals who choose to pay through monthly bank drafts, the TEFRA Premium Unit will draft the account for the third month after approval and the following months. Each draft will be made on the first day of the covered month. The TEFRA Premium Unit will send monthly invoices that the bank account has been drafted.

For those who choose quarterly payments, the individual must initially pay for the month after the month of approval and the following month in advance by check, after which the TEFRA Premium Unit will send monthly invoices requesting premium payment in the month prior to the covered quarter.

If eligibility ends during the quarter, any premiums already paid for months after the month of closure will be reimbursed. Whether paying by monthly bank drafts or through quarterly payments, if eligibility ends in the middle of the month in which payment has been made, the premium will be prorated and the family will be reimbursed for the partial month.

Failure to provide the Payment Selection Form or make the two month initial payment will cause the child to be ineligible, and the case will be closed after proper advance notice. For ongoing cases, if the premium is not paid for three months, advance notice will be sent and the case will be closed. The TEFRA Premium Unit will notify the county office if the Payment Selection Form is not received.

Monthly aged reports will be sent to each county showing the cases with overdue premiums and the number of monthly payments in arrears. The caseworker will send a 10-day advance notice to each case showing three months of non-payment, advising that the case will be closed if payment is not made. At the end of the notice period, if payment of the premiums has not been made, the case will be closed. (Refer to C-231 for re-application when TEFRA case is closed due to non-payment of premiums.)

F-180 Other Health Insurance Coverage

MS Manual 01/01/14

For most eligibility groups, an individual may be covered by other health insurance without affecting his or her eligibility for Medicaid. There are two exceptions to this which are described below.

Health Care Independence Program

An individual who is eligible for or enrolled in Medicare is not eligible for the Health Care Independence Program.

ARKids B

Children who have health insurance or who have been covered by health insurance other than Medicaid in the 3 months preceding the date of application will not be eligible for ARKids B unless one of the following conditions is met:

a. The health insurance is a non-group or non-employer sponsored plan.
b. The health insurance was lost through termination of employment for any reason.
c. The health insurance was lost through no fault of the applicant. For example, health insurance is lost through no fault of the applicant if the employer ceases to provide employer-sponsored health insurance.

d. The health insurance is/was not primary comprehensive. Primary comprehensive health insurance is defined as insurance that covers both physician and hospital charges.

e. Health insurance coverage is available to a child through a person other than the child's custodial adult and is determined to be inaccessible (e.g., the absent parent lives out of state and covers the child on his or her HMO, which the child cannot access due to distance). This determination will be made on a case-by-case basis by the caseworker based on information provided by the applicant.

If a parent or guardian voluntarily terminates insurance within the 3 months preceding application for a reason other than those listed above, the children will **not** be eligible for ARKids B.

The applicant's declaration regarding the child's health insurance coverage will be accepted.

This is a special requirement for ARKids B <u>only</u> and does not apply to ARKids A or other Medicaid categories.

F-190 Medicare Entitlement Requirements for MSP Eligibility Groups

MS Manual 01/01/14

Medicare entitlement is an eligibility requirement for all Medicare Savings Programs (except ARSeniors), even though the requirement differs somewhat between the five groups. Medicare entitlement means that the individual has applied for, is eligible for, and is enrolled in Medicare Part A. Conditionally eligible means that an individual can be enrolled (entitled) for Part A Medicare only on the condition that he/she is eligible for QMB, and thus eligible for the state Medicaid agency to pay the Part A premium as part of the QMB benefits. The Medicare entitlements requirement is as follows:

- ARSeniors-Individuals do not have to be entitled to Medicare (e.g., Qualified Aliens who have not worked enough quarters to Qualify for Medicare can still be eligible for ARSeniors). However, individuals who are entitled to Medicare and choose not to enroll in Medicare are not eligible for the ARSeniors program.
- QMB-Individuals must be entitled to or conditionally eligible for Medicare Part A.
- SMB-Individuals must be entitled to Medicare Part A.
- QI-1- Individuals must be entitled to Medicare Part A.

- QDWI-Individuals who lost Medicare Part A & SSA-DIB benefits due to SGA. The individual must be eligible to reenroll in Medicare Part A (Re MS F-192).

F-191 Medicare Part A Entitlement

MS Manual 01/01/14

Medicare Part A beneficiaries include the following groups:

1. Persons age 65 or older who are:
    a. Entitled to monthly Social Security benefits on the basis of covered work under the Social Security Act; or qualified Railroad Retirement beneficiaries; or
    b. Not entitled to monthly Social Security or Railroad Retirement benefits, but meet the requirements of a special transitional provision (some individuals who are not eligible for regular SSA or Railroad Retirement benefits still qualify for Part A hospital insurance); or
    c. Not entitled to monthly Social Security benefits and not a qualified Railroad Retirement beneficiary, but enrolled and paying a monthly premium. To be eligible under this provision, an individual must be age 65 or older, a U.S. resident, and a U.S. citizen or an alien lawfully admitted for permanent residence who has resided continuously in the U.S. for 5 years, and enrolled for Part B medical insurance or has filed a Part B enrollment request which will entitle the individual to Part B, or
    d. Conditionally eligible except that they are not receiving Part A Medicare because they cannot afford to pay the premium for Part A.
2. Persons under age 65 who are entitled to or deemed entitled to Social Security disability benefits for 24 months (included are workers with disabilities, widow(er)s with disabilities, surviving divorced wives with disabilities, and individuals entitled to childhood disability benefits) beginning with the 25th month of entitlement to such benefits, and certain individuals entitled to Railroad Retirement benefits due to a disability.
3. Persons of any age who have end-stage renal disease (ESRD) who require a kidney transplant or a regular course of dialysis and who are Social Security or Railroad Retirement recipients, or the spouse or a child of an SSA recipient when the spouse or child has ESRD.

Entitlement to Part B Medical Insurance is not an eligibility requirement for QMB, SMB or QI-1. An individual must be entitled to Part A for SMB or QI-1 and entitled to or conditionally eligible for Part A to be eligible for QMB.

For QMB, SMB and QI-1, if an individual is receiving Part A Medicare but not receiving Part B Medicare, the application will be approved, if eligible. Being enrolled in Part B Medicare is not an eligibility requirement. After the approval and the individual's name appears on the buy-in rolls, the Centers for Medicare and Medicaid Services (CMS) will receive notice that the individual is eligible and entitled to Part B Medicare. The individual will not be assessed a late filing penalty.

Individuals Entitled to Part A Without Payment of Part A Premium

A person entitled to Social Security retirement benefits or a qualified Railroad Retirement beneficiary is automatically eligible for hospital insurance beginning with the first day of the month of attainment of age 65, but the individual must apply with SSA in order to be enrolled in Part A Medicare.

An individual who fails to enroll for Medicare upon attainment of age 65 may enroll during the General Enrollment Period (January through March of each year). If the individual enrolls during the General Enrollment Period (January through March), coverage starts on July 1 following enrollment.

Individuals Who Would Be Entitled to Part A if They Could Pay Part A Premiums:

1. SSI Recipients

   Ordinarily, the Social Security Administration will refer these individuals directly to the DHS Central Office for accretion to the system and, thus, for QMB benefits, including payment of Part A Premium. If a County Office has an inquiry or application for QMB benefits from an individual receiving SSI, the individual should be informed that he/she is eligible for QMB benefits, and that the benefits will begin as soon as the automated system accretes him/her for these benefits. A QMB application from an SSI recipient will be denied by the County.

2. Non-SSI Individuals Receiving Part B Medicare

   An individual already receiving Part B Medicare may have a QMB eligibility determination made without going to SSA to apply for Part A. If found QMB eligible and certified by the County, the individual will become entitled to Part A Medicare (and all other QMB benefits) when the system accretes the individual and the State Medicaid

Agency begins paying the Part A Medicare premiums. The system accretions for these individuals and for SSI QMB eligibles may be made at any time of the year, i.e., they do not have to be done during a general enrollment period or at any other specified time.

3. Individuals Not Receiving Part A or Part B Medicare
   An individual not receiving Part A or Part B Medicare must first go to SSA to apply for Medicare benefits. If SSA determines an individual meets the Medicare requirements, SSA may refer the individual to DHS for a QMB eligibility determination.

F-192 Medicare Entitlement Requirements for QDWI

MS Manual 01/01/14

The following requirements must be met by an individual to qualify for benefits as a QDWI:

1. Lost Medicare Part A and SSA-Disability (SSA-DIB) due to Substantial Gainful Activity (SGA)-The individual must have previously received and lost entitlement to SSA-DIB and Medicare Part A solely due to earnings that exceed the SGA amount, as determined by the Social Security Administration. If the individual's loss of SSA-DIB and Medicare Part A was for another reason (e.g., no longer has a disability), the individual will not qualify as a QDWI.
2. Entitled to Reenroll in Medicare Part A-- The individual must be entitled to reenroll for Medicare Part A and must reapply for coverage with the Social Security Administration prior to QDWI certification.

   The following information must be verified:

   a) Individual's blindness or disability is continuing,
   b) Individual's entitlement to SSA-DIB and Medicare Part A was lost solely due to SGA,
   c) Individual has reenrolled for Medicare Part A,
   d) Effective date of Medicare Part A coverage.

   The individual will be asked to provide any notices received from SSA or to obtain the needed information directly from SSA. The County Office can also access the information through SOLQ if needed.

F-193 Initial Enrollment Period and General Enrollment Period for Medicare Part A

MS Manual 01/01/14

A QDWI applicant must reenroll for Medicare Part A, if he/she has not previously reenrolled prior to making application.

The Social Security Administration will send notices to those individuals who lost or will lose Medicare Part A solely due to SGA, advising them to contact the SSA office. Once reapplication has been made for Medicare Part A, SSA will refer potentially eligible individuals to the County Office to make a QDWI application.

If an individual applies at the County Office prior to reenrolling for Medicare Part A, the individual will be instructed to contact the SSA Office to reenroll for Medicare Part A and provide verification of reenrollment and the effective date of coverage.

The Individual Enrollment Period begins with the month in which the individual receives notice from SSA that his/her entitlement to Disability and Medicare will end solely due to SGA. The enrollment period ends 7 months later.

There will also be a General Enrollment Period each year from January 1 - March 31.

G-100 Verification Standards

MS Manual 01/01/14

Arkansas Act 1265 requires that the agency conduct electronic data matches first through the Federal sources and then through State sources if unable to obtain the required verification needed to determine eligibility for Medicaid through the Federal source. However, additional verification sources may be used if there is a discrepancy between the information provided by the individual and the electronic data source or the information can't be verified through the data matches.

G-110 Verification Requirements

MS Manual 01/01/14

Certain eligibility factors must be verified either through electronic sources or by the individual. See below which eligibility factors require verification and which factors do not require verification.

G-111 Eligibility Factors That Require Verification

MS Manual 01/01/14

The following must be verified when determining eligibility for Medicaid:

- Social Security Number (SSN)
- Citizenship
- Alien Status
- Income
- Age/Date of Birth
- Disability (when required)
- Resources (For categories that require a resource test (Refer to MS Policy E-110).

Refer to sections below for specific information regarding verification of the above eligibility factors.

G-112 Eligibility Factors That Do Not Require Verification

MS Manual 01/01/14

The following eligibility criteria do not require verification unless questionable:

- Residency

- Pregnancy
- Household Composition

G-113 Verification Sources

MS Manual 01/01/14

The primary source of verification is through electronic sources such as the Federal Data Services Hub (FDSH) and the Arkansas verification database, ARFinds. The FDSH is only available to the Family and Individuals Group.

The FDSH is a verification source that enables immediate access to multiple data bases via a single electronic transaction. Information provided by the individual will be verified through the federal data services by the following federal agencies:

- Social Security Administration (SSA) – Citizenship
- Internal Revenue Service (IRS) – Income (Most recent Federal tax return information)
- Department of Homeland Security (DHS) – Immigration status
- TALX (The Work Number) – Employment and income data from the employer.

The Arkansas verification database, ARFinds, is a multiple source database directly integrated with the eligibility system. It eliminates the need to access multiple screens. Information provided by ARFinds includes:

- SOLQ - Inquiry of SSA information
- WESD (Workforce and Employment Security Data) – Wage history and unemployment insurance benefits
- OCSE (Office of Child Support Enforcement) – Child support
- Vital Records – Births, deaths, marriages, and divorces
- DMV (Department of Motor Vehicle).

Other sources of verification include:

- Paper Documentation provided by the individual
  - ✓ Check Stubs
  - ✓ Employer Statements
  - ✓ Bank Statements

- ✓ Collateral Statements
- ✓ Legal Documents

- SNAP – verified information in the individual's SNAP record.

G-114 Reasonable Opportunity for Providing Verification

MS Manual 01/01/14

Verification must first occur through electronic sources. If unable to obtain verification though electronic sources, verification will be required from the client and a 10 day notice will be sent requesting the required verification. Additional time to provide the verification will be allowed if requested. Information that is not necessary to determine eligibility will not be requested.

G-120 Verifying the Social Security Number

MS Manual 01/01/14

The SSN will be verified via the Federal Data Services Hub (FDSH) or through the SSN enumeration process for all individuals that have been entered into the eligibility system. If all match data agrees with SSA records, the system will be updated to reflect that the SSN has been verified.

If a mismatch occurs, an SSN mismatch report will be generated to the county office and the procedures in Appendix C will be followed to resolve the mismatch.

G-130 Verifying Citizenship

MS Manual 01/01/14

Federal Law and Regulations require that citizenship must be verified for all Medicaid recipients declaring to be citizens or nationals of the United States.

Exceptions to the verification requirement

Citizenship verification is not required for the following:

a. Individuals entitled to or enrolled in Medicare.

b. Individuals in receipt of SSI payments.

c. Individuals receiving SSDI benefits based on disability

d. Children who are in foster care

e. Children who are recipients of foster care maintenance or adoption assistance payments under Title IV-E.

G-131 Methods of Citizenship Verification

MS Manual 01/01/14

Families and Individuals Group

Verification of citizenship will occur through the Federal Data Services Hub (FDSH). If citizenship cannot be validated through the FDSH, the agency will conduct an electronic data match directly with Social Security Administration (SSA) or by obtaining acceptable documentation from the individual.

AABD and Other Groups

Verification of citizenship will occur directly through the SSA State Verification and Exchange System (SVES). The individual's name, Social Security Number (SSN) and date of birth (DOB) will be compared to the SSA master file. (Refer to Appendix C).

G-132 Reasonable Opportunity for Verifying Citizenship

MS Manual 01/01/14

When citizenship cannot be verified through an electronic source or SVES, the agency will provide the applicant a "90-day reasonable opportunity period" to provide the necessary documents to verify citizenship. (Refer to Appendix C).

Situations that may trigger the reasonable opportunity period:

- The individual is unable to provide a SSN, needed for electronic verification with SSA;
- Either the federal data services hub or SSA or DHS databases are temporarily down for maintenance or otherwise unavailable, thereby delaying electronic verification;
- There is an inconsistency between the data available from an electronic source and the individual's declaration of citizenship which the agency must attempt to resolve, including by identifying typographical or clerical errors; or
- Electronic verification is unsuccessful, even after agency efforts to resolve any inconsistencies, and additional information, including documentation is needed.

A notice will be sent to the applicant advising that verification of citizenship must be provided within 90 days. The due date must be included on the notice. The reasonable opportunity begins on the date the notice is received by the individual. The date the notice is received is considered to be five (5) days from the date on the notice (day one is the date of the notice).

Eligibility for Medicaid will begin on the same date the reasonable opportunity period begins.

> **NOTE:** If the individual clearly shows that the notice was not received on the 5th day, the 90 days will start from the date the notice was actually received.

If the needed verification for an individual is not provided within the reasonable opportunity period, then benefits for that individual will be terminated. Timely and adequate notice must be provided. Other eligible members for whom citizenship is verified will remain eligible.

When the recipient tries in good faith to present satisfactory documentation, but is unable to obtain the necessary documents and needs assistance (e.g. homeless, mentally impaired, or physically incapacitated), and lacks someone who can act on their behalf, the caseworker should assist the recipient with obtaining the documentation of U.S. citizenship.

G-133 Acceptable Documents for Proof of Citizenship

MS Manual 01/01/14

When citizenship cannot be verified via the electronic sources, the applicant will be notified to provide verification. Refer to Appendix C for acceptable documents for proof of citizenship.

G-134 Subsequent Citizenship Verification

MS Manual 01/01/14

Once an individual's citizenship is documented and recorded, any subsequent changes in eligibility should not require repeating the documentation of citizenship. If an individual's Medicaid case is closed and he later reapplies, the worker will not need to request additional verification as long as proper documentation has been retained in the case file or narrated properly in the electronic record. However, if one of the two exceptions below occurs, the individual's citizenship must be verified again.

1. If later evidence raises a question of a person's citizenship or identity; or,
2. If there is a gap of more than 5 years since the Medicaid case was closed and the verification had been previously destroyed.

G-140 Alien Status Verification Requirements

MS Manual 01/01/14

For the Families and Individuals group, verification will first occur through the FDSH. For other groups, alien status will be verified through SAVE (Systematic Alien Verification for Entitlement). If verification cannot be completed through these processes, refer to Appendix C.

In order to obtain verification from SAVE, the alien must provide documentation of alien status. In addition to providing alien documentation, all aliens must provide verification of their identity. If the documentation provided does not contain a photograph, another form of identification must be obtained.

If the alien does not have any documentation, refer him/her to the Immigration and Naturalization Service (INS) to obtain proof of status. Provide the individual with a 10-day written notice requesting the documentation and extend the 10-day notice if additional time is needed. The INS address for applicants in Arkansas is:

Immigration and Naturalization Service
Attn: Status Verifier/SAVE
701 Loyola Avenue, Room T-8011
New Orleans, LA 70113

If the individual does not provide necessary documentation of alien status for the person requesting Medicaid coverage, the individual will be eligible for emergency services only.

NOTE: INS does not require children under age 14 to have documentation of their alien status. Therefore, if the adult who is applying for benefits has a documented legal alien status and attests to the child's legal status, the adult's statement is sufficient proof of the child's alien status.

INS requires children aged 14 through 17 to have documentation, but they are not required to carry it on their persons. The Immigration and Nationality Act (INA) requires all aliens 18 or older to carry INS documentation on their persons at all times.

G-150 Income Verification

MS Manual 01/01/14

Income will be verified for each individual in the Medicaid household at initial application and renewal. The Federal Data Services Hub will be used only for the Families and Individuals group. If needed, ARFinds, verified information from the SNAP record and documentation provided by the individual can also be used. For all other eligibility groups, sources for verification of income are ARFinds, verified information from the SNAP record and documentation provided by the individual. If the income reported by the applicant exceeds the income limit, it is not necessary to check the verification sources. The applicant's statement of income may be accepted without further verification.

G-151 Reasonable Compatibility Standards for Electronic Data Sources

MS Manual 01/01/14

Income is considered verified when the income reported by the individual is reasonably compatible with the income verified by the electronic data source.

Reasonable compatibility is met when the amount reported by the individual and the amount obtained through the electronic process are:

1. Both are equal to or below the income limit;
2. Both are greater than the income limit; or
3. If one is above and one is below the income limit but the difference between the two amounts is within 10% of the 100% Federal Poverty Level (FPL) for the appropriate household size.

The only time reasonable compatibility must be established is when the applicant's reported income is below the income limit and the verification source is above the income limit. See examples below.

EXAMPLE: The applicant reports a household size of one and a monthly income of $900 per month. The FDSH provides data that the applicant has an income of $975 per month. The 100% Federal Poverty Level (FPL) for a household of one is $957.50 per month. A 10% Reasonable Compatibility Standard would equal an amount of $96 (957.50 X 10% = 95.75 rounded up to $96). The two reported amounts are within $96 of each other ($975 - $900 = $75) and therefore meet the reasonable compatibility standard. No additional verification is required.

EXAMPLE: The applicant reports a household size of three and a monthly income of $1,600 per month. The FDSH provides data that the applicant has an income of $1,800 per month. The 100% Federal Poverty Level (FPL) for a household of three is $1,627.50 per month. A 10% Reasonable Compatibility Standard would equal an amount of $163 (1627.50 X 10% = 162.75 rounded up to $163). The two reported amounts are not within $163 of each other ($1,800 - $1,600 = $200) and therefore do not meet the reasonable compatibility standard. In this example, the client would need to provide proof of the reported income amount.

G-152 Reasonable Compatibility of Income Does Not Exist

MS Manual 01/01/14

If there is a discrepancy between the information provided and the electronic data, the individual must resolve the discrepancy by submitting verification of the income. For earnings, this can be verified with check stubs, pay slips, or a collateral contact with the employer. Sufficient verification must be obtained so that the actual income of the employee can be determined. The caseworker should not automatically assume that one check stub accurately reflects earnings for an entire month. Verification of payment for the last 30 days will be required if available.

EXCEPTION: For cases in which the individual has recently started employment and 30 days of verification is not available, the caseworker will compute the income from the best information available. Verification of all, if any, paychecks already received by the individual should be obtained and/or an employer's statement of anticipated earnings (e.g., hourly wage, number of hours expected to work/week, etc.).

Verification of earnings from self-employment will be from the Federal Income Tax Return, purchase, sales, and account books or by any other source which establishes the source and amount of income. As soon as an individual is known to be engaged in a farming business or other self-employment enterprise, he will be advised of the necessity of keeping accurate records so that his income can be determined.

Verification of in-kind earned income (e.g., free rent, groceries, etc.) will be obtained from the employer. The verification must include the value of the in-kind benefit (e.g., the rent amount the client would otherwise pay, the cost of groceries provided, etc.) and how often it is provided (e.g., monthly, weekly, etc.). If the amount fluctuates from week to week or month to month, verification of the in-kind earned income paid during the last 2 months should be obtained.

Verification of unearned income is normally obtained from documentary evidence from the source (e.g., award letter). However, another source may be used if it clearly establishes the source and amount of income.

G-160 Age/Date of Birth

MS Manual 01/01/14

Age and date of birth will be verified via the Federal Data Services Hub or other electronic sources. If there is a mismatch, a task will be generated. Refer to Appendix C for procedures.

G-170 Disability

MS Manual 01/01/14

Verification of disability must be established either through information from the Social Security Administration (SSA) or a determination by the Medical Review Team. Refer to MS F-121 and MS F-122 for procedures.

G-180 Resources

MS Manual 01/01/14

Resources will be verified for all categories with a resource test. Refer to MS E-110. Examples of verification include bank statements, trust documents, deeds, etc.

H-100 Long Term Services and Supports

MS Manual 01/01/14

The policies located in Section H of this manual describe programs and procedures that are unique to the Long Term Services and Supports eligibility groups. These sections include:

1. Income Trusts, (MS H-110-116)
2. Spousal Impoverishment Rules, (MS H-200)
3. Transfer of Resources, (MS H-300) and
4. Post Eligibility rules. (MS H-400)

H-110 Income Trusts

MS Manual 01/01/14

An individual with income in excess of the income limit may establish an income trust for the purpose of becoming Medicaid eligible. This type of trust is commonly referred to as a Miller Income Trust.

H-111 Requirements for an Income Trust

MS Manual 01/01/14

An Income Trust must meet the following conditions:

1. Terms and Other Conditions

   The trust must be irrevocable. It can be terminated or amended only by mutual agreement between DHS and the trustee.

   The trust may be used to establish Medicaid eligibility only for individuals determined to be medically in need of nursing facility care.

   The trust must have been established on or after August 11, 1993.

   The trust can only be funded from Social Security, pension, and all other income payable to an individual, including income earned by the trust account. If assets other than income, such as real or personal property, are placed in the trust, the individual cannot be eligible for facility services under the income trust provisions.

The trust must contain a provision that all assets remaining in the trust at the individual's death will be transferred to DHS up to an amount equal to medical payments made by DHS on behalf of the individual subsequent to establishment of the trust.

2. Consideration of Income
An individual with gross monthly countable income, excluding VA A&A and CME/UME, which exceeds the federal cap of 3 times the SSI payment for an individual living in his own home, may establish eligibility through an income trust.

All of an individual's income must be placed in the trust, except VA A&A and/or CME/UME.

Income received by an individual and placed in the trust, or an individual's income paid to the trust by direct deposit, is not countable income for eligibility purposes. Income which is received directly by an individual must be transferred to the trust immediately upon receipt.

The income (other than income accumulated by the trust) must be income payable to the individual, and the income must first be received by the individual before being placed in the trust. If the individual assigns the right to receive any or all of the income to the trust, the income assigned is no longer considered income to the individual under SSI rules. Such an assignment will be considered a disqualifying transfer. However, for purposes of this section, if an individual authorizes the income to be paid into the trust <u>by direct deposit</u> from the payor, the direct deposit will not be considered an assignment (disqualifying transfer).

If in any month the income is not placed in the trust, the individual is not eligible for Medicaid benefits or vendor payment in that month.

The income must be placed into and maintained in a single trust account.

If an individual receives income on an irregular basis, (such as royalty or farm rental income, or lump sum payments such as SSA retroactive benefits) the income must be placed into the trust when it is received.

If an individual receives income paid jointly to him and another person(s), the facility resident's share of the income must be separated from the other owner(s) share(s) before depositing his share in the trust account. No income belonging to any other individual may be placed in the income trust of a Medicaid recipient.

3. Fees and Other Disbursements

   When no relatives are available to serve as the trustee, a commercial institution such as a bank can be named as trustee. Commercially reasonable administrative fees that are charged by the commercial institution may be allowed as trustee fees. The fee will be considered commercially reasonable if the fee is consistent with administrative fees charged to other customers for similar services. Trustee fees will not be allowed except in these instances. The bank service charges for maintaining the bank account are allowable fees.

4. Trustee Responsibilities

   A trustee may serve without bond or supervision of any court.

   Prior to a distribution from the trust, the trustee must notify the caseworker responsible for the case of any fees, income taxes or other payments which must be made from the trust before these disbursements can be made. The advance notice must be made no later than the month which precedes the month in which the disbursements will be made.

   After certification of the case, no disbursements of any kind can be made by the trustee until the trustee has been provided a current Post Eligibility Income Worksheet, DCO-712, completed by the caseworker in charge of the case.

   Any disbursements made that are not for the benefit of the recipient, the community spouse or other dependents, as specified on the DCO-712, will be considered a transfer of resources and a penalty period may be applied.

   Payments must be made from the trust each month, during the first week of the month, and only in the amounts specified on the DCO-712. The payments must be made directly to the designated recipient, i.e., to the recipient or responsible person for the personal needs allowance (PNA); to the community spouse and/or dependent(s) for their allowances; to the recipient or responsible party for the recipient’s non-covered medical expenses; and to the facility for the patient’s share of cost.

   While an individual is receiving Medicaid benefits in a facility, no disbursements other than those specified on the DCO-712 may be made.

   The trust records shall be open to inspection and for copying by DHS, and periodic reporting may be required at the discretion of DHS.

   If the trustee becomes aware of any change in circumstances which will affect the recipient’s eligibility or the amounts being distributed monthly from the trust, the trustee shall be responsible for notifying the caseworker of such changes. Changes to be reported include income changes, increase or decrease of cost of non-covered medical expenses, recipient dies or leaves the facility, community spouse enters a facility, etc.

The trustee must notify the caseworker if in any month the funds are not disbursed according to the DCO-712 or if the balance in the trust account exceeds the maximum allowed as specified in MS H-140, Post Eligibility Procedures, so that the worker can adjust the facility payment(s) for the month(s) in which the vendor payment is affected.

H-112 Income Trust Application Process

MS Manual 01/01/14

The process of applying for a Miller Income Trust consists of the following steps:

1. Request for Eligibility Determination
   Individuals with income above the federal cap who inquire regarding Medicaid eligibility in a facility or for the Waiver program will be given information regarding eligibility limits under the income trust provisions along with a resource assessment (Re. MS E-500) if requested. Individuals with excess resources cannot establish eligibility through an income trust.

2. Application for Benefits
   At application for facility care or the Waiver program, the applicant, representative, guardian or other person responsible for the application, must inform the caseworker of the existence of an income trust, or that such a trust is to be established, and must provide the worker with a copy of the trust document.

   An application will not be held longer than 45 days to permit the finalization of an income trust. If all eligibility requirements have been met with the exception of income in excess of the federal cap and the trust has not been finalized within 45 days since the date of application, the application will be denied and the individual or responsible party will be informed that reapplication may be made when the trust agreement is finalized.

3. Review for Validity
   As soon as possible after receiving the trust document, the caseworker must submit it to the Office of Program Planning and Development (RE. MS E-501) to obtain an opinion that the trust document meets the requirements of a valid income trust in Arkansas.

4. Certification Procedures
   Counties must complete the DCO-730 at certification and send the form to the **Medicaid**

Eligibility Unit, P. O. Box 1437 - Slot S-333, Little Rock, AR, 72203. The form will also be indexed into the electronic case record.

H-113 Post Eligibility Procedures

MS Manual 01/01/14

1. Post Eligibility Consideration of Income
   The total net countable income of an individual will be included in the post eligibility consideration. Net income will be calculated as for all other Medicaid eligible individuals in the post eligibility process.

   For example, an individual has $1500 net countable monthly income. For post eligibility purposes, the calculations will begin with $1500. The PNA, the spousal/dependent allowances (if applicable, but not in amounts greater than the maximum allowed on the DCO-712), and non-covered medical expenses of the recipient will be deducted. The balance remaining must then be applied to the individual's cost of care in the facility.

   The caseworker will be responsible for providing the trustee and the recipient or his/her representative with a copy of the DCO-712 at initial certification and each time it is necessary to make a revision in the post eligibility budget due to income changes or other changes such as those made on the DCO-712 mandated by the spousal laws.
2. Begin Date of Eligibility
   Eligibility for facility care or Waiver services shall not begin prior to the month in which the trust is established. A trust is considered established when the completed document is signed by the applicant and the trustee. The first possible beginning date of eligibility will be the first day of the month in which an approved trust was signed, provided that the individual's income has been placed in the trust that month, that no funds that cannot be authorized have been disbursed during the month, and that the individual is otherwise eligible. If funds that are not or will not be allowed by the DCO-712 have been disbursed from the trust during or after the month in which the trust is established, eligibility cannot begin until the first of the month in which all disbursements are correctly made.

EXAMPLE: An applicant submits an unsigned trust on January 15, which is approved on February 5. The applicant and the trustee sign the approved trust on February 10. Eligibility may begin no earlier than February 1. If the applicant and the trustee had signed the trust when it was submitted on January 15, eligibility could have begun on January 1.

5. It must be verified prior to beginning eligibility that the individual's income has been placed in the trust.

3. Penalty for Transfer of Assets
There is no penalty for transfer of income into an income trust fund. However, if the balance of the trust at the end of any month (excluding any deposits which represent income for the following month and any spousal/ dependent/non-covered medical expenses amounts specified on the DCO-712 which were not disbursed for the month) exceeds the amount of the current divisor used for transfer of resources (Appendix R), the individual will not be eligible again for facility care payment until the first of the month after the month in which the balance in the trust has been spent down for the benefit of the facility resident. During any such month(s) of ineligibility the spousal, dependent, and non-covered medical allowances may be paid according to the DCO-712, and Medicaid benefits other than the facility vendor payment will be continued.

EXAMPLE: In October a caseworker learns that an income trust had a $7,208 balance at the end of the preceding month which included a $1,200 SSA check deposited the last day of September, representing payment for October. The trustee failed to make any disbursements for September, including $600 to the community spouse and $200 for non-covered medical expenses. When the October SSA check and the non-payments for September are subtracted from $7,208 ($7,208 - $1,200 - $600 - $200 = $5,208), the remainder is greater than the current divisor. Therefore, the individual is not eligible for vendor payment in September and the vendor payment will be stopped for that month.

For any such month(s) of ineligibility, the caseworker will send a DCO-707, Notice of Adverse Action, to the recipient or representative, and a copy of the notice to the trustee.

H-114 Changes to an Income Trust

MS Manual 01/01/14

1. Medicare and Other Third Party Payments
If in any month or part of a month a patient is in a Medicare bed or has other third party coverage which lessens or eliminates the obligation of the trustee to pay the facility for the patient's share of cost as computed on the DCO-712, the funds which would have been paid to the facility in that month shall remain in the trust and may not be disbursed for reasons other than for the recipient's medical care for which there is no other third party liability.

If a trustee has made the patient's share of vendor payment at the first of a month and later is reimbursed the funds from the facility due to payments from other third party coverage, the reimbursement must be returned immediately to the trust. If the facility does not make the refund to the trustee, i.e., places the payment(s) in the patient's facility account, the funds placed in the account will be countable toward the $2000 resource limit.

2. Client Leaves Facility

   If an individual leaves a facility for a therapeutic home visit (up to 14 days) or for a hospital visit (up to 5 days), Medicaid benefits and vendor payment will continue, and the trustee will make disbursements in that month as specified on the DCO-712.

   If an individual has not returned to the facility after 14 days on a home visit or after 5 days of hospitalization, Medicaid will no longer pay the vendor payment, and the individual will be responsible for arrangements with the facility. Medicaid benefits other than the vendor payment may continue unless a formal notice of discharge is sent to the DHS County Office via DCO-702 (and the recipient has not entered, nor is it anticipated that he will enter, another facility). During any such period of extended home visit or hospitalization when Medicaid is not paying the facility vendor payment, the trustee may continue to disburse the spousal/dependent/ non-covered medical expenses as specified on the DCO-712 and may disburse funds from the trust for medical expenses of the recipient which are not specified on the DCO-712 and not covered by Medicaid or other insurance.

   The caseworker must determine the residence of a recipient when receiving a DCO-702, Notice of Discharge from a facility, because facilities may erroneously send discharge notices when an individual has been hospitalized for more than 5 days. A facility may also correctly send notice of discharge when an individual has been transferred directly from one facility to another, from a hospital to a second facility, or from a therapeutic home visit to a second facility. In any of the above situations, the case should not be closed and Medicaid benefits should not be terminated.

   If an individual improves to the extent that he or she is able to return home and is deemed unlikely to need continuing care in a facility according to written medical statement, the Medicaid case must be closed. However, the trust must be maintained according to the terms of the trust, i.e., the individual's income must continue to go into the trust, no other individual's income may be put into the trust, etc. Disbursements may be made only for medical care, food, clothing, transportation and shelter for the individual.

3. Changes in Community Spouse or Dependent Status
   If a community spouse or dependent who has been receiving a monthly income allowance from the facility resident enters a facility, has an income change, divorces the recipient or dies, the worker in charge of the case must be notified immediately by the recipient, representative, trustee or other responsible party. No additional disbursements for the spouse or dependent can be made until the worker has revised the DCO-712 and provided the trustee with a copy.

H-115 Reevaluations with an Income Trust

MS Manual 01/01/14

In addition to the required verification of other eligibility factors at annual reevaluation, the caseworker will verify and document that the individual's income has been placed in the trust and disbursements made as required since the last reevaluation. This may be done by viewing bank statements, or other trustee records that may be available.

H-116 Termination of an Income Trust

MS Manual 01/01/14

When a Medicaid case is closed due to permanent discharge from a facility, out-of-state move, or death, the DCO-730 must again be submitted, with the closure section completed, to:

Medicaid Eligibility Unit
P.O. Box 1437 - Slot S-333
Little Rock, AR 72203.

NOTE: Do not submit the form with closure information if a case is temporarily closed for excess resources, excess income in the trust, or for other reasons.

A copy of the DCO-730 will be indexed into the electronic case file.

1. Termination of the Trust
   Within 10 days of receiving a notification of the death of an individual certified under the income trust provision, the caseworker will:
   a. Send a Notice of Action to inform the trustee: That if disbursements as specified on the most recent DCO-712 were not made for the month in which death occurred, these disbursements may be made. After these disbursements have been made, no other disbursements may be made from the account until the trustee has received instructions from the DHS Third Party Liability Unit section regarding termination of the trust (Form DCO-733).

b. Complete Form DCO-734, Report of Case Closure Due to Death, and send the form to:

Arkansas Department of Human Services
Division of Medical Services
Third Party Liability
PO Box 1437 Slot- S-296
Little Rock, AR 72203-1437

The Third Party Liability Unit will use the information provided in the DCO-734 to complete and mail the trustee the DCO-733 with instructions regarding termination of the trust.

H-200 Spousal Impoverishment - AABD

MS Manual 01/01/14

The following eligibility groups will use the spousal impoverishment guidelines listed in this policy section:

1. Long Term Services and Supports (LTSS)
    a. Nursing Facility care
    b. Assisted Living Facility (ALF)
    c. Home and Community Based Waivers
        i. ElderChoices
        ii. Alternatives for Adults with Physical Disabilities waiver (AAPD)
    d. PACE program

H-201 Treatment of Income and Resources for Certain Institutionalized Spouses

Manual 01/01/14

As of September 30, 1989, the Medicare Catastrophic Coverage Act (MCCA) of 1988 (P. L. 100-360) requires special treatment of the income and resources of institutionalized individuals who are legally married to spouses living in the community.

Consider a couple to be husband and wife if they are:

1. Legally married under State law, or
2. Either determined to be the spouse of a Title II (Social Security) recipient, or
3. Living together and holding out to the community in which they live as husband and wife.

NOTE: A married couple no longer living together as husband and wife will be considered as individuals the month after they separate.

No comparable treatment of income and resources is required for noninstitutionalized individuals or for institutionalized individuals who do not have a spouse living in the community. If there are changes in the marital status or other changes (e.g., the spouses divorce or separate, or the institutionalized spouse returns home), the rules apply in the month following the month of change.

Except as specified in MS E-400 through MS E-530 this section does not affect the determination of what constitutes income or resources, or the methodology and standards used to determine or evaluate income or resources.

H-202 Initial Assessment

MS Manual 01/01/14

Upon application for LTSS or upon request by the Institutionalized Spouse (IS), Community Spouse (CS), or representative, the caseworker will assess and document the total value of countable resources less exclusions specified in MS E-516 and MS E-523, to the extent that either the IS or the CS or both hold an ownership interest, as of the date on which the first continuous period of institutionalization begins.

The purpose of the initial assessment is to record the total amount of resources held by both the IS and CS at the first continuous period of institutionalization and to compute a spousal share of the total resources for the CS, which will be a protected amount and will remain constant as long as there is an IS/CS situation (Re. MS H-206).

For the purposes of this policy, an institutionalized individual is an individual who is an inpatient of a medical institution and nursing facility (or nursing facility only) for a period of at least 30 days. The term nursing facility includes all licensed nursing facilities and ICF/MR facilities.

The IS, CS, or representative will be responsible for providing relevant documentation of the composition and value of all resources held by the couple as of the beginning of the first period of institutionalization. The caseworker will assist in obtaining such documentation when requested. The assessment will be completed in all cases within 45 days unless pending receipt of information from the requesting party or a third party (bank, insurance company, etc.). A DCO-002, Notice of Delayed TEA/Medicaid Application, will be given or sent to the requesting party to inform the party that the information should be provided as soon as possible but within 45 days and that the assessment cannot be completed until the information is provided.

If the request was for an assessment only, no further action is required by the county until the information has been provided.

At the time of the assessment, form DCO-710, Long Term Care Spousal Resources Assessment, will be completed to reflect all countable resources held by either the CS or IS, or both, at the beginning of the first period of institutionalization. The total value of these resources and the spousal share (equal to one-half of the total value) will be entered on the DCO-710. The resources owned solely by the CS will also be totaled on the form.

The caseworker will provide a copy of the DCO-710 to each spouse or representative and retain the original, regardless of whether an application for LTSS is made at that time. Only an applicant or applicant's spouse will have appeal rights if there is disagreement with the attribution of assets on the form. A person requesting only an assessment has no right to appeal if an application has not been made.

The DCO-710 will be indexed in the electronic record. If no application has been made, the DCO-710 will be indexed in the electronic record for future reference if the individual later makes application.

EXAMPLE: An individual enters a Nursing Facility and makes application on September 30, 2010, and an assessment of resources made on October 1, 2010, results in an ineligibility determination. A reapplication is made two years later, after two years of continuous residence in a Nursing Facility. The county must look at resources held at the beginning of that first continuous period of institutionalization, i.e., September 30, 2010. Reference to a form on file will be preferable to reconstructing the resources held two years earlier. If the applicant left the Nursing Facility at any time during the two year period but returned to a Nursing Facility, the county will use the assessment of resources made at the time of first entry in determining eligibility.

H-203 Resource Eligibility

MS Manual 01/01/14

At the time of application, all resources held by either the IS or CS shall be considered available to the IS to the extent that the resources exceed the Community Spouse Maximum Resources (CSMR), the maximum resources that are considered available to the CS.

When an application has been made the caseworker will compute the CSMR and the Community Spouse Resource Allowance (CSRA), and will determine resource eligibility on the DCO-713, Long Term Care Spousal Resource Eligibility Worksheet.

The CSRA is computed to determine the amount of the IS's resources which may be transferred to the CS. Resources of the IS may be transferred for less than fair market value to the CS (or to another for the sole benefit of the CS) only to the extent allowed by the CSRA. For rules regarding transfer by the IS, refer to MS H-209.

H-204 CSMR and CSRA Computation

MS Manual 11/01/95

The Community Spouse Maximum Resources (CSMR - the maximum amount of resources that a CS is allowed to retain) and the Community Spouse Resource Allowance (CSRA - the amount of resources that an IS may transfer to the CS in order to give the CS the maximum allowed) are computed on Form DCO-713.

By following the instructions on the DCO-713, the CSMR, Line 2 of the form, and the CSRA, Line 4 of the form may be computed.

MCCA of 1988 set a maximum amount (the dollar amount shown in Section 1, #1 of the DCO-713) that a CS is allowed to keep under the law, and also allowed states to set a minimum amount (the dollar amount shown in Section 1, #2 of the DCO-713) that a CS could keep. These amounts are subject to change by the Consumer Price Index and will be changed annually on the DCO-713.

The total amount of resources that a CS is allowed to retain depends on the total amount of combined resources that a couple has and also on the current minimum state standard and the current maximum standard set by law.

RESOURCE RULE

- If total combined resources are equal to or less than the state minimum standard, the CS may keep all.
- If total combined resources are between the state minimum standard and twice the state minimum standard, the CS may keep an amount equal to the state minimum standard.
- If total combined resources are in an amount of twice the state standard up to twice the maximum standard, the CS may retain one-half of all resources.

- If total combined resources are greater than twice the maximum standard, the CS may still keep only the maximum standard allowed by law.
- The CSRA may only be changed by a hearing officer or by a court order. (Re. MS H-208)

H-205 Determining Resources of the IS After CSRA Computation

MS Manual 01/01/14

To determine the IS's resource eligibility, Part II of the DCO-713 will be utilized. If the amount in Line 7 exceeds the one person resource level, the IS is ineligible and the application will be denied.

If the amount in Line 7 is at or under the one person resource level, the IS will be considered resource eligible for the month of determination.

When determined eligible, it will be necessary for the IS or representative (guardian or power of attorney) to sign the statement on the reverse side of the DCO-713, agreeing to transfer the described property to the CS. If the IS or representative refuses to sign, then the combined resources will be considered fully available to him/her and the IS will not be resource eligible at that time.

A copy of the DCO-713 will be provided to each spouse upon determination of eligibility, or to the spouse requesting the CSRA and eligibility determination, if a request by either spouse is made prior to application.

The DCO-713 will be indexed in the electronic case record.

H-206 Spousal Protected Amount (CSMR)

MS Manual 01/01/14

When resources exceed the limits, the IS will be ineligible until combined countable resources are reduced to the greater of the following:

1. The state standard plus the one person resource amount for the IS;
2. The spousal share (one-half of the total resources, as computed at the beginning of the continuous period of institutionalization) plus the one person resource amount for the IS;
3. Court ordered spousal share plus the one person resource amount for the IS; or
4. Spousal allowance determined necessary by a hearing officer plus the one person resource amount for the IS.

EXAMPLE: A couple's combined countable resources at the beginning of the first continuous period of institutionalization are $140,000; the spousal share is $70,000, the CSMR, which is the protected amount, and there is not a court order. At the time of application the combined countable resources are $90,000. (These dollar amounts are used for purposes of illustration only.)

Deduct from current combined countable resources ($90,000) the greater of the following:

$70,000, the spousal share (protected amount), or
$14,000, the state standard
($90,000 less $70,000 equals $20,000)

The remaining $20,000 is a countable resource used to determine eligibility of the IS, and the IS is not eligible. However, if the couple's combined resources are later reduced to $72,000, the IS will be resource eligible (protected amount of $70,000 for the CS plus $2000 for the IS).

If after the time of initial assessment ($140,000/$70,000 spousal share) and first application, there is a break in institutionalization, the initial assessment will be used at the time of reentry to re-determine eligibility for the IS. The $70,000 protected amount from the first assessment is still a protected amount for the CS, and a new amount need not be calculated.

EXAMPLE: The IS above left the Nursing Facility for 60 days and then reenters. The couple has combined countable resources of $65,000 at reentry; the spousal share earlier computed was $70,000. Since total combined resources are now only $65,000, which is less than the spousal share, all of the resources may be attributed to the CS, and the IS is eligible for LTSS.

H-207 Retroactive Eligibility

MS Manual 01/01/14

Retroactive eligibility may be given under these rules, provided all eligibility requirements are met. For example, application is made January 1, 2014, after entry into a Nursing Facility on October 1, 2013. The assessment of resources owned by the couple as of October 1, 2013, will be made and, if eligible, the case may be opened retroactively to October 1, 2013). (MS A-211)

H-208 Appeal Rights Regarding Changing the CSMNA and/or CSRA

MS Manual 01/01/14

If either spouse is dissatisfied with the determination of:

- the CS's monthly income allowance,
- the amount of monthly income otherwise available to the CS,
- the computation of the spousal share of resources, or
- the attribution of resources or the CS's resource allowance,

such spouse is entitled to a hearing, if application has been made on behalf of the IS. (Re. MS L-110). Any hearing regarding the determination of the CS's resource allowance shall be held within 30 days of the date of the request for the hearing.

REVISION OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE

If it is established that the CS needs income above the level provided by the minimum monthly maintenance needs allowance (CSMNA) due to exceptional circumstances resulting in significant financial duress, a greater allowance may be substituted by a hearing officer, but only to the extent the IS is willing to make the IS's income available to the CS.

"Exceptional circumstances resulting in extreme financial duress" are defined as circumstances other than those taken into account in establishing the maintenance standards for the CS, such as unreimbursed medical expenses or household repair and maintenance for which the income allowance calculated by the county worker on the DCO-712, Post Eligibility Income Worksheet, along with the CS's income, is inadequate to pay.

If an income allowance greater than the one calculated by the county worker on the DCO-712 is granted by a hearing officer, the greater amount cannot exceed the current maximum, as shown on the DCO-712. For example, in 2013 the maximum CSMNA is $2898. A CS's CSMNA computed on the DCO-712, based on rent and utilities, is $2600. The CS's income is $1800 a month, and the IS is allowed to give the CS $800 per month, giving the CS a total of $2600. The CS establishes that her monthly expenses are $3000, due to exceptional circumstances. A hearing officer may allow the IS to give the remainder of the IS's income, if any, to the CS (excluding the $40 PNA). If the IS has $298 additional income, it may be given to the CS to bring the CS's income up to the maximum CSMNA ($1800 + $800 + $298 = $2898, the maximum allowed). No additional amount can be granted to raise the CS's total income to $3000, because $3000 is over the maximum.

H-208 Appeal Rights Regarding Changing the CSMNA and/or CSRA

REVISION OF COMMUNITY SPOUSE RESOURCE ALLOWANCE

If an IS is willing to contribute all of the IS's monthly income (less the $40 PNA) to the CS and the CS still does not have enough monthly income to raise the income to meet the needs of a CS when financial duress exists, a hearing officer may change the CS's resource allowance to bring the CS's income up to the maximum CSMNA. Any additional resources attributed to the CS must be income producing, otherwise the resources would not serve to increase the CS's income. In determining an increased resource allowance, no resources can be transferred which, along with the CS's other income (including the income from the IS) would generate total income to the CS in an amount greater than the current maximum CSMNA limit shown on the DCO-712.

If a greater CSMIA is awarded by a hearing officer due to extreme financial duress, the county may:

- Request the hearing officer to reopen and review the case when the county has reason to believe the exceptional circumstances no longer exist;
- Have the hearing officer schedule future hearings to review the circumstances and determine if financial duress still exists; and
- Monitor the case(s) to assure that exceptional circumstances still exist, and make adjustments when indicated.

The CSRA may be changed by court order, or may be changed by the Agency in the following three instances:

1. By a hearing officer, when either the IS or CS establishes that income generated from the CSRA will be inadequate to meet the minimum monthly maintenance needs allowance (CSMNA) as computed on the DCO-712 due to exceptional circumstances resulting in significant financial duress. There will be NO substitute CSRA made by a hearing officer when an IS does not make a living allowance (CSMIA) available to the CS.

2. By a hearing officer who confirms the allegation by either spouse that the initial determination was incorrect, or

3. By the county when it is determined that inaccurate information was provided and used in determining the CSMR.

   Refer to MS L-100 for additional information on Appeals and Hearings.

H-209 Rules for Transfer by the IS

MS Manual 01/01/14

If the IS or a representative acting on his/her behalf, transfers resources in an amount less than or equal to the CSRA for less than fair market value (FMV) to the CS or to another for the sole benefit of the CS, no penalty period will be applied to the IS.

If resources are transferred by the IS for less than FMV to anyone other than the CS or to another but not for the sole benefit of the CS, a penalty period will be applied according to the resource transfer provisions in effect at the time of the transfer. (Re. to MS H-308) The penalty period will apply to the vendor payment only. If the IS is otherwise eligible, he/she may be given eligibility for Medicaid ONLY. Prohibited transfers for uncompensated value will not affect eligibility for Medicaid.

H-210 Time Period for Transfer of CSRA to Community Spouse

MS Manual 01/01/14

The IS will be encouraged to transfer the CSRA to the CS as soon as possible. He/she will be given a period of 12 months (from the date the notice of approval is completed) to transfer the property in the amount of the CSRA to the CS.

If the transfer has not been made by the end of the 12 month period, the case will be closed, and the IS will not be eligible in the 13th month. No penalty will be applied, i.e., no overpayment will be written if the CSRA transfer was not made.

H-211 Rules for Transfer by the CS

MS Manual 01/01/14

If a spouse transfers property to his/her spouse before or after entry into a Nursing Facility and the receiving spouse transfers it to a third party for uncompensated value, a penalty period will be imposed on the IS. The transfer will be treated as if the IS had transferred directly to the third party.

EXAMPLE: A man transfers his home and land worth $40,000 to his wife on 11/1/13. His wife gives the property to her nephew without compensation on 3/1/14, and the man enters a Nursing Facility on 4/1/14. An assessment will be made at application, and the caseworker will inquire about transfers. A penalty period will be imposed on the IS. (Re. MS H-308)

H-212 Consideration of Resources After Eligibility is Determined

MS Manual 01/01/14

During the continuous period in which an IS is in an institution and after the month that the IS is determined eligible for LTC, any resources owned solely by the CS which were considered available to the IS at determination of eligibility (i.e., any resources of the CS which exceeded the CSMR, and were considered available to the IS at determination of eligibility) will not be considered available following the month of eligibility determination. Resources will be considered available to each spouse according to actual ownership of those resources, except that the period for transfer specified in MS H-210 will be allowed.

H-300 Transfer of Resources

MS Manual 01/01/14

H-301 Transfer of Resources Definition

MS Manual 01/01/14

A transfer of a resource occurs when an individual, the individual's spouse or an Authorized Representative of either of them gives away or sells property that belongs to the individual or spouse. Valid transfers of resource ownership may occur through any of the following types of transactions:

- Sale of property;
- Trade or exchange of one property for another;
- Spend-down of cash;
- Giving away cash;
- The establishment of or placement into a trust
- Transferring any financial instrument (e.g., stocks, bonds);
- Giving away property (including adding another person's name as an owner of the property).

Example: If the owner of a home adds the name of another person to the deed as a co-owner, the owner has transferred a portion of the value of the resource to that person. This transaction is considered a transfer of resources.

The policy for the transfer of resources for less than fair market value (FMV) applies only to individuals applying for or receiving Long Term Services and Supports. (Re. MS H-303) Treatment of resource transfers for less than fair market value made by an applicant/recipient, his/her eligible spouse, or his/her representative is governed by the date of transfer, the institutional or waiver status of the applicant/recipient, and whether the transfer was to the applicant/recipient's spouse.

A transfer of a resource made by an applicant/recipient, his/her eligible spouse, or a representative acting on their behalf must be verified and evaluated to determine:

1. Whether the transfer is validly irrevocable;

2. Whether any interest remains legally available to the individual or is declared by the current legal owner(s) to be available; and
3. Whether a resource was transferred for less than fair market value within the applicable look back period preceding the date of application/redetermination. (Re. MS H-303)

When it is determined that an applicant/recipient, his/her eligible spouse, or representative has the authority or ability to revoke the transfer and regain the transferred interest, the value of such interest will be included with countable resources.

When it is determined that an applicant/recipient or his/her eligible spouse has remaining interest or ownership in a transferred resource, the value of such interest will be included with countable resources.

NOTE: The above guidelines apply not only to an applicant/recipient or his/her eligible spouse but also to any fiduciary or individual legally authorized to act on their behalf, such as holder of power of attorney, parent of a minor child, guardian, etc. The guidelines also apply to other persons acting on behalf of the applicant/recipient or eligible spouse, e.g., an ineligible spouse.

H-302 The Look Back Period

MS Manual 01/01/14

The "Look Back Period" is the period of time prior to an individual's application for either Long Term Care facility or Home and Community Based Waiver services during which a transfer of resources for less than FMV may affect the individual's current eligibility for vendor payment or waiver services. The length of the look back period is governed by federal law and regulations and thus is subject to change. The current look back period of 60 months was established by the Deficit Reduction Act of 2005 (DRA) for transfers occurring on 2/8/2006 or later.

- **NOTE:** For detailed instructions on transfers prior to 2/8/06, see Appendix H.

The caseworker will look at all transfers made during the look back period. The look back period is the 60 months immediately prior to the date on which an individual is both in an institution and has applied for medical assistance or, in the case of a Waiver individual, prior to the date the individual applies for Waiver assistance.

EXAMPLE: An individual submits an application for Long Term Care on March 8, 2013. The beginning date of the 60 month look back period is March 9, 2008. Any resource transfers occurring on or after March 9, 2008 through March 8, 2013 must be reported by the applicant and evaluated in accordance with this policy.

If an institutionalized or Waiver individual is not eligible when he first applies for assistance and later reapplies, the caseworker will ask about transfers in the appropriate look back period from the date of the second application, or the dates of subsequent applications if the individual is not eligible at the second application.

H-303 Transfer for Less than Fair Market Value

MS Manual 01/01/14

Fair market value (FMV) is the amount for which property would sell on the open market if put up for sale in the ordinary course of business i.e. the actual or cash value of property. Fair market value is usually determined by the purchase price of similar goods or property in the same locality. A compensated transfer results when an individual receives compensation for transferred resources equal to the fair market value of the transferred resources in the form of money, stocks, bonds, material goods, services, etc.

When it is determined that an applicant/recipient, his/her eligible spouse, or their representative has transferred a resource at less than fair market value within the applicable look back period prior to application, the transfer will be presumed to be for the purpose of establishing eligibility and the amount of uncompensated value from the transfer(s) and the appropriate penalty period will be determined. Transfer(s) of resources presumed to be for the purpose of establishing eligibility will be subject to rebuttal (Re. MS H-312) and, in some cases, subject to exclusion based on other circumstances.

Individuals and/or their spouses who transfer resources for less than fair market value will be ineligible for nursing facility vendor payments for a period of time as specified at MS H-308. Waiver applicants who transfer resources for less than fair market value will be ineligible for all Medicaid benefits (Re. MS H-308). A penalty shall be applied to both institutionalized individuals and non-institutionalized Waiver individuals who have transferred resources and who apply for Medicaid assistance.

For the purposes of this policy, an institutionalized individual is an individual who is an inpatient of a medical institution and nursing facility (or nursing facility only) for a period of at least 30 days. The term nursing facility includes all licensed nursing facilities and ICF/MR facilities. A Waiver recipient is an individual who is certified by the Agency for services under a Home and Community Based Services Waiver Program.

SSI recipients who transfer property for less than FMV on or after 7/1/88 will not be penalized unless they become institutionalized or apply for Waiver services. SSA will provide information to the agency regarding any uncompensated transfers made by SSI applicants/recipients after 7/1/88. If an SSI recipient becomes institutionalized or applies for Waiver services, this policy will apply.

Refer to Appendix H for information regarding how to treat transfers prior to 2/8/06.

H-304 Transfers to Trusts

MS Manual 01/01/14

A transfer to a trust occurs when an individual, the individual's spouse or the representative of either the individual or spouse transfers the ownership of the individual's resources to the corpus of a trust.

"Trust" means a trust, or similar legal device, established other than by will by an individual or an individual's spouse under which the individual may be a beneficiary of all or part of the payments from the trust, and the distribution of such payments is determined by one or more trustees or other fiduciaries who are permitted to exercise any discretion with respect to the distribution to the individual, and shall include trusts, conservatorships, and estates created pursuant to the administration of a guardianship.

"Grantor" means the individual, institution or entity that established, created or funded the trust and shall also include fiduciaries as 1) defined by Arkansas Code 28-69-201 and third parties as contemplated by 2) Arkansas Code 20-77-301, et seq. Definition of a Trust.

TRUSTS ESTABLISHED PRIOR TO 8/11/93

1. State Law

   All transfers to trusts established on or before August 10, 1993, are governed by the terms of Act 1228 of 1993 and by federal law in #2 below. Act 1228 of 1993 provides the following guidelines:

   A provision in a trust, other than a testamentary trust, which limits the availability of, or provides directly or indirectly for the suspension, termination or diversion of the principal, income or beneficial interest of either the grantor or the grantor's spouse in the event that the grantor or grantor's spouse should apply for medical assistance or require medical, hospital or nursing care or long term custodial, nursing or medical care shall be void as against the public policy of the State of Arkansas, without regard to the irrevocability of the trust or the purpose for which the trust was created and without regard to whether the trust was created pursuant to court order.

2. <u>Federal Law</u>

The following federal policy was applicable to trusts established prior to 8/11/93.

a. Trust Established by the Client or Spouse - Medicaid Qualifying Trust

A Medicaid Qualifying Trust is a trust or "similar legal device" established by an individual (or his spouse) who is the beneficiary of the trust and who gives a trustee any discretion for use of the trust fund.

A "similar legal device" is defined as an arrangement, instrument, or other device which does not qualify as a trust under state law, but which has other characteristics of a trust (e.g., escrow account, savings account, pension fund, investment account or other account managed by a custodian, guardian or other individual with a fiduciary obligation). Any such legal device described above will also be considered a Medicaid Qualifying Trust.

If an individual is not legally competent and a trust is established for the individual by a guardian or legal representative (including a parent for a child), using the individual's resources, the trust will be treated as having been established by the individual, since he could not do it for himself.

With a Medicaid Qualifying Trust, consider as a resource to the beneficiary (for eligibility purposes) the maximum amount that a trustee could disburse if he exercised his full discretion allowed under the terms of the trust. This amount is deemed available to the individual whether or not the distribution is actually made. The amount actually distributed by a trustee is counted as income (if paid from the current monthly interest) or a resource (if paid from the principal or from past months' accumulated interest). This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of an individual with a developmental disability who resides in an ICF/MR facility.

1) <u>If Client is Trustee</u> - If the client is trustee of a trust established by himself or his spouse, consider the trust assets as a resource if he has legal authority to revoke or dissolve the trust, or to use the assets for the benefit of himself or his spouse.

2) If Appointed Trustee with Full Discretion - If the client is beneficiary of a trust with an appointed trustee who has full discretion for use of trust funds for the client's benefit, consider the trust assets as a resource to the client.

3) If Appointed Trustee With Limited Discretion
If the appointed trustee has limited discretion, the assets will be considered available to the maximum extent allowed by the trust, whether they are distributed or not.

EXAMPLE A: The trust allows only a monthly payment of $300. This will be income in the month available, whether paid or not, and, if not paid or used, will be a resource in the month(s) following.

EXAMPLE B: The trust allows only payment of interest earned on the principal. This will also be considered income in the month available, whether paid or not, and, if not paid or used, will be a resource in the month(s) following.

EXAMPLE C: If trust limits invasion of the principal to "care and maintenance" of the client, the monthly amount required for "care and maintenance" will be considered as an available resource for such care.

b. Trust Established by Other(s) for Client

1) Consideration of Trust Principal - If the applicant, as beneficiary of the trust, has no access to the trust principal, it is not considered a resource to him. If the trust agreement provides for regular payments from the principal to the beneficiary, they are considered to be income in the month of their receipt and, if retained, to be a resource in the month(s) following.

When the beneficiary of the trust has direct access to the principal of a trust it is considered as a resource and withdrawals are not considered as income.

2) Consideration of Interest Income from Trust Principal - When the beneficiary has legal access to the income from the trust principal, it is considered to be income as it becomes available, whether used or not. If not used, the amount will become a resource in the month(s) following its availability.

When the beneficiary has no right to the interest income from the trust principal and it is added to the principal, it is not income to the beneficiary, and only the trust payments made to the beneficiary are considered to be income. If retained, the payment(s) will be considered a resource in the month(s) following.

If the trustee exercises authority over the use of trust payments, the payments are still considered to be income to the beneficiary whether received direct or "in-kind".

TRUSTS ESTABLISHED 8/11/93 AND LATER

1. General Provisions

   All transfers to trusts established August 11, 1993, or later are governed by the terms of OBRA 1993 which, as federal law, supersedes Act 1228 and other applicable policy previously considered.

   The consideration of trusts established August 11, 1993, or later is as follows:

   a. An individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust, other than by will:

      1) The individual;
      2) The individual's spouse;
      3) A person, including any court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or
      4) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

   b. If the corpus of a trust includes resources of an individual and resources of any other person(s), the provisions of this section shall apply to the portion of the trust attributable to the resources of the individual.

   c. With the exception of a trust as described below in subsection No. 5 (Trusts Not Considered an Available Asset), this section (1a & b) shall apply without regard to:

      1) The purpose for which a trust is established;
      2) Whether the trustees have or exercise any discretion under the trust;
      3) Any restrictions on when or whether distributions may be made from the trust; or
      4) Any restrictions on the use of distributions from the trust.

2. Consideration of Revocable Trusts
    a. The corpus of the trust is considered available to the individual;
    b. Payments from the trust to or for the benefit of the individual are considered income to the individual, and
    c. Any other payments from the trust (e.g., to another individual) will be treated as a transfer of resources.
3. Consideration of Irrevocable Trusts
    a. If the trust permits payments, under any circumstances, to or for the benefit of the individual, the portion of the corpus from which payment to the individual could be made (or the income on the corpus from which payment to the individual could be made) shall be considered a resource available to the individual; and payments actually made from that portion of the corpus shall be considered as follows:
        1) Payments to or for the benefit of the individual shall be considered income of the individual, and
        2) Payments for any other purpose shall be considered a transfer of resources by the individual.
    b. Any portion of the corpus of a trust from which, or any income on the corpus from which, no payment could under any circumstances be made to or for the benefit of the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be a transfer of resources. The value of such trust shall be determined by including the amount of any payments made from such portion of the trust after such date.
4. Trusts Not Considered an Available Resource

    A trust will not be considered an available resource to an individual if it meets the criteria of one of the 3 trusts described below:

    a. A trust containing the resources of an individual under age 65 who is disabled, as determined by SSI or MRT, and which has been established for the benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court, if the state will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual;

b. A trust (Re. MS H-110) established for the benefit of an individual receiving Social Security and other pension:

   1) If the trust is composed ONLY of pension, Social Security, and other income to the individual (and accumulated income in the trust),

   2) If the state will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual subsequent to establishment of the trust, and

   3) As long as the state provides facility services to individuals in institutions under the federal income level (3 times the SSI payment level) but does not provide the same assistance to medically needy individuals.

c. A trust containing the resources of an individual who is disabled, as determined by SSI or MRT, that meets the following conditions:

   1) The trust is established and managed by a non-profit association;

   2) A separate account is maintained for each beneficiary of the trust but, for purposes of investment and management of funds, the trust pools these accounts;

   3) Accounts in the trust are established solely for the benefit of individuals with disabilities (by SSI or MRT determination, including individuals age 65 and older) by the parent, grandparent, or legal guardian of such individuals, or by a court; and

   4) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays the state from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.

5. Hardship

   If it is determined that denial of eligibility due to the transfer of resources into a trust would work an undue hardship on an individual, the hardship provisions at MS H-720 may be applied.

6. Inquiries to the Office of Policy and Legal Services (OPLS)

   When a caseworker becomes aware of the existence of a trust or of the transfer of resources into a trust, whether made by an individual, spouse, court of law, etc., the trust document along with other pertinent documents and a cover memorandum giving all information available will be sent through eDoctus to the OPPD Medicaid Eligibility Unit with a request for review by the Office of Policy and Legal Services. (Re. MS E-501)

H-305 Documentation of Resource Transfers

MS Manual 01/01/14

Each individual who is subject to a penalty for uncompensated transfers and who applies for Medicaid must complete Form DCO-727, Disposal of Assets Disclosure, in conjunction with his/her application for assistance. The caseworker will explain to each applicant/recipient (or to his/her representative) that transfers of any resources within the applicable look back period must be disclosed as a part of the eligibility determination.

Reported property transfers will be documented by copy of bill of sale, title transaction, deed, business records, receipts, account statements, etc. A signed statement from the receiving party of the transaction may also serve as evidence. The applicant/recipient or person acting on his behalf must provide necessary documentation to verify the transfer. The caseworker will give assistance when necessary.

In addition to documenting the actual transfer, when a transfer has been made by an applicant/recipient, his/her eligible spouse, or another joint owner or account holder and fair market value compensation was not received, the caseworker must complete a Form DCO-778, Resource Inquiry, and forward it to the individual who received ownership of the resource. This inquiry is completed to document current ownership of the resource, the purpose of the transfer, and any expected compensation. If a complete Asset Inquiry Form cannot be obtained, the worker should attempt to gather the information through other means, e.g., direct from the client, etc. Assistance cannot be denied solely on the basis of not being able to obtain a completed Asset Inquiry Form.

H-306 Determining the Value of Compensation Received

MS Manual 01/01/14

The value of compensation received is based on the agreement and expectation of the parties at the time of transfer. For example, if the purchaser agreed to pay the individual $10,000 in 10 installments of $1,000 each, the compensation is valued at $10,000 regardless of the amount of any payment(s) actually received at the time of application or redetermination.

The value of compensation is the gross amount paid or to be paid in a tangible form (such as cash, real or personal property) by the purchaser (the value is not reduced by expenses attributed to a sale). When compensation is equal to or greater than the value of the resource transferred, the transfer will not be considered uncompensated. However, any balance of resources from the transaction will be counted toward the resource limit.

- **NOTE:** A transfer for love and consideration is not considered a transfer for fair market value. It is presumed that services provided for free at the time were intended to be provided without compensation. Therefore, any transfer for care or services provided for free is a transfer of resources for less than fair market value.

When uncompensated value exists, refer to MS H-308.

H-307 Ownership Held in Common with Others

MS Manual 01/01/14

When resources are held by an individual in common with another person or persons in joint tenancy, tenancy in common or other similar arrangements, the resource (or portion of the resource) shall be considered to be transferred by the individual when any action is taken, either by the individual or by any other person, that reduces or eliminates the individual's ownership or control of such resource. For example, Mrs. White adds her daughter's name to a bank account. Adding a name to a resource in itself does not necessarily constitute a transfer because, in this case, Mrs. White still has full access to her money. However, the daughter later withdraws the money. The withdrawal shall be viewed as if Mrs. White had directly transferred the money to her daughter, and a penalty period will be imposed on Mrs. White if she applies for facility or Waiver assistance. (Re. MS H-308)

If in the case of joint tenancy property ownership where an individual cannot access his interest in property due to the refusal of the other owners to give consent to sell the property, it should be determined when the joint tenancy ownership was established.

EXAMPLE: During the look back period an individual had full ownership of 10 acres of land but, prior to entering a facility, deeded the property to himself and two brothers as joint owners who will not consider sale of the property. In this situation, a transfer of resources should be considered, because an action occurred which eliminated or reduced the owner's access to a resource. If, on the other hand, the joint tenancy ownership has existed for a period of time longer than the look back period, a transfer of resources will not be considered and the applicant's interest in the property will not be considered a resource if the other owners will not consider sale of the property.

When a transfer was made in the look back period by a joint owner which reduces or eliminates an individual's ownership or control of a resource, the individual will be given the right to rebut the presumption of ownership of joint accounts, if applicable (Re. MS H-307), and to rebut the presumption that resources were transferred to establish eligibility (Re. MS H-312).

H-308 Determination of Uncompensated Value and Penalty Period

MS Manual 01/01/14

This section of policy provides guidelines on:

1. Determining the value of an uncompensated transfer,
2. Determining the appropriate penalty period,
3. Determining the penalty period for multiple transfers,
4. Determining the penalty period for an uncompensated transfer to an annuity, and
5. Determining the penalty period an uncompensated transfer due to the purchase of a life estate.

When an uncompensated transfer is made and an individual applies for nursing facility services, that individual will not be eligible for a vendor payment until the penalty period has expired. An individual in a nursing facility will be eligible to receive a Medicaid card during the penalty period, provided he/she is otherwise eligible.

The uncompensated value from a resource transfer is the difference between the fair market value of the resource at the time of transfer (Re. MS E-514 for real property and MS E-522 for personal property) and the value of compensation (cash, material goods, services, etc.) received for the resource (Re. MS H-306).

EXAMPLE: An individual transfers a piece of real estate to his uncle two years prior to the individual's application for Long Term Care. The property is assessed as of the date of the transfer with a value of $10,000. The individual receives $10,000 for the property from his uncle. Fair market value was received for this transfer. There will be no penalty period imposed.

EXAMPLE: An individual transfers an automobile worth $25,000 to a grandson. The grandson agrees to pay the individual for the vehicle but only reimburses the individual for $20,000. This would result in an uncompensated transfer of $5,000, the amount of the fair market value for the auto minus the amount that the individual received as payment for the auto. A penalty period will be determined based on this amount.

H-300 Transfer of Resources

H-308 Determination of Uncompensated Value and Penalty Period

A Waiver applicant and/or spouse who transfers resources for less than fair market value either during the look back period or after approval for the Waiver program will be ineligible for the Waiver program until the date of the transfer is no longer in the look back period or the applicant enters a nursing facility and the appropriate penalty period based on the transfer begins.

Determining the Penalty Period

The number of months of ineligibility for facility services will be determined by dividing the uncompensated value of all resources transferred by the individual or spouse on or after the look back date by the current divisor (see Appendix R). There is no cap on the total number of months of ineligibility. Any fraction remaining after dividing the total uncompensated value by the divisor will not be dropped. The remaining fraction will be multiplied by 30 (days) and the resulting number will be rounded up to calculate the additional number of days of ineligibility. The penalty period will begin either on the date of the transfer or the date of Medicaid eligibility, whichever is the later date.

EXAMPLE: An applicant transferred $250,000 to his children 6 months before entering a nursing facility and received no compensation for the transfer. As 6 months is within the 60 month look back period, there will be a penalty for the uncompensated transfer. The divisor at the time of his admission was $4,955. $250,000 divided by 4955 equals 50.454 months of ineligibility. The fraction remaining after dividing the total uncompensated value by 4955 will not be dropped. The fraction .454 multiplied by 30 (days) equals 13.62 which rounds up to 14 days. Do not round down. The penalty period will be for 50 months and 14 days.

Multiple Transfers – The caseworker will determine the penalty period for multiple resource transfers by treating the total cumulative, uncompensated value of the resources transferred by the individual, the individual's spouse or the designated representative during all the months of the look back period as one transfer. This applies to all transfers regardless of the amount transferred. The caseworker will add the amount of all the transfers together to calculate the penalty period. The penalty period will begin on either the date of the transfer or the date of Medicaid eligibility, whichever is the later date.

EXAMPLE: An individual gives away $8,000 in May 2010; $10,000 in June 2010; $12,000 in July 2010; and $4,000 in August 2010. He receives no compensation for these transfers. He then applies for assistance in May 2013. The total value of the uncompensated transfers, $34,000 will be divided by 4,955 (2013 divisor) resulting in a penalty of 6 months and 26 days.

Penalty for an Uncompensated Transfer to an Annuity - If an applicant with an annuity has not yet annuitized (i.e., started receiving regular payments) and the annuity is revocable, the principal of the annuity is a countable resource. If annuity payments have begun and the contract is irrevocable, the number of years of payout of the annuity must be equal to or less than the number of years of expected life remaining for the individual, based on the life expectancy tables at Appendix L. If the payout years are greater than the life expectancy years, a transfer of resources for less than fair market value has been made.

EXAMPLE: A male at age 65 purchases a $10,000 annuity that will be paid over the course of 10 years. Since his life expectancy according to the table is 16.33 years, he can expect to recover the full amount of his investment. However, a male at age 80 has a life expectancy of only 7.43 years. If he purchases a $10,000 annuity to be paid over the course of 10 years, the payout of the annuity for approximately two and a half years is considered a transfer of resources for less than fair market value and the amount is subject to penalty. To determine the penalty, subtract the total payout for 7.43 years from $10,000. Divide the difference by the current divisor (See Appendix R) to determine the number of months of ineligibility.

If an annuity is made irrevocable and there will be no payout during the life of the annuitant, the full purchase price of the annuity is subject to a penalty for transfer of resources.

Penalty for an Uncompensated Transfer Due to the Purchase of a Life Estate - The purchase of a life estate will be treated as an uncompensated transfer of resources if the purchaser does not live on the property for at least 12 consecutive months after the property is purchased. Also, if an individual purchases a life estate in someone else's home the individual must live in that home for a period of 12 consecutive months after the date of purchase. The full amount of the purchase price of the life estate will be considered as the uncompensated transfer.

If the transfer occurred after more than one year of occupancy, the case worker will look at the purchase price of the life estate to determine if the purchase price was for fair market value. (See MS H-306) If the person's life expectancy is less than the life estate purchased, a transfer penalty is imposed.

- **NOTE:** The Asset Transfer Worksheet is available in ANSWER to assist the caseworker in computing the correct penalty period.

H-309 Exceptions to the Penalty Period

MS Manual 01/01/14

A penalty period shall not be calculated according to MS H-308 if:

1. The resource transferred was a home, and title to the home was given to:
    a. The individual's community spouse;
    b. A child of the individual who is under age 21, or who is blind or has a disability (as determined by SSA or MRT);
    c. A child of the individual (other than a child described in " b" above) who lived in the home for at least two years immediately before the individual was admitted to a medical institution, Waiver program or nursing facility and who provided care to the individual which allowed the individual to remain at home during that time rather than enter an institution; or
    d. A sibling of the individual who has an equity interest in the home and who was residing in the home for at least one year immediately before the individual was admitted to a Medical institution, Waiver program or nursing facility;
2. The resources were transferred:
    a. To the individual's spouse or to another for the sole benefit of the individual's spouse;
    b. From the individual's spouse to another for the sole benefit of the individual's spouse;
    c. To the individual's child who has a permanent disability or is blind as determined by SSA or MRT, solely for the benefit of that child, or to a trust, described at MS H-304, solely for the benefit of that child; or
    d. To a trust (including a trust described at MS H-304) established solely for the benefit of an individual under 65 years of age who is has a disability (as determined by SSA or MRT).

- NOTE: Sole benefit means that it will benefit that individual only and that no other individual will derive benefit from the transferred resource during the lifetime of the individual to whom the resource was transferred. There must be a legal document executed to establish the transfer and evidence of "sole benefit", and it must be established that the transferred resource will have some immediately measurable monetary value which will benefit the spouse or child, e.g., a CD or other instrument which produces income, land or rental property which produces income, etc.

3. The individual intended to dispose of the resources either at fair market value or for other valuable consideration, or that the resources were transferred exclusively for a purpose other than to qualify for medical assistance (the procedures for rebuttal of the presumption that resources were transferred to establish eligibility in MS H-312 are applicable), or
4. All resources transferred for less than fair market value have been either returned directly to the client or used for the client's care.

H-310 Imposing the Penalty

MS Manual 01/01/14

The penalty period begins with the date of the transfer or the date of Medicaid eligibility, whichever is the later date. Once a penalty period begins, it continues to run until expiration. (MS H-315) No penalty period will apply if the transfer can be excluded under the provisions listed in MS H-309. During the penalty period, the individual is not eligible for a vendor payment until the expiration of the penalty period but may receive other Medicaid services with the exception of Waiver services. The application must be approved for Medicaid without the vendor payment if all eligibility requirements have been met.

EXAMPLE: For applicants, the penalty period will begin on the date of Medicaid eligibility. The Medicaid eligibility date is 10/30/13 and the transfer occurred 5/30/13. The penalty period will begin with the date of Medicaid eligibility, 10/30/13.

EXAMPLE: For recipients, the penalty period will begin on the date of the transfer. At reevaluation on 9/1/12, the caseworker discovers that an uncompensated transfer occurred on 4/10/12 which resulted in ineligibility for vendor payments for 8 months. The penalty period will begin 4/10/12, the date of the transfer. The caseworker will send a 10 day notice and stop the vendor payment effective the day the 10 day notice has expired. The remaining balance of the penalty period will continue. Any payments made prior to the end of the 10 day notice will result in an overpayment.

Even though the vendor payment has been closed, Medicaid will continue to cover services not covered under the vendor payment. However, the imposition of a penalty for an uncompensated transfer of resources negates any eligibility for Home and Community Based Services (HCBS). The penalty for an uncompensated transfer for HCBS waiver recipients is total ineligibility for waiver services. Unless the individual enters a nursing facility, the individual will remain ineligible until the transfer date moves out of the look back period. If the individual enters a nursing facility, the penalty period will be determined and will begin with the date of entry to the facility. It will continue uninterrupted for the appropriate period of time even if the individual leaves and returns home. In that situation, Waiver services can resume when the penalty period is over.

EXAMPLE: An applicant for ElderChoices transferred $50,000 without compensation to his children 6 months before application. The penalty for this uncompensated transfer is complete ineligibility for Waiver services. Unless the applicant enters a nursing facility, he/she will remain ineligible until this transfer is no longer within the look back period. If the client enters a nursing facility and is otherwise eligible for Medicaid, the following penalty period will be imposed. The transferred amount of $50,000 divided by 4,955 (the divisor at the time of admission) equals 10.090 months. The remaining fraction .090 multiplied by 30 (days) equals 2.7 which rounds up to 3 days. The applicant will be ineligible for vendor payment for 10 months and 3 days upon entry to a nursing facility.

EXAMPLE: An applicant transferred $250,000 to his children 6 years before entering a nursing facility. No penalty will be assessed as the transfer occurred before the 60 month look back period.

H-311 Notifying Individual of Established Uncompensated Value and Penalty Period

MS Manual 01/01/14

When uncompensated value is established, the individual must be advised of that fact before the application or redetermination is completed. The individual will be informed by letter (Form DCO-732) that he transferred a resource at less than fair market value and that the uncompensated value will result in a penalty period unless he can provide convincing evidence that the action was exclusively for some purpose other than establishing eligibility. A copy of the letter will be scanned in the electronic record.

If the individual does not respond to the letter within 15 days, it will be assumed that he does not wish to rebut the presumption that the transfer was for the purpose of establishing eligibility.

H-312 Rebuttal of Presumption that Resources Were Transferred to Establish Eligibility

MS Manual 01/01/14

When an individual elects to rebut the presumption that the resource was transferred to establish eligibility, he will be informed that it is his responsibility to present convincing evidence that the resource was transferred exclusively for some other purpose.

The individual's statement concerning the circumstances of the transfer will be obtained and should include (but need not be limited to) the following points:

1. Purpose of transfer of resource,
2. Attempts to transfer resource at FMV,
3. Reasons for accepting less than FMV for the resource,
4. Means of or plans for supporting himself after the transfer, and
5. Relationship, if any, to the person(s) to whom the resource was transferred.

The individual will be required to submit any pertinent documentary evidence (e.g., legal documents, realtor agreements, relevant correspondence, etc.).

The individual's statement of purpose for transfer of the resource and any documentary evidence provided will be evaluated to determine if the transfer was exclusively for some purpose other than establishing Medicaid eligibility. Refer to MS H-313 for factors which indicate the transfer was for a purpose other than to establish Medicaid eligibility.

H-313 Factors Which Indicate Transfer Exclusively for Some Other Purpose

MS Manual 01/01/14

The presence of one or more of the following factors may indicate that resources were transferred exclusively for some purpose other than establishing eligibility:

1. The occurrence after transfer of the resource of:
    a. Unexpected (traumatic) onset of disability, or
    b. Unexpected loss of other resources which would have precluded eligibility at the time the resource was transferred, or
    c. Unexpected loss of income which would have precluded eligibility at the time the resource was transferred.

2. The resource (if retained) would not have caused total resources to exceed the resource limit at the time of transfer.

EXAMPLE: An individual who has a car worth $1500 and $300 in a checking account gives away the car. No penalty period will be imposed, because the value of the car would not have made him ineligible had he kept it. THIS EXCEPTION DOES NOT APPLY TO A HOME; IF A HOME IS GIVEN AWAY, THE EQUITY VALUE WILL BE COUNTED AS AN UNCOMPENSATED TRANSFER unless one of the exceptions may be applied (e.g., it is transferred to a spouse).

3. The transfer was court ordered for the purpose of satisfying an obligation in existence at the time of that transfer.

If the individual indicates that he had another purpose for transferring the resource but protection of the resource against use for medical or nursing home expenses was a factor in transferring it, the presumption that it was transferred to establish eligibility is not rebutted.

H-314 Apportionment of Penalty for Spouses

MS Manual 01/01/14

If the Institutionalized Spouse is serving a penalty period due to a transfer of resources for less than fair market value, the penalty period will be apportioned between spouses if the Community Spouse otherwise becomes eligible for medical assistance.

EXAMPLE: A CS of an institutionalized individual has transferred resources valued at $50,000, which results in a period of 10 months and 3 days of ineligibility for the IS (This penalty period is calculated by dividing 50,000 by the 2013 divisor, 4,955 which equals 10.090. The remainder of .090 is multiplied by 30 which equals 2.7. This number is rounded up to 3 days. Thus, the penalty period is 10 months and 3 days). Two months and 1 day after the transfer, the CS must also enter the nursing home and she meets all the eligibility requirements for Medicaid assistance. The remaining 8 months and 2 day penalty period will be divided between spouses, leaving only 4 months and 1 day of ineligibility remaining for the spouse who was institutionalized first and giving 4 months and 1 day of the penalty to the spouse who entered last, thus allowing both to become eligible in 4 months and 1 day.

If a penalty has been apportioned between two institutionalized spouses and one spouse dies, the penalty period for the surviving spouse will be extended by the appropriate amount.

EXAMPLE: An institutionalized couple is under a penalty period of five months each from January through May. One of the spouses dies in March. The remaining penalty months of April and May for the deceased spouse will be added to the surviving spouse's penalty, causing that spouse to be ineligible for services through June and July.

When an IS under a penalty dies or goes home, the CS of that individual later enters a facility and the penalty period of the IS has not yet expired, the CS entering the facility will inherit the remainder of the penalty previously imposed.

EXAMPLE: An individual under a 12-month penalty imposed January through December of a year dies in July. The surviving spouse enters a nursing facility in September. The remaining months of the penalty (September through December) will be imposed on the surviving spouse. The above rules will also apply if one member of a couple is an IS and under a penalty and the CS applies for Waiver services, or if both members of a couple are requesting Waiver services, and one is under a penalty previously imposed.

H-315 Penalty Continues Without Interruption until Expiration

MS Manual 01/01/14

If an institutionalized resident under a transfer penalty leaves the institution, the penalty period will continue to run. If the individual later reenters an institution and reapplies for Medicaid, the worker will not only inquire about transfers in the appropriate look back period from the date of reapplication, but will also check the case record to determine the length of the penalty previously imposed and whether or not that penalty has expired. The break in institutional status does not eliminate or disrupt a penalty previously imposed.

EXAMPLE: An individual who transferred $400,000 was penalized from receiving vendor payments for 80 months and 22 days. After 12 months and 17 days in an institution, the individual is able to return home for a period of 13 months before it again becomes necessary to enter a Nursing Facility. The previously imposed penalty period will continue (80 months and 22 days less the 25 months and 17 days which have elapsed since the penalty began) and the individual will remain ineligible for Nursing Facility services until the full 80 months and 22 days have passed.

If he or she reapplies, for example, when 65 of the 82 month period has elapsed and the county worker inquires about transfers in the 60 month look back period, the $400,000 transfer would have occurred more than 60 months prior to this reapplication. However, the original penalty imposed (80 months and 22 days) will continue to expiration before vendor eligibility can be considered. If the individual has made additional transfers in the 60 month look back period, an additional penalty period will be imposed.

Even though the penalty for nursing facility services continues until expiration, an individual living in the community may still be found eligible for Medicaid in a Medicare Savings Program category.

- **NOTE:** In order to track the periods of ineligibility, when an applicant is denied due to transfer of resources, the worker will complete Form DCO-723, Report of Resource Transfer, and route the form to:

  Medicaid Eligibility Unit
  P. O. Box 1437 - Slot S-333
  Little Rock, AR 72203

The Medicaid Eligibility Unit will key the transfer information to WRTR so that, if the individual later applies in another county, workers can determine whether a previously imposed penalty is still in effect.

H-316 Transfer of Resources Divisor Definition

MS Manual 01/01/14

The Transfer of Resources Divisor is one of the numbers used in the calculation to determine the penalty period resulting from a transfer of resources for less than fair market value.

The divisor is defined as the weighted average per diem Medicaid rate multiplied by 30.42 and rounded to the nearest dollar to obtain a monthly amount, calculated from cost reports submitted for the cost reporting period from July to June, and then applied to the following calendar year. The weighted average rate is calculated annually. Medicaid LTC resident days reported on each facility's cost report will be multiplied by each facility's per diem rate. The sum of the calculated amounts will be divided by the total resident days to get the weighted average rate. The divisor will be re- determined yearly by the Division of Medical Services with any resulting changes taking effect on April 1st. The divisor for the current year is indicated on Appendix R.

When there is a change in the divisor, the penalty period will be reassessed at the next reevaluation, or earlier if requested, or at reapplication.

If the client is currently eligible in a LTC Medicaid case, but not receiving a vendor payment due to penalty, the client will be reassessed at reevaluation or earlier if requested. If the client is now eligible for vendor payment, vendor payment will be approved beginning the month of reassessment.

If the client is not currently receiving LTC but reapplies and is under a previously imposed penalty, the penalty period will be reassessed using the current divisor. If eligible, the case will be approved with coverage not granted before April 1st or before the three-month retro period based on the recent application, whichever is later.

H-317 Reacquisition of/or Additional Compensation Received on Resource Transfer at less than FMV

MS Manual 01/01/14

Resources that are either returned directly to the client or used for the client's care will reduce the penalty period. The caseworker must verify the value of resources that were either returned to the client or spent for the client's care, and make a determination as to the extent the returned resources should reduce the penalty period. This determination will include ensuring that the returned resources were returned from the individual to whom they were originally transferred.

If transferred resources are returned to the individual who transferred them, no penalty period will be imposed, i.e., the transfer will be considered as if it had never occurred. However, an individual who regains transferred resources may not be eligible for a period of time due to the value of the resources. If only a portion of the transferred resources are returned, a penalty period will be calculated based on the value of the resources not returned and will begin with the date of transfer of the first transferred resource not returned.

The receipt of additional compensation for a resource which was transferred at less than fair market value reduces the consideration of uncompensated value for that resource by the amount of additional compensation received. The additional compensation received plus remaining uncompensated value (if any) will be counted with the value of the other resources of the individual.

H-320 Income Transfers

MS Manual 01/01/14

As the definition of assets includes income to which an individual is entitled but does not receive, a penalty for transfer must be considered when, for example, an individual takes action to:

1. Irrevocably waive pension income,
2. Waive an inheritance,
3. Divert income to another recipient, or
4. Give away income during the month of receipt by the IS/CS.

The penalty period due to the uncompensated value of an income transfer is determined according to MS H-322. Amounts of uncompensated value and their periods of consideration may be affected by the receipt of compensation at a later time. Refer to MS H-317 for treatment.

H-321 Failure to Apply for Benefits

MS Manual 01/01/14

Federal regulations require that, as a condition of eligibility, an individual must take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which the individual is entitled. These benefits include, but are not limited to, veterans' compensation and pensions, OASDI benefits, railroad retirement benefits, and unemployment compensation. If an individual fails to access any benefits to which he is entitled, he will not be eligible for Medicaid.

If otherwise eligible, Medicaid coverage will begin/resume on the first day of the month that the individual takes the necessary steps to obtain the other benefits.

H-322 Determination of Uncompensated Value and Penalty Period when Income has been Diverted or Waived

MS Manual 01/01/14

When income has been given away, the penalty period during which vendor payment will not be paid will be determined according to the amount of income not received, based on the life expectancy of the individual who is being penalized. (Re. Appendix L)

EXAMPLE: An individual with income $300 over the NF income limit irrevocably revokes his company pension of $400. The life expectancy tables at Appendix L will be utilized to determine the penalty period. If he is age 76, for example, when he enters a NF and gives away his right to income, his life expectancy is 8.70 years. The income he elected not to receive is valued at $41,760 ($400 monthly x 12 months x 8.70 years). The $41,760 will be divided by 4,955 (2013 divisor), resulting in a penalty of 8 months and 13 days. (See Appendix R for current divisor.)

There is no penalty when an eligible Institutionalized Spouse gives part or all of his income to a Community Spouse in accordance with the methodology at MS H-200 and on the DCO-712.

H-323 Income Received and Transferred in the Same Month

MS Manual 01/01/14

If funds are received AND transferred in the same month, the funds are treated as income in the month received and also treated as a resource in that month when considering transfer of resources. The penalty period will begin on either the date on which the funds were transferred or the date of Medicaid eligibility, whichever is later.

H-324 When an Ineligible Spouse Gives Away Income

MS Manual 01/01/14

No penalty will be imposed on an institutionalized spouse (IS) if the individual's community spouse (CS) gives away income belonging to the CS or fails to access CS income, since the CS's income is not counted toward the IS's eligibility nor in the budget for vendor payment. However, if a CS takes such action, no payment will be made from the income of the eligible IS's income to compensate the CS for the income not received.

EXAMPLE: An eligible facility resident agrees to give his spouse $300 of his monthly income and is allowed to give her this amount under the provisions of MS H-200 and the DCO-712. The facility resident's spouse has elected to give an elderly sister $100 of her monthly income. An additional $100 of the NF resident's income cannot be given to his spouse ($400 total) to bring her income back up to the level it would have been had she not given $100 to her sister.

If the ineligible spouse of a Waiver applicant/recipient has given away income or refused to access income to which that spouse was entitled, no penalty will be imposed on the Waiver applicant/recipient, since the ineligible spouse's income has no effect on a Waiver applicant/recipient's eligibility.

However, if an ineligible CS later enters a facility or requests Waiver services, the CS will be penalized for the income he/she has given away.

H-325 Spousal Transfers in Excess of Community Spouse Minimum Resource Allowance (CSMRA)

MS Manual 01/01/14

If an IS transfers resources or income to the CS in amounts greater than the amounts allowed by the spousal rules (Re. MS H-200) no penalty period will be imposed on the IS. However, the assets will still be considered available in the eligibility determination of the IS.

H-400 Post Eligibility

MS Manual 01/01/14

The eligibility groups Nursing Facility, Assisted Living Facility and PACE require procedures to complete the enrollment process following the determination of eligibility. These eligibility procedures are explained in the following sections.

H-401 Income Eligibility Determination for the Institutionalized Spouse (IS)

MS Manual 01/01/14

Income eligibility for the IS will be determined in general following the procedures in MS H-405-452. Gross income of the IS cannot exceed the current LTC income limit in determining eligibility, unless an income trust has been established. Income of the Community Spouse (CS) will not be deemed to the IS in any month or partial month of institutionalization. If an IS is receiving full SSI payment for the first three months of institutionalization, the SSI payment will be disregarded as income.

H-402 Consideration of Income

MS Manual 01/01/14

After the IS has been determined to be resource eligible for Long Term Care, income of the IS and CS will be considered as follows:

1. Income Not From A Trust

    a. Income received solely in the name of either spouse will be considered income only to that spouse;

    b. If payment of income is made in the names of both the IS and CS, half will be considered available to the CS and half to the IS;

    c. If payment of income is made in the names of the IS and/or the CS and another person, the income will be considered available to each spouse in proportion to each spouse's interest. If payment is made with respect to both spouses, and no such interest is specified, one half of the joint interest will be considered available to each spouse.

2. Income From A Trust

   Income from a trust will be considered available to each spouse as provided by the trust or, in the absence of a specific provision in the trust, according to the rules in 1. a-c above. If the IS or CS established the trust, refer to MS H-304 for consideration of income from the trust.

3. Income Through Property With No Instrument Establishing Ownership

   When income is from property which has no instrument establishing ownership (i.e. unprobated, income-producing heir property), one half of the income will be considered to be available to the IS and one-half to the CS.

H-403 Rebutting Consideration of Income

MS Manual 01/01/14

The caseworker will advise the applicant or representative of the income that will be considered in the gross income test of the IS.

If the IS or representative disagrees with the treatment of ownership interest in income (other than from a trust) required by MS H-402, the IS or the representative will be given the opportunity to rebut the presumption of ownership. In order to successfully rebut the presumption of full or partial ownership, he/she must provide the following within 30 days of the date on the DCO-712, Post Eligibility Income Worksheet:

1. A written, signed statement by the IS giving his/her allegation regarding ownership, the reason for the applicant's receipt of the income or for his/her name appearing as an owner on the payment of the income;

2. Corroborating, signed statements from the other owner(s);

3. A change in the instrument of ownership removing the IS's name from the instrument or a change which redirects the income to the actual owner(s); and

4. Copies of the original and revised documents reflecting the change in 3.

A successful rebuttal will result in a finding that supports the individual's allegation regarding ownership of the income.

If the individual elects not to rebut the consideration of ownership interest, obtain a written statement from the individual which documents his/her election.

If the individual elects not to rebut, does not provide a rebuttal within the allotted time, or does not provide all of the required evidence, the income produced from the presumed ownership interest will be used in his/her eligibility determination.

If the individual submits all required evidence within the allotted time, the individual's ownership interest will be determined and the findings documented in the case record. The income from the actual ownership interest (i.e., the interest determined by the rebuttal) will be used in the eligibility determination.

When the individual has successfully rebutted ownership of all or a portion of the income, income payments will be considered available to the IS in proportion to his/her interest (if any).

NOTE: This section does not apply to federal, state or other entitlements, pensions or retirement benefits. For example, ownership of a $600 Social Security income entitlement for an IS cannot be rebutted.

H-410 Factors Used to Determine the Cost of Care

MS Manual 01/01/14

Nursing facility recipients are required to contribute all of their monthly income, minus certain approved deductions, to the cost of their facility care. Medicaid pays the balance of the monthly charges due based on a per diem rate according to the individual's Level of Care.

Note: AAPD, ElderChoices and DDS Waiver recipient make no contribution to the cost of their care. For the contribution to the cost of care guidelines for Assisted Living and PACE recipients, refer to MS H-412 and MS H-413.

After determination of resource eligibility and the post-eligibility consideration of income (or upon request by the IS, CS, or their representative), the Nursing Home Net Income, Community Spouse Minimum Monthly Maintenance Needs Allowance (CSMNA), Community Spouse Monthly Income Allowance (CSMIA), and any Family Member Allowances (FMA) will be computed on form DCO-712, Post Eligibility Income Worksheet. Amounts will be rounded to the nearest dollar (Round .50 up). These amounts will be deducted from the IS's gross income, in the following order:

1. The $40.00 personal needs allowance.

2. The Community Spouse Monthly Income Allowance (CSMIA), which is determined by:
   a. Computing The Excess Shelter Allowance in Section 5a of the DCO-712. Total shelter costs may include:
      1) Rent or mortgage, including principal and interest;
      2) Prorated taxes and insurance, including personal property taxes and insurance on household contents if paid yearly;
      3) Condominium or cooperative fee, including maintenance charges; and
      4) The standard utility allowance.

   Shelter costs must be verified. Utilities need not be verified.

NOTE: Do not add the standard utility allowance in computation if utilities are included in rent or if someone else is paying the utilities. If only partial utilities are included in rent (Ex. - water), the full utility allowance may be used.

   b. Computing the Community Spouse Minimum Monthly Maintenance Needs Allowance (CSMNA) by adding the amount shown in 5b of the DCO-712 to the Excess Shelter Allowance. The total CSMNA amount may not exceed the maximum indicated on the DCO - 712 (the maximum will be adjusted annually according to the Consumer Price Index).
   c. Computing the Community Spouse Monthly Income Allowance (CSMIA) by subtracting the CS's gross income from the CSMNA (VA A&A and CME/UME are not countable income to the CS).

      The CSMIA will only be deducted to the extent contributed by the IS. If the IS contributes an amount less than the computed CSMIA, only the actual amount contributed will be deducted from the IS's gross income; i.e., the actual contributions will be deducted instead of the computed CSMIA (Re. MS H-416). An IS may not contribute more than the CSMIA unless under a court order, or unless a hearing officer has determined the CS needs income greater than the CSMNA (Re. MS H-208).

      If a court orders the IS to contribute a larger amount for the support of the CS, then the amount of support ordered by the court will be used instead of the CSMIA. Any amount ordered by a court will be not subject to the limit on the CSMNA.

3. A Family Member Allowance (FMA) for each dependent family member.

   The FMA is computed for each dependent family member by deducting the family member's income from the amount shown in Section 4 of the DCO-712 and by dividing the result by 3.

   The FMA will only be deducted from the IS's income to the extent that it is actually contributed by the IS. If the IS contributes an amount less than the FMA, only the actual amount contributed will be deducted from the IS's gross income, i.e., the actual contribution will be deducted instead of the computed FMA (Re. MS H-415).

   A CS who is an SSI recipient, or who has children receiving SSI, will have the right to choose whether or not to accept a CSMIA or FMA. It should be explained to the CS that the result of accepting an allowance may be reduction or termination of SSI benefits and Medicaid. A dependent family member receiving SSI (parent or sibling of the IS) will also be given the same choice.

4. Monthly noncoverable medical expenses of all facility recipients which are not subject to payment by a third party (including Medicaid). The medical expenses must be verified as currently due and unpaid. Future anticipated expenses may be used when it is verified that these expenses have occurred with regularity in the past and will continue to occur with regularity in the future.

   When there is a contract between an applicant and a medical provider and regular payments on a medical bill are being made, the monthly payment will be deducted as a noncoverable medical expense. When there is no contract, the monthly amount of the medical expense being paid may be deducted, with verification that regular payments are being made.

   Deduction of medical expenses is not allowed for nursing facility and ICF/MR residents for items and services included in the state's Reimbursement Cost Manual as allowable cost items (items the facility will provide). Examples of these include wheelchairs, canes, crutches, walkers, ambulance services or enrollment fees for ambulance services (unless there is not a Medicaid enrolled ambulance provider in the area), other transportation services, over-the-counter pain killers, antacids, laxatives, cough syrups, suppositories, anti-diarrhea medication, diapers, band-aids, bandages, peroxide, antiseptics, etc. Facilities are required to provide these items and services at no additional charge to the recipient.

An income offset for the purchase of eyeglasses, contact lenses, hearing aids, prostheses, and dentures can be made only if the following procedure is followed:

1) The items must be prescribed by a physician or other licensed medical practitioner.
2) The items must be a part of the recipient's plan of care. It must be determined by the facility interdisciplinary team that the recipient's quality of life will be enhanced and that he or she is able to utilize the item(s).
3) The request must be approved by the facility's Quality Assessment and Assurance Committee.
4) The cost of the item(s) must be determined.
5) The recipient or authorized representative must provide the caseworker with verification of the above. The recipient or authorized representative must not make the purchase or pay the medical bill until the caseworker has made an adjustment to the patient liability.

Other allowable medical expenses (if not subject to payment by a third party) include: health insurance premiums, deductibles, and coinsurance; prescription drugs not in the Medicaid formulary; physician, hospital, and dental charges; etc. These are not subject to approval through the facility's Quality Assessment and Assurance Committee. However, prior to making the purchase or paying the bill, the recipient or authorized representative must provide the caseworker with proof that the item or items were prescribed by a physician or other licensed medical practitioner, and with proof of the cost.

Deduction from income for cosmetic and elective procedures (e.g., face lifts or liposuction) will not be allowed from the income of a facility recipient. Other expenses not allowed are the premiums for insurance which pays cash to a recipient when medical expenses have been incurred and Medicare premiums deducted from SSA payments prior to buy-in. The only allowable medical deductions will be the recipient's noncovered medical expenses. Medical expenses of family members cannot be deducted from facility income.

NOTE: As of January 1, 1990, there is no monthly limit on the number of prescription drugs for facility recipients receiving vendor payment, as long as the prescribed medicine is within the Medicaid formulary. Medicaid facility recipients who are not certified for vendor payment are limited to three prescriptions per month.

Medical expenses can be of three types:

a. Monthly - Expenses incurred regularly each month such as doctor visits and medical supplies;
b. Nonmonthly - Expenses which are not incurred monthly but are incurred periodically, such as quarterly doctor visits;
c. One-time - Expenses incurred such as hospital bills.

   If the caseworker is unable to determine within a fair degree of certainty what the non-covered medical expenses will be, then no medical expenses will be deducted from the income.

The remaining income (if any) is the net income which will be applied to the client's cost of care.

If all of the IS's gross income is depleted at any step in the computation, the amount applied to the LTC vendor payment (cost of Care) will be $0.

After the DCO-712 is completed, a copy of the DCO-712 will be provided to each spouse. If the form is completed prior to application, at the request of either spouse, the DCO-712 will only be provided to the spouse making the request.

H-411 Cost of Care Determination

MS Manual 01/01/14

When categorical eligibility and medical necessity have been established for Nursing Facility and PACE applicants/recipients, the caseworker will determine the amount of the individual's income that will be applied to the cost of facility care. Steps for determining the amount of income to be applied to the cost of care are shown below.

1. <u>Total Earned and Unearned Income</u>

Total all income of the recipient by type and amount with the following exceptions:

- For State Human Development Centers and Arkansas Health Center residents, interest income is not counted in the monthly budget. A semi-annual cost accounting will be made by these facilities that will take this income into consideration.
- VA Aid and Attendance payments and VA CME/UME will not be counted as income.
- Mandatory deductions and work related expenses will be deducted from gross earnings.

- An additional amount of up to the current SSI/SPA will be deducted from the earnings of residents in 10-bed ICF/MR facilities and State Human Development Centers.

2. Fees for Income Trusts

Deduct any applicable fees from income trusts.

- The monthly service charges for maintaining the bank account and trustee fees may be deducted in cases certified November 1, 1995 and later. Refer to MS H-100.

3. Personal Needs Allowance

Deduct the personal needs allowance (PNA).

- Subtract a $40 PNA for most facility residents.

  Note: Facility residents whose only income is SSI will be allowed to keep $30 as their PNA. The PNA of a SSI recipient who also has other income is $40.00. Refer to MS H-420.

- Single veterans and spouses of veterans with no dependents whose VA pensions have been reduced to $90 will be given the full $90 as a personal needs allowance. An additional $40 will not be given. A $90 PNA will not be given to any individual whose VA pension has not been reduced to $90 by the Veterans Administration (VA). If VA later reduces the pension to $90, an income adjustment will be made.

  It will not be the responsibility of the caseworker to attempt to identify individuals who may be eligible for a $90 PNA or to allow a $90 PNA when the VA benefits have not been reduced to $90. If a single veteran or surviving spouse of a veteran with no dependents is receiving VA pension and the benefits have not been reduced to $90 at certification, only a $40 PNA will be given. The case will be adjusted when the caseworker learns that the pension has been reduced to $90.

  Individuals may be instructed to contact the Veterans Administration if they believe they are entitled to a $90 reduced pension.

- For residents of ICF/MRs and State Human Development Centers with earned income, $40 may be given as a PNA in addition to a disregard of earned income up to the current SSI/SPA.

  If the individual has no spouse or dependents or noncovered medical expenses, the PNA will be the only allowance given to arrive at net income. If the individual has dependent children, but no spouse, refer to step 4 below. If the individual has a spouse or spouse and other dependents living in the community, refer to MS H-410.

4. Protected Maintenance Allowance for Dependent Children When There is No Spouse in the Home

In certain cases, an allowance may be given from the eligible individual's income for the protected maintenance of dependent children living in the home when there is no spouse in the home.

Eligibility for the individual in a facility must be established before consideration is given for protected maintenance. If there are dependent children under the age of 18, the combined income of the children must be less than the Medically Needy Income Level for the appropriate number of children in the household to qualify for protected maintenance. (See MS Appendix N for MNILs.)

In addition to meeting the stated income limitations, the countable resources of the dependent children must be within the AABD resource limitations to qualify for protected maintenance. Actual amounts allowed for protected maintenance are determined as follows:

- Determine the children's maintenance level using the appropriate MNIL for the children.
- Total any income that the children may have. If the total gross income equals or is greater than the maintenance level in the step above, no protected maintenance from the institutionalized individual's income will be allowed. If the children's income total is less than the maintenance level, their total gross income will be subtracted from the maintenance level to arrive at the amount that will be given from the individual's income for protected maintenance.

  Example: Two dependent children each have $75 monthly income, for a total of $150. The $150 income will be subtracted from the 2 person MNIL of $216.66, leaving $66.66. $66.66 of the institutionalized individual's income will be given to the children as protected maintenance.

  If there are no noncovered medical expenses, the net income after deducting the protected maintenance for the child(ren) will be applied to the cost of facility care. If there are noncovered medical expenses, proceed to step 5 below.

5. **Non-Covered Medical Expenses**

After deducting the personal needs allowance and maintenance allowance, if any, the total of non-covered medical expenses will be deducted. Only the non-covered medical expenses for the facility recipient may be deducted. For noncovered medical expenses allowable as deductions, refer to MS H-410 #4. The remaining amount, after all allowable deductions, is the net income that the individual will be expected to apply to the cost of care.

Net Income

The total of any excluded earnings, income trust fees (when applicable), maintenance allowance and non-covered medical expenses (if any) will be entered in the system as Protected Maintenance. The net amount remaining will be the amount the individual is expected to apply to the cost of care. The actual vendor payment will be determined by the eligibility system based on the net income entered by the caseworker.

For active cases where the VA pension has been reduced by VA to $90, $90 will be entered as VA pension. $50 plus any additional amounts considered as non-covered medical expense will be entered as Protected Maintenance. The system will automatically exclude the $40 PNA resulting in the full $90 being given to the recipient.

H-412 Contribution to the Cost of Care for Assisted Living Facilities

MS Manual 01/01/14

Assisted Living Facility (ALF) Waiver recipients are allowed to keep a flat 90.8% rounded up of the SSI/SPA for room and board. This will allow the individual to purchase food from the facility, or elsewhere, if they prefer. In addition to the charge for room and board, a monthly personal allowance will be deducted. The personal allowance will be based on 9% of the SSI/SPA and rounded up. Both will increase each January with the SSA/SSI Cost of Living Increases.
See Appendix S for current amounts.

In addition to room and board and the personal allowance, the following expenses are to be deducted from the cost of care:

1. Monthly medical insurance premiums for the ALF recipient.
2. Non covered medical expenses including over the counter medications and medical supplies for the ALF recipient.
3. Spousal support payments for the community spouse and Family Member Allowance. Refer to MS H-410 #2-3.

4. Bank service charges on the Income Trust account. Refer to MS H-111 #3.
5. Earnings up to the monthly SSI/SPA amount if employment is prescribed as therapeutic by the attending physician.

The ALF recipient's income, minus room and board, personal allowance and certain other expenses, will be contributed to their cost of care each month.

H-413 Contribution to the Cost of Care for PACE

MS Manual 01/01/14

Post-eligibility treatment of income provisions will apply to PACE participants upon entry into a nursing facility using the procedures for Long Term Care Medicaid. Refer to MS H-410 thru 411. For PACE participants in the community, there is no cost of care unless the individual has income over the income limit and has established an income trust. For income trust guidelines, refer to MS H-110.

The caseworker will calculate a patient liability amount for those PACE participants in nursing homes and those who are eligible through establishing an Income Trust. The PACE provider will collect and retain the patient liability. For individuals in nursing facilities, a personal needs allowance (PNA) equal to the current LTC PNA, any applicable community spouse allowances and/or family allowances and excess medical expenses will be deducted from the PACE participant's monthly income. Refer to MS H-410 thru 411.

For individuals in the community who are eligible through establishing an income trust, income in excess of the current LTC Medicaid limit will also be paid to the PACE provider. A personal needs allowance equal to the current LTC/PACE limit of three times the current SSI/SPA, plus any applicable spousal or family support or excess medical expenses will be deducted before making payment to the PACE provider.

H-415 Option to Estimate Net Income

MS Manual 01/01/14

The caseworker may elect to estimate for a period not to exceed six months any or all of the following: the income of the IS, the spousal and family member maintenance allowances, and the medical expenses. The six month projection will show reasonable income and expenses, based on the six month period immediately preceding the projection and may be preferable when income or living/medical expenses fluctuate.

H-416 Verification or Refusal of Contributions

MS Manual 01/01/14

Prior to certification of the IS, the IS or representative must complete and sign the statement on the reverse of the DCO-712 to indicate that the IS plans to contribute the CSMIA and the FMA specified on the front of the DCO-712, during the period of institutionalization.

If the DCO-712 is not completed and signed, no allowances for the CS or other family members will be used in determining Nursing Home Net Income. The CSMIA and FMA will only be deducted to the extent actually contributed by the IS.

If the CS does not want to accept the contribution from the IS, the CS should decline the income by completing the appropriate section on the DCO-712.

H-420 Treatment of Extended SSI Benefits for Institutionalized Recipients

MS Manual 01/01/14

As of 7/1/88, those SSI recipients entering a medical or nursing facility:

a. who have a home to maintain, and
b. who obtain a medical statement for SSA to document that the medical confinement will not exceed 3 calendar months after the month of entry to the facility

will be allowed to retain their full SSI benefits for a period up to 3 full months. No extension beyond the 3 months will be allowed.

When aware of the extension of SSI benefits for facility applicants/recipients, the caseworker will totally disregard the SSI benefits for determination of facility eligibility and vendor payment. If the applicant/recipient has income from any other source (e.g. VA, SSA, RR Retirement, etc.), that income will be included in the facility budget.

At certification of facility care applicants receiving the full SSI benefit (who have no other income), only the $30 personal needs allowance will be displayed on the WNHU interface and the remaining income will be disregarded.

When certifying recipients with a combination of SSI and other income, all of the SSI benefit will be disregarded. The other income will be entered on the income tab. The $40 personal needs allowance will be deducted from the countable income and the remaining income will be shown as NH Net Income (patient liability) on the WNHU interface.

If the SSI recipient's stay in the facility actually exceeds three months, no adjustment in the budget will be required, as it remains correct.

H-421 Consideration of Ineligible Spouse/Parent(s) Income after Initial Eligibility Has Been Established

MS Manual 01/01/14

After initial eligibility has been established, income of the noninstitutionalized ineligible spouse/parent(s) may be considered available to the eligible spouse/child in a facility only to the extent that it is voluntarily contributed either to the eligible spouse/child in a facility or directly to the facility for partial vendor payment.

The ineligible spouse/parent(s) is not required to make a contribution to the eligible spouse/child in a facility or to the facility and may, in fact, choose to make no contributions.

If, however, the ineligible spouse/parent(s) indicates that he/she will voluntarily contribute any income, determine whether the contribution is made directly to the eligible person in the facility or directly to the facility for partial vendor payment.

Contributions made directly to the eligible person in the facility will be considered as unearned income both in determination of eligibility and in determining the net income to be applied to the vendor payment.

Contributions made directly to the facility as partial vendor payment will only be considered for the individual's share of the facility vendor payment, and will not be considered for recipient eligibility. The payment made by the ineligible spouse/parent(s) must be for covered services under the LTC program to be considered available to apply toward the vendor payment. Payments made by the ineligible spouse/parent(s) for special charges or additional services and items not covered by the facility vendor payment will not be considered. This includes payments made by the family of the facility recipient to the facility for the cost of a private room.

Each ineligible spouse/parent will be advised that income contributions may be made on a voluntary basis to the eligible spouse/child in a facility or to the facility, and of the different ways that the contributions may be considered. The decision of whether to contribute or not is left to the ineligible spouse/parent(s) to make, and no suggestions or recommendations of action will be given. Any questions that the ineligible spouse/parent(s) has regarding the effects of a specific action will be answered.

Non-voluntary contributions can only be effected by court order, and only considered when actually paid by the ineligible spouse/parent(s). The eligible person in a facility is not required to seek support from the ineligible spouse/parent(s) to remain eligible for facility care.

H-430 Earnings of ICF/MR Facility Residents

MS Manual 01/01/14

Residents of ICF/MR facilities, including residents of State Human Development Centers, who have earned income may be given an earnings disregard of up to an amount equal to the current SSI SPA in addition to the $40 personal needs allowance. Nursing facility residents with earnings may be given a disregard of up to $100 of their monthly earnings, provided there is documentation that a physician has prescribed employment activity as a therapeutic or rehabilitative measure. If a nursing home resident receiving skilled care reports earnings, the Office of Long Term Care (OLTC) should be contacted and requested to reevaluate medical necessity.

All nursing facility and ICF/MR residents must first pass the gross income test, with no disregards allowed. If found eligible, the consideration of earnings will be as follows.

1. Ten Bed ICF/MR Facilities and State Human Development Centers

   Earnings of residents of these facilities must be taken into consideration for both eligibility and net income determinations. If residents pass the gross income eligibility test, their earnings will be included in the net income determination. In determining the net income to be applied toward the vendor payment, first subtract the mandatory deductions (e.g., federal and state income taxes) from gross income and, from the remaining earned income, up to an amount equal to the current SSI SPA for personal needs. Refer to MS H-411 for consideration of earnings at certification.

2. Fluctuating Earnings

   If the earnings of ICF/MR facility residents stay below the SSI SPA, no reporting of fluctuations is needed.

   The facility administrator will report to the caseworker any month in which a resident's earnings exceed the SSI SPA.

   If earnings consistently stay above the SSI SPA, they may be averaged (MS E-415), provided the facility administrator will agree to report to the caseworker:

a. every 6 months when earnings are fairly stable, or
b. more frequently if the resident loses employment, changes jobs, or has earnings in any month which are more than $15 above the computed average.

H-440 Effective Eligibility Dates for LTC and ICF/MR Services

MS Manual 01/01/14

The effective date of eligibility of an applicant for LTC and services in an ICF-MR depends on three factors:

1. Date of Entry - The individual's date of entry into a participating facility is indicated on the DCO-702, Notice of Admission, Discharge or Transfer From A Facility, which is completed by the facility and forwarded to both the Office of Long Term Care and the county office for initial certification. Vendor payments cannot begin prior to the individual's date of entry into a facility.

2. Date of Medical Necessity - Medical necessity is determined by the Office of Long Term Care. The medical necessity decision is transmitted to the county office and the facility by the DCO-704, Evaluation Of Medical Need Criteria, which classifies the patient for a specific level of care. If a DCO-704 is received by the county office on an applicant which classifies him/her for a specific level of care, medical necessity exists to the date of the individual's entry or to the date of application if the patient was accepted as private pay only until the application for Medicaid was made. However, if the patient is in an ICF/MR facility or was subject to PASARR, medical necessity begins on the DCO-704 decision date for ICF/MR or PASARR date for PASARR residents, and Medicaid and vendor payment cannot begin prior to this date.

3. Date of Categorical Eligibility - Categorical eligibility for facility care and services under the AABD criteria can be established to begin three months prior to the date of application provided all eligibility conditions are met. If categorical eligibility is established by receipt of SSI or Foster Care, the date to begin vendor payment is not governed by the three month retroactive eligibility limitation as applied under the AABD eligibility criteria. Even though categorical eligibility may be established prior to application, however, the begin date for Medicaid and vendor payment cannot be prior to the decision date on the DCO-704 for ICF/MR applicants or PASSAR date for individuals subject to PASARR.

Authorization of services cannot be made until all three factors have been met.

H-450 Approval of an Applicant Who is in a Medicare Bed

MS Manual 01/01/14

When Medicare approves individuals for skilled nursing care/extended care, the facility receives reimbursement in the form of Medicare per diem and Medicaid coinsurance (if applicable) for up to 100 days, provided the individual continues to meet Medicare criteria.

Applications for Medicare approved admissions will be processed in the same manner and timeframe as applications for non-Medicare approved admissions, except that nursing home services will not be authorized on the WNHU interface in ANSWER until Medicare benefits have been exhausted. Medicare pays 100% of facility expenses for only 20 days. After this time, the individual becomes liable for coinsurance, which cannot be paid by Medicaid until the case is opened on the WASM interface in ANSWER. Therefore, Medicaid for Medicare eligible individuals will be authorized on the WASM interface in ANSWER so that all other Medicaid covered services may be paid. The caseworker will use the characteristic code of “entered LTC as Medicare” on the Budget Unit characteristic tab when approving Medicaid only.

The monthly Medicare per diem amount will not be considered when determining income eligibility, but it will be treated as a third party resource to be applied to the cost of care in a facility.

When Medicare approves an individual for skilled nursing care, the facility should notify the caseworker of the Medicare admission via the DCO-702. Refer to MS H-460.

If at some point, the individual fails to meet Medicare criteria or exhausts his/her benefits, Medicare will stop payment. The facility will notify the caseworker of the change in status via the DCO-702. On the day following termination of Medicare benefits, the caseworker may authorize facility services on the WNHU interface in ANSWER to be effective on that date, provided the individual continues to meet all LTC requirements.

H-460 When a LTC Recipient Transitions to a Medicare Bed

MS Manual 01/01/14

When an individual transitions from a Medicaid bed to a Medicare bed, the nursing facility will send the county office a DCO-702, Notice of Admission, Discharge or Transfer from a Facility, with the date of the transition.

The caseworker will close the vendor payment in ANSWER by entering a vendor end date on the budget summary tab. The Medicaid portion will remain open. A notice will be sent via the DCO-

700 to the recipient or authorized representative stating that the bank account or patient fund account at the facility will accumulate additional income due to the vendor payment being suspended and this could result in excess resources. A copy of the notice will be provided to the facility.

If the caseworker receives notification from the facility via a DCO-702 stating that the recipient has moved back to a Medicaid bed, a resource assessment must be done prior to reopening the vendor portion of the case.

H-470 Quality Control Errors

MS Manual 01/01/14

The amount computed as net income to be applied to the vendor payment will be subject to Quality Control error.

If a contribution or medical expense is deducted from gross income and the IS is not actually meeting the contribution or expense, this will be an understated liability and a dollar error.

If the contribution (or full contribution) or medical expense is not being deducted from the income, and the IS has agreed to pay the contribution, or has incurred a medical expense, this will be an overstated liability but no dollar error.

H-480 Acquisition of Additional Income and Resources

MS Manual 01/01/14

The acquisition of additional income and resources by a recipient will be verified in the same manner used for determination of initial eligibility. Necessary income adjustments or closures will be entered in the eligibility system. Advance notice will be given when required for terminations of assistance or increased vendor payment liability.

Refer to: MS E-500 thru E-530 and MS Section H for specific information regarding resource evaluations, changes, etc.; MS E-400 thru MS E-451 for specific information regarding income treatment; and MS H-410 for specific information regarding the net income determination (or MS H-207 when there is a CS).

H- 481 Case Adjustments for Lump Sum Payments in Prior Months

MS Manual 01/01/14

When a caseworker learns that a recipient received lump sum benefits in a prior month which caused ineligibility for the month of receipt only, it will not be necessary to close the case if the recipient regained eligibility the month following the receipt of the lump sum. If the recipient has lost eligibility for more than one month, then the case will be closed and a new application will be required.

EXAMPLE: The caseworker learns in March 2013 that the recipient received a lump sum payment in January 2013 which caused ineligibility due to excess income but, in February 2013, the recipient's income and resources were below the limits again. The case will not be closed and a new application will not be required because the recipient regained eligibility the month following receipt of the lump sum.

Case adjustments in this situation will be made as follows:

1. Case Adjustment for LTC Ineligibility Period - To adjust the case for the month of ineligibility, an entry should be made on the WNHU interface for the month of ineligibility. The caseworker should key the start date as the first day of the month the client was income ineligible, and the stop date as the last day of the month the client was ineligible. The income amount keyed should be the total income received in the month or one dollar more than the maximum skilled care rate whichever is greater.
2. No System Case Adjustment is needed for Medicaid categories other than LTC.
3. Overpayments - Overpayment reports for LTC and other Medicaid categories will be submitted to recover any Medicaid payments made during the month of ineligibility (Re. MS Section M). If the facility has retained the lump sum benefits, no overpayment is required to recoup the vendor payments.

When the caseworker has advance knowledge of lump sum payments (e.g., land rent paid annually) that will result in one month of ineligibility, procedures at MS E-411 #1 will be followed, advance notice given, and the case adjusted at the appropriate time.

H-500 Long Term Care Insurance Partnership Program

MS Manual 01/01/14

The Deficit Reduction Act of 2005, Pub. L. 109-171, Section 6021 allows for the expansion of a Qualified State Long Term Care (LTC) Partnership Program. This permits States to disregard as a resource when determining Medicaid eligibility an amount up to the total amount of benefits paid out of a LTC Insurance Partnership policy. The benefits will be disregarded in determining an individual's Medicaid eligibility for Facility Care as well as Home and Community Based Services. The Arkansas General Assembly passed Act 99 on February 13, 2007 to establish the Arkansas Long Term Care Partnership Program.

The Qualified State LTC Partnership Program encourages individuals to accept personal responsibility for their future long term care needs by purchasing insurance and reduces the incentive to transfer or hide resources that can be protected legally. It will help individuals better plan for long term care needs they may have in the future.

NOTE: Purchasing or owning a LTC Partnership policy does not guarantee Medicaid eligibility. Other eligibility factors must be met also.

H-510 Resource Disregard

MS Manual 01/01/14

A resource disregard in an amount up to the amount of benefits paid out by a Qualified Long Term Care Insurance Partnership policy will be allowed when determining eligibility for Medicaid. This is a "dollar for dollar" calculation for resource protection. The benefits will be disregarded in determining an individual's Medicaid eligibility for Facility Care as well as Home and Community Based Services.

EXAMPLE: An individual purchased a qualified policy with a benefit of $100,000. Application is made for Medicaid and the policy has paid out $90,000 in benefits. The policyholder's resources can be protected up to $90,000.

Only certified "partnership qualified" LTC insurance policies provide this resource protection. The resource disregard cannot be allowed for a non-qualified LTC insurance policy.

H-520 Policy Identifiers

MS Manual 01/01/14

The Arkansas Department of Insurance has established specific criteria that the qualified long term care insurance policy must meet. The criteria are:

1. The policy must cover a person who is a resident of the Qualified Partnership State when coverage first became effective.
2. The policy must meet the definition of a “qualified long term care insurance policy” established by the Internal Revenue Code of 1986.
3. The policy must not have been issued earlier than July 1, 2008.
4. The policy must include inflation protection which is established at the time of purchase. The inflation protection can be up to 5% but not less than 3%.

The resources to be protected will be designated during the initial application process and the value of the designated resources must be verified by the caseworker.

NOTE: Under the spousal impoverishment rule, only resources that belong to the institutionalized spouse (IS) are protected.

H-530 Disclosure

MS Manual 01/01/14

A statement disclosing partnership qualified status will not be included on the policy. A separate disclosure document will be sent to the individual by the insurance company after the purchase of the policy.

The content of the disclosure notice will include:

1. The insured’s name, policy number, date of issue,
2. A statement that the disclosure form should be kept with the policy,
3. An overview of resource disregard,
4. Any policy changes that might affect partnership qualified status; and
5. A website address for more information.

When an individual applying for Medicaid states that he or she has a Qualified LTC Partnership policy, the caseworker will request the disclosure notice or other documents so that contact can be made to the insurer to verify the amount of the policy and benefits paid to determine the amount of the resource disregard.

H-540 Policy Exchanges

MS Manual 01/01/14

If an individual has an existing LTC insurance policy that does not qualify as a Partnership policy due to the effective/issuance date of the policy, individuals may exchange their current policies for partnership qualified policies through their insurance agents. If the policy is exchanged for another, the insurance company will provide the policyholder with a disclosure statement with a new effective/issuance date.

H-550 Exhaustion of Benefits

MS Manual 01/01/14

An individual who owns a Qualified Long Term Care Partnership policy can apply for Medicaid before the exhaustion of policy benefits.

The Qualified Partnership policy is treated as a third party liability and Medicaid will pay for services not covered. Medicaid will be payor of last resort.

H-560 State Reciprocity

MS Manual 01/01/14

If an individual purchased a qualified partnership policy in another state, it will be accepted in Arkansas. Qualified partnership policy status will be verified by the caseworker. The caseworker will request the disclosure notice or other documents so that contact can be made to the insurer to verify the amount of the policy and benefits paid to determine the amount of the resource disregard. The caseworker will request the individual to complete Consent for Release of Information form, so the insurer can release requested information.

H-570 Transfer Protection

MS Manual 01/01/14

A transfer of the protected resources will not be an uncompensated transfer and will not be subject to a penalty period. When disregarded resources are given away, the disregarded amount cannot be replenished nor can additional resources of the policyholder be eligible for protection.

EXAMPLE: Mrs. Jones, who bought and used a Qualified Partnership policy, applies for Medicaid after her long-term care insurance policy is depleted. Under her policy, she used $100,000 in insurance benefits and is eligible for a resource disregard of $100,000. The $100,000 is set aside in a separate savings account.

While on Medicaid, Mrs. Jones uses the funds in her account to buy gifts for family members, and to make other purchases. This is not considered an uncompensated transfer because the transferred resources were protected.

H-580 Effect of Resource Disregard in Estate Recovery

MS Manual 01/01/14

The initial amount of protected resources, if the policyholder still has ownership, will be disregarded from estate recovery when the policyholder dies. If a Qualified Partnership policyholder spends or transfers the disregarded resource prior to death, then only the disregarded amount remaining is exempt from estate recovery (Re. MS H-600).

EXAMPLE: Mrs. Jones was eligible for a resource disregard of $100,000. At the time of her death, there is $20,000 remaining in the account. During the estate recovery process, the state will allow an exemption of $20,000 from the amount that would otherwise be eligible for estate recovery.

H-600 Estate Recovery

MS Manual 01/01/14

The Omnibus Budget Reconciliation Act of 1993 and Arkansas Act 415 of 1993 mandate recovery of medical payments correctly made from 8/13/93 and later from the estates of:

- Individuals of any age who were considered to be permanently institutionalized, who received medical services in a nursing or ICF/MR facility, and who were required to pay all but a minimal amount of income for their care, and for
- Individuals age 55 and older who received medical services in a nursing or ICF/MR facility or in a home and community based waiver program, whether or not they were considered to be permanently institutionalized.

Estate recovery will not be made from the estate of deceased individuals when:

- There is a surviving spouse, dependent children under age 21, or children that are blind or have a disability (as determined by SSA disability guidelines),
- Recovery will create an undue hardship for other surviving family members, or
- Recovery is not cost effective.

Estate recovery will not be made from resources which were protected as a result of the individual having a Qualified Long Term Care Insurance Partnership Policy. The maximum amount protected at estate recovery will be the amount protected when eligibility was established. If any of the protected resources have been spent or given away, only the amount remaining will be protected at estate recovery.

H-610 Definitions

MS Manual 01/01/14

Estate - The term “estate” under Arkansas law, with respect to a deceased individual, means all real and personal property owned by the individual at his death.

Permanently Institutionalized - An individual is considered to be “permanently institutionalized” if a medical determination is made which indicates there is no reasonable expectation that the individual is likely to return home.

The date on which an individual was determined to be permanently institutionalized is irrelevant. If services were provided prior to the time a decision was made regarding permanent institutionalization, recovery will include assistance provided prior to the decision.

Intent to Return Home - When an individual who enters an institution states his intent to return home, the home may be excluded from countable resources in determining eligibility, even when a medical decision has been made that the individual is “permanently institutionalized”.

Undue Hardship - Undue hardship may exist when the estate’s resource is the sole resource of the survivors, the resource is their sole source of income, the income is not sufficient to meet their living expenses and also repay the debt to DHS, or there are other compelling circumstances (e.g., the estate resources cannot be readily converted to cash).

Cost Effective - Recovery is cost effective if the amount which can be recovered from an estate is greater than the cost of recovery to DHS.

Personal Representative - The executor of a will or administrator of an estate who has been appointed to the position by a probate court.

Distributee - A person entitled to real or personal property of a decedent, either by will, as an heir, or as a surviving spouse.

Affidavit for Collection of Small Estates - The affidavit permitted by Ark. Code Ann § 28-41-101 to allow the distributees of an estate that does not exceed $100,000 to receive the estate without the appointment of a personal representative or administration of the estate.

Notices - An initial notice of intent to recover from the estate of individuals who received Medicaid services in an institution or a waiver program will be given at the time of application for services. The notice is printed on the application, Form DCO-777. PUB 428 will also be given to the applicant or their authorized representative.

A second notice, DHS-20 - Notice of Estate Recovery, will be sent to the personal representative of the deceased’s estate or to a distributee of the estate who has signed an “Affidavit for Collection of Small Estates”. The notice will inform the individual of the intent to recover, of the hardship and cost effectiveness provisions, and of appeal rights. The notice will be mailed by the Third Party Liability Unit (TPL).

H-620 County Office Responsibilities

MS Manual 01/01/14

During the application process for nursing facility, ICF/MR, or waiver services, the caseworker will review the initial estate recovery notice on the back of the DCO-777 with the applicant or representative. The MS H 600-650 section can be used as the basis to provide additional information if needed. If the applicant or representative has questions which the caseworker cannot answer, a suggestion may be made to make further inquiries of an attorney.

The determination that an individual under age 55 is considered permanently institutionalized will be made based on the medical information submitted on the DHS-703 for nursing facility residents, or on the DHS-703A for ICF/MR residents.

Administrators of nursing and ICF/MR facilities have been requested to submit copies of the completed DHS-703s or DHS-703As to county offices for new applicants who are under the age of 55. If the estimated duration of need for facility care is checked "permanent" on page 3 of the DHS-703, or is checked "indefinite" on page 3 of the DHS-703A, the individual will be considered permanently institutionalized. If the DHS-703 or the DHS-703A has not been received prior to certification for services, a copy will be requested from the facility. Certification will not be delayed pending receipt of either form.

The determination need not be made again as long as the individual resides in a facility. The DHS-703 or DHS-703A will be indexed in the recipient's electronic record to show that a determination of permanent institutionalization was made.

Within 10 days of case closure due to the death of a Nursing Facility, ICF/MR, or Home and Community Based Waiver recipient, the caseworker will complete the "Report of Case Closure Due to Death (Form DCO-734) and mail it to the **Third Party Liability Unit, Decedents' Estates, P. O. Box 1437, Slot S296, Little Rock, AR 72203-1437.**

H-630 Recovery Procedures

MS Manual 01/01/14

State law requires in most cases that the appointed personal representative of the estate of a deceased person shall promptly mail to the creditors of an estate, including the Department of Human Services (DHS), a copy of the notice of their appointment which has been published in the newspaper. The published notice is to include the requirement that all claims against the estate be submitted within six months of the date of publication of the first notice. A copy of the petition for probate of a will or administration of an estate and the decedent's Social Security number shall be attached to the notice forwarded to DHS.

After receiving notice of the opening of an estate or filing of an "Affidavit for the Collection of a Small Estate", the TPL Unit will check the MMIS System to determine if the decedent received Medicaid benefits in a nursing facility, ICF/MR facility, or under a home and community based waiver program.

TPL will not pursue recovery if:

1. There is a surviving spouse;
2. There are surviving minor children;
3. There are surviving children of any age who are blind or permanently and totally disabled as defined in 42 U.S.C. §§ 1381 et seq;
4. In cases of a home, there is a son or daughter currently lawfully residing in the home and was residing in the recipient's home for at least two years immediately before the recipient's admission to the medical institution, and who establishes to the satisfaction of the State that he or she provided care to the recipient which permitted the recipient to reside in the home rather than in an institution;
5. In cases of a home, there is a sibling currently lawfully residing in the home, and the sibling was residing in the home at least one year immediately before the date of the recipient's admission to the medical institution; or,
6. The recovery is not cost effective.

For factors one (1) through five (5) of the above-listed, recovery is not waived. Instead, it may be postponed until the individuals identified in those factors die or move from the home.

If benefits were paid for services in a nursing facility, ICF/MR facility, or home and under a home and community based waiver program, TPL will mail to the personal representative or the distributee of a small estate a Notice of Estate Recovery (DHS-20), advising of the intent to recover Medicaid payments and of the procedures for requesting a hardship waiver.

A payment profile for the decedent will be ordered from the Division of Medical Services (DMS). When the payment profile is received, a claim against the estate will be prepared for the signature of the Director of DMS. The claim will be filed with the appropriate Probate Clerk and a copy mailed to the personal representative, attorney for the estate, or distributee of the estate.

If no benefits were paid, no further action will be taken.

H-640 Application for a Hardship Waiver

MS Manual 01/01/14

The personal representative or distributee of an estate may apply for a hardship waiver at the time notice of the estate is given to DHS, or within 30 days after receiving notice from DHS of intent to recover Medicaid payments and the procedures for requesting a hardship waiver (DHS-20). Refer to MS H-730 for procedures.

H-650 Appeal Rights

MS Manual 01/01/14

The waiver applicant may appeal the DHS decision regarding the hardship waiver by writing to the Office of Appeals and Hearings and requesting an administrative review of the decision. The request must be received no later than 30 days from the date of the notice of negative action.

H-700 Undue Hardship Waiver

MS Manual 01/01/14

An individual may request an Undue Hardship Waiver:

1. When denied eligibility due to excess home equity ,
2. When denied nursing facility vendor payment due to a transfer of resources/income for less than fair market value, or
3. After receiving notice from DHS of intent to recover Medicaid payments through the Estate Recovery process.

The individual or Authorized Representative will need to provide the caseworker verification to support the allegation of hardship.

H-710 Hardship Waiver for Home Equity

MS Manual 01/01/14

An individual who is denied eligibility due to excess home equity may request an Undue Hardship Waiver. (Re. MS E-517) An example of a situation in which an undue hardship may exist is if the individual makes an allegation that the home equity should not be counted because of a legal impediment to selling or transferring the home.

The caseworker will submit all Home Equity Undue Hardship Waiver requests and supporting documentation to the OPPD Medicaid Eligibility Unit. A decision on the hardship waiver will be made by the Hardship Waiver Committee. The caseworker will send the committee decision and information about the right to appeal the decision to the person who applied for the waiver. If the person who applied for the waiver disagrees with the DHS decision, he/she may appeal the decision within 30 days' receipt of the notice about the DHS decision (MS J-100).

H-720 Hardship Waiver for Transfer of Resources/Income

MS Manual 01/01/14

An individual who is denied nursing facility vendor payment due to a transfer of resources/income for less than fair market value may request an Undue Hardship Waiver. No penalty period for uncompensated transfer will be imposed upon an institutionalized or Waiver individual to the extent that it is determined that denial of eligibility would work an undue hardship. Undue hardship exists if each condition below is met:

1. Counting uncompensated value would make an individual ineligible;

2. Lack of assistance would deprive the individual of food, shelter, and care determined to be medically necessary;
3. The individual's total resources are not great enough to pay for facility care for one month; and
4. The resource(s) cannot be recovered from the individual(s) to whom the resource(s) was transferred without compensation due to loss, destruction, theft, or other extraordinary circumstance.

Undue hardship does not exist when applying the transfer provisions merely would cause the individual inconvenience, or would restrict his lifestyle without putting him at risk of serious deprivation.

The individual or the individual's authorized representative may apply for an undue hardship waiver. In addition, a representative from the facility in which an individual is residing may apply for an undue hardship waiver on behalf of the client with either the consent of the client or his/her personal representative. To ensure consistency with decisions regarding what constitutes a hardship, the caseworker will route all applications for an undue hardship waiver to OPPD, Medicaid Eligibility Unit.

A decision on the hardship waiver will be made by the Hardship Waiver Committee. The caseworker will send the committee decision and information about the right to appeal the decision to the person who applied for the waiver. If the person who applied for the waiver disagrees with the DHS decision, he/she may appeal the decision within 30 days' receipt of the notice about the DHS decision (MS J-100).

H-730 Hardship Waiver for Estate Recovery

MS Manual 01/01/14

The personal representative or distributee of an estate may apply for a hardship waiver at the time notice of the estate is given to DHS, or within 30 days after receiving notice from DHS of intent to recover Medicaid payments and the procedures for requesting a hardship waiver (DHS-20).

To apply for a waiver, the representative or distributee must mail a statement setting forth the facts which constitute the undue hardship to:

Third Party Liability Unit
Attention: Decedents' Estates
P. O. Box 1437, Slot S296
Little Rock, AR 72203-1437.

H-700 Undue Hardship Waiver

H-730 Hardship Waiver for Estate Recovery

The statement must set forth the facts which constitute the undue hardship. Tax returns, income statements or other documents which support the position that estate recovery would work an undue hardship on the survivors must be submitted. The Third Party Liability Unit will send the hardship request and supporting documents to the Office of Program Planning and Development, Central Office Hardship Waiver Committee. In determining the existence of an undue hardship, the Central Office Hardship Waiver Committee will consider factors including, but not limited to the following:

1. The estate asset subject to recovery is the sole-income producing asset of beneficiaries of the estate;
2. Without receipt of the proceeds of the estate, a beneficiary would become eligible for federal or state benefits;
3. Allowing a beneficiary to receive the inheritance from the estate would enable a beneficiary to discontinue eligibility for federal or state benefits;
4. The estate asset subject to recovery is a home with a value of fifty percent (50%) or less of the average price of homes in the county where the homestead is located, as of the date of the decedent's death; and
5. Other compelling circumstances.

A determination that hardship does not exist will be made if the individual created the hardship through estate planning in which assets were divested in order to avoid estate recovery.

A decision on the hardship waiver will be made by the DHS Central Office Hardship Waiver Committee.

The DHS decision and information about the right to appeal the decision will be sent by certified mail, return receipt requested, to the person who applied for the waiver. If the person who applied for the waiver disagrees with the DHS decision, he/she may appeal the decision within 30 days' receipt of the notice about the DHS decision (MS J-100).

If recovery is not made due to the determination of hardship, DHS may decide to recover at a later time if the conditions which caused the original hardship cease to exist.

I-100 Renewals and Changes

MS Manual 01/01/14

A renewal is a periodic redetermination of eligibility after initial eligibility has been established. Only factors of eligibility which are subject to change (e.g., financial) must be redetermined. Factors not subject to change such as age or citizenship will not be redetermined at renewal.

A change is a report of a difference in circumstances within the family household. Individuals are only required to report changes that may affect the individual's eligibility such as income that exceeds the applicable income limit. Changes should be reported within ten (10) days of the date the change occurred to avoid any potential overpayment. Eligibility will be redetermined when a change that may affect eligibility is reported.

The individual will not be asked to provide verification of information that is not relevant to ongoing eligibility, or that has already been provided and is not subject to change. This applies at both renewal and a change report.

I-110 Renewal Process

MS Manual 01/01/14

A renewal will be conducted once every 12 months and no more frequently than once every 12 months. Depending upon the Medicaid eligibility group, a renewal form completed by the individual may or may not be required in order to complete the redetermination of eligibility.

Renewals for individuals in the Families and Individuals (MAGI) groups may be completed without information from the family or individual as described in MS I 200-210.

Specific renewal forms are required to be completed by individuals in the AABD Eligibility Groups in order to redetermine eligibility and complete the renewal. See MS I-300 and Appendix O for those specific processes and forms.

I-200 Families and Individuals (MAGI) Groups Renewal Process

MS Manual 01/01/14

The renewal processes described in MS I-200-230 apply to all eligibility groups using the MAGI financial methodologies. See MS E-200.

For those factors of eligibility subject to change, eligibility will be redetermined during the renewal process in accordance with the applicable eligibility requirements described in MS E 200-270 and F 110.

Before requesting information from the individual, the agency must first attempt to make a redetermination of eligibility based on information available through the Federal Data Services Hub, ARFinds, and other information known to the agency (e.g., through the SNAP program.) This is called an *ex parte* renewal. If an *ex parte* renewal cannot be completed, then a renewal form pre-populated with the information known to the agency will be sent to the individual for review. This form must be signed and returned to the agency.

The system will initiate the renewal process in the *10th* month following the last renewal or application so that the renewal can be completed prior to the end of the 12th month. The first step will be to attempt to complete an *ex parte* renewal as described below.

I-210 *Ex Parte* Renewal

MS Manual 01/01/14

The system will take the following actions to complete an *ex parte* renewal:

1. Conduct an electronic review by collecting income information from available data sources such as the Federal Data Services Hub, ARFinds and other available programs (e.g., SNAP), and

2. Determine continued eligibility if sufficient information is found through the data matches.

3. Generate and send a notice to the individual advising of the renewal decision. The notice will include the information used to determine eligibility or ineligibility. The notice will advise the individual to review the information used to determine eligibility and respond to the agency only if any of the information is inaccurate. If the individual is no longer eligible, the notice will also serve as an advance adverse notice of action to terminate the individual's Medicaid eligibility.

4. Update the individual's record to reflect continued eligibility or effective date of ineligibility. If ineligible, trigger an Account Transfer to the Federally Facilitated Health Insurance Marketplace (FFM) as appropriate.

Caseworker Responsibilities

No action is required by the caseworker when an *ex parte* renewal is completed unless the individual responds to the eligibility decision notice indicating the information upon which the determination was made is inaccurate. When that occurs, the caseworker will review the information provided by the individual, request any necessary verification to validate the information, if validated, enter the new information to the system and trigger a new eligibility determination within the system. The system will then generate appropriate notices to the individual.

I-220 Regular Renewal

MS Manual 01/01/14

If the system cannot complete an *ex parte* renewal because sufficient information to determine eligibility is not available through existing data sources, then the individual will be required to provide the necessary information.

The system will take the following actions:

1. Generate and send to the individual a renewal form that is pre-populated with the information known to the agency. Specific information needed from the individual will be requested on the form. The individual will be given 30 days from the date of renewal form to provide any necessary information and return the form to the agency.
2. Set a due date in the system by which date the form must be returned.
3. Redetermine eligibility once the renewal form and any other necessary information has been returned and entered to the system and generate the same notices described in MS I-210 #3.
   If the individual returns the renewal form after the case is closed but within 90 days from the date of the renewal form, the form will be used to determine eligibility. A new application will be required if the renewal form is returned after 90 days.
4. Update the individual's record to reflect continued eligibility or effective date of ineligibility. If ineligible, trigger an Account Transfer to the FFM as appropriate.

5. Generate an adverse notice of action to the individual to terminate Medicaid eligibility when the form is not returned by the due date and update the individual's record to end Medicaid coverage. In this situation, no Account Transfer is made to the FFM.

Caseworker Responsibilities

The caseworker is responsible for the following actions to complete a regular renewal:

1. Ensure that the completed renewal form and any verification provided by the individual is scanned into the system upon receipt;
2. Review the information provided and request any necessary verification to validate the information; and
3. If validated, enter any new or changed information to the system and trigger a new eligibility determination within the system. The system will then generate appropriate notices to the individual and take action to continue Medicaid coverage or terminate it if eligibility no longer exists.

I-230 Newborns Renew in ARKids First

MS Manual 01/01/14

Newborn coverage ends the last day of the month of the child's first birthday. Prior to that date, an ARKids First eligibility determination using the *ex parte* renewal process described in MS I-210 will be attempted based on information already known about the newborn's household composition and income. If sufficient information is not available to determine the newborn's ARKids First eligibility, then a pre-populated form as described in MS I-220 will be sent to the newborn's parent or caretaker adult for completion. Upon the form's return, eligibility for either ARKids A or B will be determined and if eligible, the newborn will be enrolled in the appropriate ARKids group. If not eligible due to household income, then an Account Transfer will be made to the FFM for an eligibility determination for Advanced Premium Tax Credits (APTCs) and selection of a Qualified Health Plan (QHP).

The ARKids eligibility determination must be completed prior to the first day of the newborn's birth month to ensure the newborn can have uninterrupted coverage either through ARKids or enrollment in a QHP.

I-300 AABD Eligibility Groups Renewal Process

MS Manual 01/01/14

The renewal processes described below apply to all eligibility groups using the AABD eligibility requirements. See MS B-300 and Section F.

For those factors of eligibility subject to change, eligibility will be redetermined during the renewal process in accordance with the applicable eligibility requirements described in MS Sections D, E, F and H. Factors which are subject to change include income, resources, disability, and medical necessity. (MS Sections E and F)

A renewal form will be system generated to the individual, his or her spouse, or authorized representative requesting updated information for those factors of eligibility subject to change. The same renewal form is not used for all AABD eligibility groups. See Appendix O for the specific renewal form that is used for each of the AABD groups. The system generated form will include a date by which the form must be returned to the agency.

The system will initiate the renewal process in the *10th* month following the last renewal or application so that the renewal can be completed prior to the end of the 12th month. The system will take the following actions:

1. Generate the appropriate renewal form to the individual, his or her spouse, or authorized representative.
2. Set the due date for return of the form. This date will be the 10th day of the 11th month.
3. If the form has not been scanned or entered to the system as received by that date, generate a Notice of Adverse Action to the individual advising that his or her Medicaid eligibility will end at the end of the notice period for failure to return the renewal form unless the form is received prior to that date.
4. If the form has still not been scanned or entered as received in the system by the date in the Notice of Adverse Action, end the individual's Medicaid eligibility as of that date and close the case.

I-310 Caseworker Responsibilities

MS Manual 01/01/14

The caseworker is responsible for the following actions to complete an AABD renewal:

1. Ensure that the completed renewal form and any verification provided by the individual are scanned into the system upon receipt.

2. Review the information provided and request any necessary verification to validate the information.
3. Redetermine the individual's eligibility based on the information received from the individual and enter any new or changed information to the system.
4. Update the system to reflect continued eligibility, level of service, vendor payment, etc. or to end the individual's eligibility if no longer eligible.
5. Generate the appropriate notice to advise the individual of continued eligibility or of ineligibility.

I-320 Alternate Renewal Processes

MS Manual 01/01/14

Some AABD eligibility groups do not follow the standard renewal process as described in I-300 above. These groups include:

- ElderChoices/AAPD Waiver,
- Assisted Living Facilities,
- PACE,
- DDS Waiver, and
- TEFRA.

The following sections describe their renewal processes.

I-321 ElderChoices/AAPD Waiver

MS Manual 01/01/14

ElderChoices and AAPD Waiver renewals will be conducted annually by the Long Term Care Unit (LTCU). Form DCO-7781, LTC Medicaid Annual Renewal, will be completed. After eligibility has been re-determined, the review date will be entered in the system.

Reassessment of medical necessity will be completed by the DHS RN. The Office of Long Term Care will review the assessment and assign the Level of Care.

I-322 Assisted Living Facility

MS Manual 01/01/14

Assisted Living Facility Waiver renewals will be conducted annually by the county office. Refer to Appendix O for the list of required forms to be used in the renewal process. After eligibility has been re-determined, the review date will be keyed to the system.

Reassessment of medical necessity will also be completed annually by DAAS.

I-323 PACE

MS Manual 01/01/14

Both financial and medical eligibility will be re-determined annually. Medical eligibility will be re-determined by the DHS RN. Financial eligibility will be conducted at each annual renewal by the county office. Form DCO-7781 and all other forms required at initial application will be completed. DAAS will complete an annual Level of Care assessment on all PACE participants using the same assessment instruments and review and approval processes as the initial assessment. DAAS may "deem eligible" those individuals who are determined to no longer meet the nursing facility Level of Care requirement, but who would reasonably be expected to meet nursing facility Level of Care within the next six months in the absence of continued coverage under PACE.

I-324 DDS

MS Manual 01/01/14

The DDS worker will be responsible for renewals. Renewals will be scheduled for completion 12 months from the date of the last approval or renewal, or at any time when a change occurs which affects eligibility. Please refer to Appendix O for a list of required renewal forms. All eligibility factors, with the possible exception of disability and medical necessity, will be redetermined. A reexamination by MRT is necessary when indicated by the DCO-109 or when a non-SSI or non-SSA client was initially accepted for Waiver Services based on a disability determination made by SSA more than one year prior to the renewal. A review by MRT is also necessary if the DDS Medicaid Eligibility worker or DDS Provider Case Manager or Specialist becomes aware of significant improvement and/or employment at or near the Substantial Gainful Activity (SGA) level (Re. MS F 120).

DDS will be responsible for securing the DHS-703s for timely redetermination of medical necessity.

The DDS Medicaid Eligibility worker will complete the renewal process in ANSWER. If an income change is made, the total gross income amount must be entered in ANSWER in the income tab. If a change is anticipated, then a task must be created.

I-325 TEFRA

MS Manual 01/01/14

TEFRA Waiver cases will be renewed every 12 months. To insure that renewals are completed by the end of the twelfth month, the renewal process should be started in the 9th month from the date of the last approval or renewal.

If the child's SSI eligibility has fluctuated due to changing parental income since the last certification or renewal, medical necessity, cost effectiveness and appropriateness of care will not be determined until the case is in, or nearing, the 9th month since completion of the last TEFRA renewal or certification.

At renewal, all eligibility factors, including appropriateness of care and cost effectiveness, will be redetermined. A MRT disability redetermination may or may not be necessary at the time the TEFRA case is reevaluated. A reexamination by MRT is necessary when indicated on the DCO-109, or one year after the initial certification for TEFRA when the certification was made based on a previous SSI determination of disability and there has been no SSI payment or subsequent redetermination by SSA.

EXAMPLE: A child received SSI for 6 months in 2011 and then lost SSI due to increased parental income. The parent applies for TEFRA in September 2011 and the case is certified in November 2011 based on the previous SSI disability determination. The child has not received SSI benefits since certified. At the annual renewal in 2012, a MRT and disability determination is required.

A review by MRT is also necessary if the caseworker becomes aware of significant improvement and/or employment at or near the SGA level (Re. MS F-124).

All forms completed for the initial application, including the DMS-2602 and DCO-2603, must be completed at renewal. In addition, the premium amount will be redetermined at renewal. If the premium changes, the parent will be notified of the new amount by the TEFRA Premium Unit.

I-400 Foster Care and Adoption Assistance Eligibility Groups Renewal Process

MS Manual 01/01/14

The Division of Children and Families Foster Care Unit is responsible for completing the renewals for foster children and those receiving adoption assistance subsidies. See MS K 100 for those procedures.

I-500 Categorical Changes

MS Manual 01/01/14

Some changes in a family's or individual's circumstances may result in an individual moving from one eligibility group to another. This can occur in conjunction with a renewal, when an income change is reported, when an individual reaches a certain age, or when a Social Security COLA occurs, etc. To ensure that the individual has uninterrupted coverage, the move from one group to another must be processed in a timely manner and according to certain processes. The most common categorical changes are described in the following sections.

I-510 ARKids A & B

MS Manual 01/01/14

If information is provided that would cause the ARKids A recipient to be ineligible for ARKids A or B, an advance notice will be sent, and the case closed after expiration of the notice. If the information provided will cause ineligibility for ARKids A and the recipient is determined to be eligible for ARKids B, the case will be certified in ARKids B and the recipient notified of the case change.

I-520 Health Care Independence Program

MS Manual 01/01/14

When individuals aged 19-64 lose eligibility in other lower income MAGI-related groups, eligibility should be redetermined in the Health Care Independence Program.

I-530 Medicare Savings Programs

MS Manual 01/01/14

Persons who are Medicaid eligible in a category that provides full Medicaid coverage and who are entitled to Medicare Part A will receive the same Medicare cost-sharing coverage as QMBs in addition to their other Medicaid benefits. County Offices need not take any action on these cases (for QMB eligibility or coverage) unless Medicaid eligibility in the other category ends.

When Medicaid eligibility in a category other than a Medicare Savings category ends for an individual who is still entitled to Medicare Part A, eligibility for Medicare Savings will be determined based on information available to the county office. A new application **will not** be obtained from the individual. ARSeniors, QMB, SMB, or QI-1 eligibility should be determined and the case certified (if eligible) in the month that the non-QMB related case was closed. If eligible, coverage will begin on the first of the month following certification. When certifying the Medicare Savings case, re-key the original renewal date in the computer system.

EXAMPLE: A nursing facility recipient loses Medicaid eligibility upon returning home from a a nursing facility. He is entitled to Medicare Part A and appears to be income and resource eligible for QMB coverage. The county will determine QMB eligibility based on available information. If eligible, the individual's coverage will begin the month following certification as a QMB. A new application will not be obtained from the individual.

NOTE: When an individual previously closed in another category is reopened as a Medicare Savings category, the closed case number will be used as the Medicare Savings category case number.

I-531 Medicare Savings Programs-COLA Increases

MS Manual 01/01/14

When the annual SSA COLA increases are received in January each year by Medicare Savings recipients, the COLA increase is disregarded until the new Federal Poverty Limits are issued in that year even if the SSA COLA increase puts the individual or couple over the current allowable income limits.

When the new Medicare Savings income eligibility limits, based on revised poverty levels, are received, the individual's or couple's current countable income (including the January COLA increases) will be compared to the revised Medicare Savings income levels to determine if eligibility will continue for April 1st and beyond.

If the individual or couple is ineligible due to the COLA increase, a DCO-700 will be sent as advance notice of closure and the case will be closed when the period expires.

The January SSA Cost of Living Adjustment will also be disregarded in determining initial eligibility for Medicare Savings applicants for the period of January 1st through March 31st of each year. Eligibility must then be redetermined for April 1st and beyond using the new Medicare Savings income limits and the increased SSA amount which includes the January SSA COLA amounts.

I-540 Alternating TEFRA and SSI Eligibility

MS Manual 01/01/14

Some children who receive SSI may intermittently lose their SSI due to fluctuating parental income and may be eligible for TEFRA in the non-SSI months. In these instances, the caseworker must redetermine TEFRA eligibility for each month in which the child is not SSI eligible. Children with alternating TEFRA and SSI eligibility will not be assessed a premium for the TEFRA months.

If fluctuating parental income causes a child's SSI eligibility status to change from month to month and less than 10 months have passed since the last full TEFRA Waiver certification or renewal, only a new DCO-9700 and a redetermination of income and resource eligibility are required to reopen the TEFRA Waiver case. Redetermination of other eligibility factors will not be required.

I-541 Autism/TEFRA/ARKids

MS Manual 01/01/14

Since coverage for the Autism Waiver eligibility group is time and age limited, once a child has reached the maximum coverage period of three years or the maximum age of seven, Medicaid eligibility should be redetermined in either the TEFRA or ARKids eligibility groups.

I-550 Money Follows the Person (MFP)

MS Manual 01/01/14

Money Follows the Person allows Medicaid eligible individuals residing in an inpatient facility, including hospitalization, to receive long term care services in the settings of their choice and reduce reliance on institutional care. The MFP grant allows for payment of claims for services up to 365 days. Participation in the MFP program is limited but the maximum number allowed to participate will increase yearly.

The Division of Aging and Adult Services (DAAS) has administrative responsibility for the MFP program to provide each participant placement through the existing Medicaid Waiver (ElderChoices, AAPD, Assisted Living, DDS) which best suits the participant's desires and needs.

DAAS will contact individuals designated as potential transitions or who expressed a desire to live in the community. To be eligible to participate, the individual must have resided in an institution (nursing home or ICF/MR) for a period of not less than 90 consecutive days and have received Medicaid for inpatient services for at least 1 day.

I-551 MFP Procedures for Medicaid Recipients Who Leave Facility Care

MS Manual 01/01/14

For MFP, a DAAS Transition Coordinator will be responsible with assisting the individual who is interested in transitioning from facility care to a home and community based waiver. This includes assisting the individual with applying for the appropriate program, accessing services, and preparation for being discharged from the nursing facility.

The Transition Coordinator will assist the client with completing and submitting form DCO-777, Long Term Care Application for Assistance. The caseworker will receive the application from the Transition Coordinator indicating this is a MFP application and the type of waiver requested. In situations in which a DHS RN has already been involved with a patient, the caseworker may receive a DHS-3330 and Page 2 of the Plan of Care signed by the applicant which is also sufficient. If the DHS-3330 and Page 2 of Plan of Care are received, procedures in MS C-250 will be followed.

Upon receipt of the DCO-777, the caseworker will send a DHS-3330 to the DHS RN to assess and develop a plan of care. The caseworker will write **MFP** in the right hand corner of the DHS-3330 prior to submitting to the DHS RN. This will make the DHS-3330 easily identified by the DHS RN that this is a MFP application. The caseworker will also inform the DHS RN which waiver category is being applied.

The DHS RN will proceed with the assessment process. The DHS RN will use the DCO-704 for medical eligibility determination if signed within the past 6 months. If the Intermediate Level of Care was entered by the county more than 6 months previously or if the Level of Care Review Date has expired, the Waiver case may not be certified until the county receives a new DCO-704 verifying Intermediate Level of Care status. The DHS RN will follow procedures outlined in MS C-241.

Refer to MS C-242 for procedures to approve an ElderChoices or AAPD waiver application and closure of the nursing facility case.

Refer to MS C-256 for procedures to approve an Assisted Living waiver application and to close the nursing facility case.

Refer to MS C-272 for procedures to approve a DDS waiver application and to close the ICF/MR facility case.

I-560 AAPD Transitioning to ElderChoices at Age 65

MS Manual 01/01/14

Individuals receiving services through AAPD lose eligibility when they reach the age of 65. These individuals are usually eligible to continue coverage through ElderChoices if they choose to make application. To allow the individual to move from AAPD to ElderChoices without a lapse in coverage, the DHS RN will determine medical necessity and then send the DHS-3330 and the Plan of Care signed by the AAPD recipient to the county office approximately two months prior to the recipient's 65th birthday. The DHS-3330 and Plan of Care will serve as the application. It is not necessary for the recipient to complete a DCO-777 or DCO-7781 unless it is time for the annual reevaluation.

The ElderChoices case cannot be approved unless all of the following conditions are met:

1. The county has received a DHS-3330 and the Plan of Care signed by the recipient.
2. The system shows an Intermediate Level of Care.
3. The Level of Care was entered into the system in the previous 6 months.
4. There is a future Level of Care Review Date
5. A 10-day notice has been sent to the recipient informing him or her that the AAPD portion of the Waiver case will be closed and an ElderChoices case opened.

If the Intermediate Level of Care was entered by the county more than 6 months previously or if the Level of Care Review Date has expired, the ElderChoices Waiver case may not be certified until the county receives a new DHS-704 verifying Intermediate Level of Care status.

If ElderChoices eligibility is finalized on or before the individual's 65th birthday, the Medicaid portion of the case will remain open, but the Waiver portion will be closed effective the day before the 65th birthday. The Waiver portion for ElderChoices will be opened beginning the day of the 65th birthday.

If approval of the ElderChoices application is not finalized by the 65th birthday, the AAPD case must be closed. Approval of the ElderChoices case cannot begin until the day after the 10-day notice has expired; therefore, the 10-day notice must be sent at least 10 days prior to the applicant's 65th birthday. If the applicant is approved for ElderChoices any time after his or her 65th birthday, the Medicaid portion of the case will remain open, but the AAPD Waiver portion will be closed effective the day of the applicant's 65th birthday. The Waiver portion for ElderChoices will be opened beginning the day of ElderChoices approval.

If the ElderChoices application is denied, the DHS caseworker will close the AAPD Waiver case the day before the recipient’s 65th birthday.

I-600 Changes

MS Manual 01/01/14

When a change occurs that will affect eligibility, the client is required to report the change within 10 days. The agency will be required to act on changes that may affect eligibility within 10 days from receipt of the change. Changes can be reported:

- In person,
- By telephone,
- Online, or
- By mail.

Dependent upon the eligibility group of which the individual is a member, changes which could affect eligibility and therefore must be reported include the following:

- A change in income that causes ineligibility or causes a change in vendor payment,
- Changes in household members,
- Death,
- End of pregnancy,
- Admission to or discharge from an institution, including a nursing facility,
- Approval or discontinued disability,
- Resource changes, including the receipt of a lump sum payment or settlement,
- Shelter and expense changes for Long Term Care Individuals who have a Community Spouse, or
- Medical Cost for Long Term Care individuals.

Although an address change does not usually affect eligibility, caseworkers should encourage individuals to report any address changes immediately to ensure renewal notices or other correspondence is sent to the individual's current address and not returned as Undeliverable. Any mail returned as Undeliverable could result in immediate case closure.

When a change is reported by the client, the caseworker will:

- Review the information.
- Verify through electronic sources, if possible. Request additional verification if required.
- Enter the changed information to the system so that eligibility can be redetermined.
- Ensure appropriate notice is sent to the individual if a change in eligibility results.

When a change is reported by the client on line, the system will basically take the same steps as above. If additional information is needed, the system will trigger a task for the caseworker to handle.

NOTE: A new application is not required to add a member.

I-610 Loss of Eligibility

MS Manual 01/01/14

Loss of eligibility occurs when the eligible individual:

- Moves from Arkansas,
- Requests closure,
- Dies,
- Is found to be over the income limit,
- Is found to be over the resource limit if applicable,
- Reaches the age limit for the eligibility, or
- Leaves the nursing facility.

Depending upon the change, the individual may be eligible in another eligibility group. For example, if a child ages out of ARKids, he or she may be eligible in an adult group such as the Health Care Independence Program. When possible, eligibility in another group should be determined at the time ineligibility for the current group is established.

EXCEPTION: Once eligibility is established for a pregnant woman in any Medicaid category, there will be "No Look Back" at later income increases throughout the pregnancy and the postpartum period. The PW will remain Medicaid eligible through the end of the postpartum period regardless of increases in income.

I-620 Alternative Change/Closure Processes

MS Manual 01/01/14

Some eligibility groups have specific processes that must be followed when a change or closure occurs. These groups include:

- ElderChoices/AAPD Waiver,
- Assisted Living Facility,

- DDS Waiver, and
- TEFRA.

I-630 ElderChoices/AAPD Waiver

MS Manual 01/01/14

Recipients will be advised to report any changes in the amount of household income or resources.

If at any time DAAS or OLTC determines that cost effectiveness is not met, that the client no longer meets the requirements for Intermediate Level of Care or that the client is no longer receiving Waiver services, the county office will be notified by DHS-3330 or DHS-704, and the Waiver case will be closed. If the Waiver case is closed for any reason, the caseworker will determine if the client is eligible for any other Medicaid category. If eligible in another category, the recipient can be certified in that category without requiring a new application.

If the ElderChoices or AAPD Waiver client loses eligibility for one month only, the case may remain open with an overpayment submitted for the month of ineligibility. When the county has advance knowledge of ineligibility in a future month (e.g., land rent paid annually), procedures at MS E-410 will be followed, advance notice given and the case adjusted on the system at the appropriate time. In both instances, a DHS-3330 and a copy of the advance notice must be submitted to the DHS RN the same day the notice is mailed to the client.

If the Waiver client will be ineligible for more than one month, the case will be closed and a new application will be required. If closure was due to a reason other than medical necessity, a new DHS-704 will not be required at reapplication if the following conditions are met:

6. The case is being reopened within 2 months of the closure date.
7. The DHS-704 was signed within 6 months prior to the new application date.
8. The DHS RN was notified by a DHS-3330 of the closure within 3 days of the action taken.
9. The DHS RN was notified by a DHS-3330 of the reopening within 3 days of the action taken.

If all of the conditions above are not met, a new DHS-704 will be needed to reopen the ElderChoices or AAPD case.

When closing an ElderChoices or AAPD case because a recipient refuses to receive at least one service, closure code “Refused Other Procedural Requirement” will be used. A manual notice will be sent to the recipient notifying him or her of the closure. If the client does not refuse services but the DHS RN determines that the recipient is no longer in need of services or that services are no longer available in the recipient's area, closure code "Other Non-Needs Related" will be used. A manual notice will be sent notifying the recipient of the closure.

A Waiver client may appeal an adverse decision made on his/her case as outlined in MS L 100-173 of the Medical Services Policy manual. If the client chooses, the ElderChoices or AAPD Waiver case may remain open until the appeal decision is rendered. Services may continue if agreed upon by the client and the service provider. Because it is the responsibility of the DHS RN to coordinate services in the client's home, he/she must be aware of planned adverse action and the request for an appeal. Therefore, when a Notice of Adverse Action is mailed to an ElderChoices or AAPD Waiver client, a copy will be emailed to the DHS RN the same day. Also, when the caseworker learns that request for an appeal has been submitted on a Waiver case, the caseworker will notify the DHS RN via DHS-3330 immediately. If the county office at any time finds the recipient ineligible for the Waiver program, the DHS RN will be notified immediately by DHS-3330 and the Waiver case will be closed.

I-631 ElderChoices/AAPD Waiver Temporary Absences from the Home

MS Manual 01/01/14

Once an ElderChoices or AAPD Waiver application has been approved, Waiver services must be provided in the home for eligibility to continue. Unless stated otherwise below, the county office will be notified immediately by the DHS RN when Waiver services are discontinued and action will be initiated by the county office to close the Waiver case.

1. Institutionalization

   An individual cannot receive ElderChoices or AAPD Waiver services while in an institution. However, the following policy will apply to active Waiver cases when the individual is hospitalized or enters a nursing facility.

   a) Hospitalization

      When a Waiver recipient enters a hospital, the county office will not be notified and no action is necessary unless the recipient does not return home within 30 days from the date of entry. If after 30 days the recipient has not returned home, the DHS RN will notify the county office via Form DHS-3330 and action will be initiated by the county office to close the Waiver case. For ElderChoices or AAPD services to resume after discharge from the hospital and after the Waiver case has been closed, the individual must make a new application.

   b) Nursing Facility Admission

I-600 Changes

I-631 ElderChoices/AAPD Waiver Temporary Absences from the Home

When a Waiver recipient enters a nursing facility and it is anticipated that the stay will be less than 30 days, the case will remain open if the client does not request vendor payment for the temporary stay. If the Waiver client returns home within 30 days, a new assessment and DHS-704 will not be required. A new DCO-777 or DCO-7781 will not be required unless it is time for the annual renewal. It is not necessary to register a new application in this situation.

If the individual requests payment for the temporary stay in the nursing facility, a signed DCO-777 or DCO-7781 must be obtained and registered, along with the assessment and DHS-704. If it is time for the annual renewal, the renewal must be completed prior to certifying the vendor payment. If all eligibility requirements are met, eligibility for vendor payment will begin effective the date of entry into the nursing facility. If the stay in the facility was less than 30 days, vendor payment may still be authorized because ElderChoices or AAPD Waiver recipients are considered to be "institutionalized" for Medicaid purposes and the Waiver eligibility prior to the facility stay may be applied toward the 30-day institutionalization requirement.

If the individual does not return home, i.e., stays in the facility and requests Nursing Facility vendor payment, the Medicaid case may be left open while processing the registered LTC application. If found eligible for vendor payment, the case will be closed with a Waiver Stop Date using the date of entry into the nursing facility. Vendor payments will also be authorized beginning the date of entry.

If found ineligible for vendor payments or if after 30 days in a facility the individual does NOT apply for vendor payment, appropriate notice will be given for case closure.

2. Absence from the Home - Non-Institutionalization

   When a Waiver recipient is absent from the home for reasons other than institutionalization, the county office will not be notified unless the recipient does not return home within 30 days. If after 30 days the recipient has not returned home and the providers can no longer deliver services as prescribed by the Plan of Care (e.g., the recipient has left the state and the return date is unknown), the DHS RN will notify the county office via DHS-3330 and action will be taken by the caseworker to close the Waiver case.

NOTE: The DHS RN may reassess an individual any time it is deemed appropriate. If in the professional judgment of the nurse circumstances have changed or an individual's overall medical condition has changed, a reassessment will be performed.

I-640 Assisted Living Facility (ALF)

MS Manual 01/01/14

ALF Waiver recipients will be advised to report any changes in income or resources to the county DHS office.

If at any time DAAS or DMS determines that cost effectiveness is not met or that the client no longer meets the requirements for an Intermediate Level of Care, the county office will be notified and the ALF case will be closed. If the case is closed for any reason, the caseworker will determine if the client is eligible in any other Medicaid category. If eligible in another category, the recipient can be certified in that category without requiring a new application.

If the ALF Waiver client loses eligibility for one month only, the case may remain open with an overpayment submitted for the month of ineligibility. When the county has advance knowledge of ineligibility in a future month, procedures at (MS E-410) will be followed, advance notice given, and the case adjusted on the system at the appropriate time. In both instances, a copy of the advance notice must be submitted to the DHS RN the same day the notice is mailed to the client.

If the ALF recipient will be ineligible for more than one month, the case will be closed and a new application will be required to reopen. If closure was due to a reason other than medical necessity, a new DHS-704 will not be required at reapplication if all of the following conditions are met:

1. The case is being reopened within 2 months of the closure date.
2. The DHS-704 was signed within six months prior to the new application date.
3. The DHS RN was notified of the closure within 3 days of the action.
4. The DHS RN was notified of the reopening within 3 days of the action taken.

If all of the conditions above are not met, a new DHS-704 will be required to reopen the ALF Waiver case.

An ALF Waiver recipient may appeal an adverse decision made on his/her case as outlined in MS Section L. If the client chooses, the ALF case may remain open until the appeal decision is rendered. Services may continue if agreed upon by the client and the facility. When the caseworker learns that request for an appeal has been submitted on an ALF case, the caseworker will notify the DHS RN immediately.

If at any time the county office finds the recipient ineligible for the ALF program, the DHS RN will be notified immediately and the county office caseworker will begin the process of closing the case.

I-641 Temporary Absences from the Assisted Living Facility

MS Manual 01/01/14

Once an ALF Waiver application has been approved, Waiver services must be provided in the facility for eligibility to continue. The county office will be notified by the DHS RN when Waiver services are discontinued and action will be initiated by the county office to close the Waiver case with the following exceptions:

1. Hospitalization
   When an ALF recipient enters a hospital, the county office will not be notified and no action will be necessary unless the recipient does not return to the ALF within 30 days. If the recipient does not return from the hospital within 30 days, dies during hospitalization, is discharged to his home or elsewhere from the hospital, the ALF facility will report to the county on Form DCO-702 and the caseworker will initiate case closure. If the recipient reenters another facility after discharge from the hospital or if the individual is reassessed and no longer meets the Intermediate Level of Care, the facility will also report to the county on Form DCO-702 and the caseworker will take appropriate action.
2. Nursing Facility Admission
   When an ALF recipient enters a nursing facility and it is anticipated that the stay will be less than 30 days; the case will remain open if the client does not request vendor payment for the temporary stay. If the individual requests payment for the temporary stay in the nursing facility, a signed DCO-777 must be obtained and registered and a new DHS-704 obtained. If all eligibility requirements are met, eligibility for vendor payment will begin effective the date of entry into the nursing facility. If the stay in the facility was less than 30 days, vendor payment may still be authorized because ALF recipients are considered institutionalized for Medicaid purposes and the Waiver eligibility prior to the facility stay may be applied toward the 30 day institutionalization requirement.

   If the individual does not return to the ALF but stays in the nursing facility and requests Nursing Facility vendor payment, the Medicaid case may be left open while processing the registered LTC application. If found eligible for vendor payment, the vendor payments will be authorized beginning the date of entry to the nursing facility.

If found NOT eligible for vendor or if after 30 days in a facility the individual does not apply for vendor payment, appropriate notice will be given for case closure.

3. Absence From the Assisted Living Center - Non-Institutionalization

   When an ALF recipient is absent from the facility for reasons other than institutionalization, the county office will not be notified unless the recipient does not return within 30 days. If the recipient has not returned to the facility after 30 days, and the providers can no longer deliver services as prescribed by the Plan of Care (e.g. the recipient has left the state and the return date is unknown), the DHS RN will notify the county office to close the ALF Waiver case.

I-650 DDS Waiver

MS Manual 01/01/14

Recipients will be required to report changes to the DDS Medicaid Eligibility worker within 10 days. The DDS Medicaid Eligibility worker will promptly redetermine eligibility when information is received about changes in a recipient's circumstances. When a change occurs that results in ineligibility, a 10 day advance notice will be given unless advance notice is not required (Re. MS J-130). Notice is made to the individual/legal representative with copy to the DDS applicable area manager and authorized case management and direct service providers.

Eligibility will end at the end of the ten-day advance notice period, unless the recipient or his/her legal representative requests a hearing, or unless whatever was causing the intent to close is resolved prior to the end of the 10 days.

If the County Office is notified at any time by DDS that the client is no longer eligible for DDS Waiver Services, the County Office will determine if the client is eligible for any other Medicaid category.

I-660 TEFRA

MS Manual 01/01/14

When a change occurs that affects eligibility, the caseworker will notify the TEFRA Committee advising when the closure will be made. The applicant will be sent a 10-day advance notice using form DCO-700, unless advance notice is not required. (Re. MS J-130) A copy of the DCO-700, a memorandum or an email will be sent to the TEFRA Committee to inform of the closure.

I-600 Changes

I-660 TEFRA

J-100 Notice of Action Requirements

MS Manual 01/01/14

A notice of action is sent to an individual whenever an application has been approved or denied, a hardship request has been denied or assistance has been reduced or terminated. All notices must include:

- A statement of action the Agency intends to take,
- The effective date of the action,
- The reason(s) for the action,
- The manual policy reference(s) supporting the action,
- An explanation of the individual's right to request a hearing, and
- An explanation of the circumstances under which assistance is continued if a hearing is requested.

Federal regulations require an advance notice be given for termination of assistance and reduction of assistance. The following sections define these notice requirements and also list when advance notice is not required. For purposes of the notices described below, day one of the 10 day advance notice period is the day after the date of the notice.

J-110 Advance Notice for Termination of Assistance

MS Manual 01/01/14

When the Division of County Operations (DCO) proposes to terminate assistance for a recipient, advance notice will either be system generated or mailed to the recipient using Form DCO-700, Notice of Action.

Advance notice must contain all information listed in MS J-100. The advance notice given on the DCO-700 must be mailed to the recipient at least ten (10) days prior to the effective date of action unless probable fraud is indicated. Where probable fraud exists, five (5) days prior notice is required.

If a hearing is requested within the advance notice period, the caseworker will forward a copy of the DCO-700 with the DCO-1200, Appeal for Hearing, and the Hearing File to Central Office Appeals and Hearings and delay action pending outcome of the appeal. If a hearing is not requested within the advance notice period, action will be taken by the caseworker on the date indicated on the DCO-700.

J-120 Advance Notice for Reduction of Assistance

MS Manual 01/01/14

Reduction of assistance means a change in vendor payment or a categorical change resulting in a reduction in benefits in the service package such as a change from ARKids A to ARKids B. When the recipient's income increases, a 10 day advance notice will be given. If the income change results in a change in vendor payment to the nursing facility, an information copy of the DCO-704, Decision for Nursing Home/Waiver Placement, will be provided to the nursing facility.

J-130 When Advance Notice is Not Required

MS Manual 01/01/14

Advance notice is not required when:

1. The Agency has factual information confirming the death of a recipient.

2. The Agency receives a clear written statement signed by the recipient that he no longer wishes assistance or that gives information that requires termination or reduction of assistance, and the recipient has indicated in writing that he understands the consequences of supplying such information.

3. The recipient has been admitted or committed to a tax supported institution and is not eligible for continued Medicaid assistance.

NOTE: Individuals under age 21 may continue to qualify for Medicaid who are receiving inpatient psychiatric care in an approved psychiatric facility. Refer to MS A-165 for specific information.

4. The recipient's whereabouts are unknown and Agency mail directed to him has been returned by the Post Office indicating no forwarding address.
5. A recipient has been accepted for assistance in a new jurisdiction (State) and that fact has been established by the caseworker.
6. A change in the level of medical care is prescribed by the recipient's physician.

7. A special granted for a specific period is terminated and the recipient has been informed in writing at the time of initiation that the allowance will automatically terminate at the end of a specific period.
8. Agency action does not propose to discontinue, terminate or reduce assistance.

NOTE: A denial does not require an advance notice, but does require an adequate notice i.e., provides the information listed in MS J-100.

J-140 Account Transfer to the Federally Facilitated Health Insurance Marketplace

MS Manual 01/01/14

When an individual is determined not eligible for Medicaid either during the application or renewal process, the agency must transfer the individual's electronic record via a secure electronic interface to the Federally Facilitated Health Insurance Marketplace for eligibility determination for advance payments of the premium tax credit and cost sharing reductions to purchase a qualified health plan. Notice text for these denials or closures must include notification to the individual that:

1. The individual's electronic account will automatically be transferred to the Federally Facilitated Health Insurance Marketplace (FFM) for eligibility determination for advance payments of the premium tax credit and cost sharing reduction to purchase a qualified health plan, and

2. The timeframe in which the individual/recipient has to complete the enrollment process.

K-100 Medicaid Coverage of Foster Children

MS Manual 01/01/14

The DCFS Eligibility Unit may authorize medical assistance for eligible Foster Children (FC) in:

- ARKids A;
- Non-IV-E;
- Category 92 - Title IV-E FC - AFDC related;
- Medically Needy – Exceptional (EC); and
- Medically Needy – Spend Down (SD).

K-101 Extent of Services

MS Manual 01/01/14

The services specified in the pamphlet "Arkansas Medicaid Beneficiary Handbook" are available to eligible individuals in any of the Foster Care categories, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT), and Family Planning Services. The exception is that EPSDT is not available to category 97 (FC-SD).

K-102 Identification of Eligibles

MS Manual 01/01/14

To be eligible for services in State FC (Cat. 91), the individual must meet the eligibility criteria of U-18 category (Re. MS E-300).

To be eligible in Title IV-E-FC (Cat. 92), the individual must meet Title IV-E eligibility requirements, as specified in the Title IV-E State Plan maintained by the Division of Children and Family Services.

To be eligible in State FC Medically Needy (Cat. 96 or Cat. 97), the individual must meet the U-18 MN requirements (Re. MS E-300).

To be eligible for services in ARKids A (category 61) the individual must meet ARKids eligibility requirements (RE. MS B-210).

Each child will be evaluated as a one person household unit against the appropriate criteria. Consideration of parental income/resources will cease effective the month a child enters Foster

Care and the Court awards custody to the Agency. If a parent voluntarily relinquishes custody of a child into foster care, that child will not be eligible for IV-E FC (Category 92).

A child taken into Foster Care on the basis of an emergency order only may be determined Medicaid eligible. If custody is later established by a judicial determination, the Family Service Worker will be required to provide a copy of the order to the DCFS Eligibility Unit.

Note: The exception to eligibility guidelines for State FC-U-18 Related (Category 91) and State FC-MN (Categories 96 and 97) is that eligibility for Foster Children in these categories may continue up to age 21, provided that the child has signed an agreement to remain in FC and that the Division of Children and Family Services continues to provide FC Services to these children.

K-103 Initial Determination of Eligibility

MS Manual 01/01/14

Children entering Foster Care will be referred by the Family Service Worker to the DCFS Eligibility Unit for initial determination of Medicaid eligibility. Referral should be made within one working day after the child's entry into Foster Care.

K-104 Family Service Worker Responsibilities

MS Manual 01/01/14

The Family Service Worker will complete placement information in the Children's Reporting Information System (CHRIS) and, upon approval of the placement information by the DCFS Supervisor, the CHRIS system will send an alert to the DCFS Eligibility Unit inbox that an application has been submitted. A separate application will be generated for every child.

If the identity of a child entering foster care is unknown and the Family Service Worker is unable to obtain birth verification through family, hospital, Vital Records, or other records, the court order placing the child in foster care may be used as acceptable verification of age and residence. Children in Foster Care, who are recipients of Foster care maintenance or adoption assistance payments under Title IV-E, are exempt from the citizenship verification requirement (RE. MS G-130 and MS G-134). The SSN enumeration requirement, however, cannot be waived.

K-105 DCFS Eligibility Unit Responsibilities for Initial Eligibility

MS Manual 01/01/14

The responsibilities of the DCFS Eligibility Unit during the initial determination of eligibility are as follows:

K-105 DCFS Eligibility Unit Responsibilities for Initial Eligibility

1. The DCFS Eligibility Unit will register the initial Medicaid application in the eligibility system.

2. In determining eligibility the following income and resource levels are applicable:

   a. Category 61 – ARKids A (Appendix F-Income)

   b. Category 91 – Appendix T

   c. Category 92 – Appendix T

   d. Category 96 - Medically Needy –EC (Appendix N)

   e. Category 97 - Medically Needy - SD (Appendix N)

   The appropriate income information will be entered in ANSWER. If the child has income greater than the applicable income level for the category, that child will not be eligible for Medicaid in that category.

3. After determination of eligibility, certification of eligible Foster Children will be done by entering the approval information in ANSWER.

4. If a Foster Care Medicaid case number has previously been obtained by the DCFS Eligibility Unit, this number will be the case number for the Medicaid case. If the Eligibility Worker approves the Foster Care Medicaid case, the Family Service Worker will be notified of the case number through the CHRIS system.

5. If an IV-E child has a child of his or her own living in the same household, the minor parent and his or her child will be set up in separate Medicaid cases. The eligibility requirements to be considered for the minor parent's child are:

   a. The minor parent is IV-E eligible, and

   b. The child is living with the minor parent.

6. If the application is denied, the denial information will be entered into ANSWER.

7. The DCFS Eligibility Worker will maintain a separate case file for each child in Foster Care.

K-106 Reevaluations

MS Manual 01/01/14

Reevaluations will be completed by the DCFS Eligibility Unit every 12 months based on the date of initial certification, or the date of the last reevaluation.

K-107 DCFS Eligibility Unit Responsibilities for Reevaluation

MS Manual 01/01/14

Responsibilities of the DCFS Eligibility Worker during the reevaluation:

1. The CHRIS system will notify the DCFS Eligibility Unit when a reevaluation is due for a non-IV-E Foster Care Medicaid case.

2. Determination of continuing eligibility will be made by the DCFS Eligibility Unit, using the same criteria that were used for determining initial eligibility.

3. If eligibility continues, the DCFS Eligibility Unit will update the information in ANSWER. If the child is ineligible, the DCFS Eligibility Unit will initiate closure of the case.

4. If the case is closed, eligibility will be determined in another Foster Care Medicaid category, if applicable.

5. The Family Service Worker will be notified by the CHRIS system of continuing eligibility or case closure.

K-108 Changes

MS Manual 01/01/14

The Family Service Worker will be responsible for notifying the DCFS Eligibility Unit of any change in the child's circumstances through the CHRIS system or form CFS 495. Notice will be made when there is a change in income, resources, Foster Care case status (closure), change of residence, or when an adoption is finalized.

The DCFS Eligibility Unit will narrate changes in ANSWER that affect the child's Medicaid eligibility.

K-109 Transfers Out-of-State

MS Manual 01/01/14

IV-E Foster or Adoptive Children

When an IV-E child who receives foster care payments or who has an adoption assistance agreement in effect is placed out-of-state, the procedures found in MS K-400 through K-403 will be followed.

Non IV-E Foster or Adoptive Children

When a non IV-E child (Category 61, 91, 96, or 97) is placed out-of-state, Medicaid coverage by Arkansas may be continued as long as Arkansas retains legal custody and continues to make a board payment. If the out-of-state placement is for adoption, the coverage may continue until the adoption is final. If the receiving State opens a Medicaid case, Arkansas Medicaid will be closed.

K-110 Placement with Parents

MS Manual 01/01/14

If a non IV-E foster child is returned to his natural/adoptive parent(s) on trial or temporary placement, the FC Medicaid case will be closed after an advance notice is sent. The parent(s) will need to apply for Medicaid for the child. If the child is returned to FC, the FC Medicaid case will be reinstated provided the child meets all eligibility requirements.

If an IV-E child is returned to the natural or adoptive parents for a trial or temporary placement, the case may remain open during the trial or temporary placement period.

K-111 Continuing Eligibility of Foster Care Children Placed for Adoption

MS Manual 01/01/14

Medicaid coverage for ARKids A (Cat. 61), State FC, U-18 Related (Cat. 91) and State FC Medically Needy (Cat. 96 or Cat. 97) may continue until the adoption is finalized, if eligibility requirements continue to be met. Prospective parents' income and resources will be disregarded.

K-100 Medicaid Coverage of Foster Children

K-111 Continuing Eligibility of Foster Care Children Placed for Adoption

The Adoption Specialist or Family Service Worker responsible for the case will provide all information relative to eligibility, reevaluations and changes, and will be responsible for notifying the DCFS Eligibility Unit when the adoption is final.

Medicaid coverage for Title IV-E-FC (Cat. 92) children who are adopted or in a pre-adoptive placement may continue provided the child remains eligible for IV-E subsidy payments. A reevaluation is not necessary for these children. The CHRIS system will notify the Adoption Specialist or Family Service Worker if the IV-E subsidy payment ends.

Once initial eligibility has been established for Title IV-E-FC (Cat. 92) children who are adopted or in a pre-adoptive placement, the agency does not have to redetermine eligibility provided the child remains eligible for IV-E subsidy payments. The CHRIS system will notify the Adoption Specialist or Family Service Worker if the IV-E subsidy ends.

K-200 Non-Title IV-E Adoptive Children With Special Needs

MS Manual 01/01/14

The Consolidated Omnibus Budget Reconciliation Act of 1985 allows states to provide medical assistance to non-Title IV-E adoptive children with special needs.

Medicaid eligibility can be determined, or continued, when an adoption agreement is entered into for non-Title IV-E foster children under age 18 who have special medical or rehabilitative needs that would preclude adoption placement if they were not Medicaid eligible. For the non-Title IV-E Special Needs Adoptive coverage to apply, a child must be receiving Medicaid (in any category) in the month in which the adoption assistance agreement is signed, or received Medicaid in any one of the three months preceding the month of the adoption agreement, or would have been eligible to receive Medicaid (in any category) in the month of the adoption agreement or in any of the three months retroactive to adoption, had application been made.

K-201 Medicaid Category for Non-Title IV-E Special Needs Adoptive Children

MS Manual 01/01/14

Medical assistance will be provided to eligible Special Needs Adoptive Children in category 91 - U-18 related.

K-202 Eligibility Requirements

MS Manual 01/01/14

The following requirements must be met to qualify for non-Title IV-E Special Needs Adoptive Children coverage.

1. Age- The non-Title IV-E Special Needs Adoptive Child must be under age 18 (eligibility may continue throughout the month of the 18th birthday) to qualify. Proof of age is required (e.g. birth certificate, court order).

2. Citizenship or alienage requirement (MS D-200).

3. Social Security enumeration requirement (MS D-400).

4. Residency requirement (MS D-300).

5. Assignment of rights to medical support/third party liability requirement (MS D-500).

6. Financial Need- It must be determined that the special needs adoptive child, if not Medicaid certified in the month the adoption agreement is signed or Medicaid certified in any one of the three months preceding the month of adoption, would have been Medicaid eligible in the month of adoption or in any one of the three months immediately preceding the month that the adoption agreement was signed, had an application been made.

   Only the income and resources of the child will be considered in making the eligibility determination for children who were not Medicaid certified in the month of adoption or in the three months preceding adoption. Any income or resources of the natural parent(s) or adoptive parent(s) will be disregarded. Once it has been established that financial eligibility exists in the month of adoption or in any month of the three month retroactive period, there will be no later income or resource redeterminations at subsequent reevaluations.

7. Special Needs- The non-Title IV-E Adoptive Child must have a special need for medical or rehabilitative care, as determined by the Division of Children and Family Services (DCFS) that would preclude adoption placement if the child were not Medicaid eligible. The special need must have existed prior to the adoption agreement (i.e., a child who develops a special need for medical or rehabilitative care after an adoption assistance agreement is in effect is not eligible for this category). Some examples of special medical or rehabilitative needs are cerebral palsy, spina bifida, Down's syndrome, psychiatric disorder, etc. Factors such as age, sex or race that might make an adoptive placement difficult do not qualify as Special Needs.

8. Adoption Agreement- A legally executed adoption agreement between the state and the adoptive parent(s) must exist before eligibility can be determined. An adoption agreement does not have to be the final decree in order for a child to receive assistance in this category. The adoption assistance agreement must remain in effect for the child to receive continuing Medicaid assistance as a Special Needs Child.

K-203 Retroactive Coverage

MS Manual 01/01/14

Non-Title IV-E Adoptive Children with special needs may be certified for retroactive coverage for up to three months prior to the month of application if all the conditions of eligibility are met and if there are unpaid medical bills for this period. If the adoption assistance agreement was not in effect in the retroactive months, then eligibility cannot be established under these provisions, but must be established under other Medicaid guidelines.

K-204 Reevaluations

MS Manual 01/01/14

Once initial eligibility has been established, the agency does not have to redetermine eligibility provided the adoption agreement remains in effect, the child continues to reside in Arkansas with the adoptive parents and a special need continue to exist. The CHRIS system will alert the Adoption Specialist or Family Service Worker if the adoption agreement ends, the child leaves Arkansas or the special need no longer exists.

K-205 Changes

MS Manual 01/01/14

The Adoption Specialist will have the responsibility of keeping the DCFS Eligibility Unit informed of any changes that might affect a non-Title IV-E child's eligibility. All changes should be reported to the DCFS Eligibility Unit (e.g., change of address, a return to foster care if the adoptive placement does not work out, etc.).

An adoption agreement will continue to remain in place for non Title-IV-E children even when the adoption decree has been finalized. Therefore, eligibility for non Title IV-E adoptive children with special medical and rehabilitative needs will not be affected by the finalization of an adoption decree.

K-206 Closures

MS Manual 01/01/14

The non-Title IV-E Adoptive Special Needs case will be closed when the adoption agreement terminates.

K-300 Medicaid for IV-E Children Who Enter Arkansas from Other States

MS Manual 01/01/14

The Consolidated Omnibus Reconciliation Act of 1985 requires that children with Title IV-E adoption assistance agreements in effect and children receiving Title IV-E foster care maintenance payments will be given Medicaid coverage by the state in which they are currently residing, even though the agreements and payments originated in another state. Children with IV-E adoption assistance agreements in effect will be Medicaid eligible whether or not the child actually receives an adoption assistance payment.

K-301 IV-E Adoptive Children

MS Manual 01/01/14

When a child under an IV-E adoption assistance agreement enters Arkansas, the sending state will notify the Interstate Compact on Adoption and Medical Assistance (ICAMA) Administrator of the child's entry on a Notice of Transfer (form CFS 6.01) that will include basic information needed for Medicaid certification.

K-302 IV-E Foster Children

MS Manual 01/01/14

When an IV-E eligible child in another state's custody enters Arkansas, the sending state will notify the Family Service Worker or ICPC Area Coordinator of the child's entry and will provide the basic information needed for Medicaid certification. The DCFS contact will refer the child to the DCFS Eligibility Unit through the CHRIS system and will also send a copy of forms ICPC-100A and ICPC-100B to the DCFS Eligibility Unit.

K-303 ICAMA/ICPC Responsibilities

MS Manual 01/01/14

The ICAMA Administrator will forward a copy of the Notice of Transfer (CFS 6.01) and/or other correspondence received from a sending state to the DCFS Eligibility Unit for ICAMA adoption cases. The ICPC Coordinator will serve as the liaison between Arkansas and the sending state provided the child remains Medicaid eligible in Arkansas.

K-304 Family Service Worker and Adoption Specialist Responsibilities

MS Manual 01/01/14

The ICAMA Coordinator will enter the identifying information into the CHRIS system for each ICAMA child, and will forward a copy of the Notice of Transfer and/or other correspondence received from the sending state to the DCFS Eligibility Unit. The ICPC Coordinator will refer the ICPC child to the DCFS Eligibility Unit through the CHRIS system and will forward a copy of the ICPC-100A, ICPC-100B, and CFS-597 to the DCFS Eligibility Unit. The appropriate ICPC Coordinator will have the additional responsibility of keeping the DCFS Eligibility Unit informed of any changes that might affect the IV-E child's eligibility.

K-305 DCFS Eligibility Unit Responsibilities

MS Manual 01/01/14

Upon receipt of the referral through the CHRIS system and related documents from the ICAMA Coordinator or ICPC Coordinator, the DCFS Eligibility Unit will register an application. The date of application will be the date the referral was made in the CHRIS system by the ICAMA Coordinator or DCFS worker.

CFS forms ICPC-100A and ICPC-100B and CFS-597 along with the attached documents will serve as an application for ICPC children. Form CFS-6.01 and other information in the CHRIS system will serve as an application for ICAMA children along with any other information received and will require no further verification.

K-306 Retroactive Coverage

MS Manual 01/01/14

Up to 3 months retroactive coverage may be provided if it is established that the child did not receive Medicaid benefits from the sending state in the retroactive months and if the child incurred medical bills in Arkansas during the retroactive months.

K-307 Time Limit for Application Processing

MS Manual 01/01/14

The application process must be finalized within a 45 day time period from the date of application by approval, denial or withdrawal.

K-308 IV-E Eligibility Requirements

MS Manual 01/01/14

The eligibility requirements for Category 92 IV-E children entering Arkansas from other states are:

1. Verification that the child has a Title IV-E adoption assistance agreement in effect, or is a Title IV-E eligible foster child from the sending state;
2. Verification that medical coverage in the sending state has terminated;
3. Assignment of rights to medical support; and
4. Social Security enumeration.

K-309 Certification

MS Manual 01/01/14

The application will be registered and approved in the eligibility system with the minimum requirements for a category 91 or 92 case.

Upon approval, a system generated notice will be sent to notify the adoptive parent or DCFS Family Service Worker of Medicaid approval.

K-310 Case File

MS Manual 01/01/14

The completed case file will consist of a Medicaid application and other documents provided by the DCFS staff.

K-311 Reevaluation

MS Manual 01/01/14

Continuing eligibility will be determined on an annual basis. Reevaluations should be scheduled for completion twelve months after initial certification or last reevaluation. Reevaluation will be limited to verification that the IV-E adoption assistance agreement or IV-E foster care eligibility continues and that the child continues to be an Arkansas resident.

The CHRIS system will generate a notice to the DCFS Eligibility Unit when a case is due for reevaluation.

K-400 Procedures for IV-E Children Who Leave Arkansas

MS Manual 01/01/14

The following procedures will be followed when a child who is IV-E eligible leaves the state of Arkansas.

K-401 Family Service Worker and Adoption Specialist Responsibilities

MS Manual 01/01/14

When a Title IV-E child under an Arkansas adoption assistance agreement or receiving a foster care maintenance payment is to be placed out of Arkansas, the Adoption Specialist or Family Service Worker will notify the Arkansas Interstate Compact on Adoptions and Medical Assistance (ICAMA) Administrator or the Arkansas Interstate Compact on the Placement of Children (ICPC) Unit of the proposed placement.

K-402 ICAMA/ICPC Responsibilities

MS Manual 01/01/14

The ICAMA Administrator or the Family Service Worker, when notified of an IV-E child's placement out of Arkansas, will provide the receiving state with ICAMA form 6.01 and will notify the adoptive or foster parent(s). The Family Service Worker will update the child's placement in the CHRIS system. This action will serve as notification to the DCFS Eligibility Unit that the child has been placed out of state.

K-403 DCFS Eligibility Unit Responsibilities

MS Manual 01/01/14

When notified, the DCFS Eligibility Unit will close the IV-E Medicaid case the date the child leaves Arkansas.

L-100 Administrative Hearings

MS Manual 01/01/14

The purpose of the administrative hearing process is to provide a procedure for DHS clients to appeal:

1. The denial of Medical Assistance,
2. The failure of the Division of County Operations (DCO) to process the application within specified timeframes,
3. When a petitioner disagrees with any DCO action resulting in suspension, reduction or discontinuance of assistance, or
4. When an Institutionalized Spouse (IS) or Community Souse (CS) is dissatisfied with the determination of:
    a. the CS's monthly income allowance,
    b. the amount of monthly income otherwise available to the CS,
    c. the computation of the spousal share of resources, or
    d. the attribution of resources or the CS's resource allowance.

A hearing will not be granted when either state or federal law requires reduction in medical assistance. A request for a hearing must be received in the Office of Appeals and Hearings (OAH) no later than 30 days from the date on the Notice of Adverse Action.

L-110 Appeal Process

MS Manual 01/01/14

A petitioner or his/her designated representative may request a hearing by:

1. Completing the reverse side of the Notice of Action.
2. Making the request by letter to OAH.
3. Completing, with assistance from DCO staff as needed, a DHS-1200, Appeal for a Hearing Form. The county office will assist the petitioner whenever necessary; however, the primary responsibility for providing all information relevant to the administrative appeal rests with the petitioner or his/her representative.

DCO will immediately forward requests for hearings to OAH.

NOTE: If the applicant/recipient indicates that he or she needs an interpreter, material in a different format or other special accommodations, DCO must immediately notify OAH.

When an appeal is received in OAH, DCO will be notified. A memorandum will be sent to the county office to:

1. Provide notification that the appeal has been received,
2. Require DCO to prepare and submit an administrative hearing file no later than seven (7) days after receiving the memorandum, if the appeal was timely filed. The hearing file must contain a County Statement (DHS-1203).
3. Require that within three (3) business days of its receipt of the memorandum, DCO will return a copy of the adverse Notice of Action to OAH with the memorandum signed by the responding caseworker if the appeal was not timely filed.

L-111 DCO Administrative Hearing File

MS Manual 01/01/14

When OAH notifies DCO that a petitioner has requested a hearing, and when the appeal was timely filed, the caseworker will prepare a county administrative hearing file which will be separate from the individual's case record. Each page in the hearing file shall be numbered. A copy of the DCO administrative hearing file will be submitted to OAH within seven (7) days after receiving the memorandum from OAH.

The DCO administrative hearing file shall contain the part of the case record that constitutes documentary evidence supporting the notice of adverse action from which the petitioner is appealing. The following information must be included in the administrative hearing file:

1. Notice of Action – The file must include all notices sent to the petitioner regarding the action under appeal. The administrative hearing can include only the action specified on the Notice of Action. The subject of the administrative hearing shall be limited to the action specified in the notice of action on which the appeal is based.

2. Documentary Evidence – The file must contain the part of the case record that constitutes documentary evidence relevant to the notice of adverse action on which the individual appealed. Examples of documentary evidence include, but are not limited to: verification obtained which resulted in the adverse action; any relevant

correspondence; a copy of the budget (if need is the issue); any information supplied by the petitioner; and any other pertinent information.

3. County Statement (DHS-1203) – The file must include a copy of the County Statement. The County Statement must state the issue and must contain a summary of all facts and evidence supporting the county office's position. All statements should be in simple language. Ambiguous and technical language must be avoided. DHS codes, abbreviations and acronyms should not be used. All information will be provided in an alternative format if requested.

The County Statement will summarize the basis for DCO's action. However, the County Statement is not evidence. Complete documentation is required in the DCO administrative hearing file to support the County Statement.

Five (5) copies of the DHS-1203 will be prepared and distributed to the following within seven (7) days of DCO's receipt of the memorandum from OAH (Slot N-420), if the appeal was timely filed:

1. The original will be mailed to the petitioner.
2. A copy will be sent to the appropriate Program Eligibility Analyst.
3. A copy will be sent to OAH along with the DCO administrative hearing file.
4. A copy will also be retained in the file at the DCO county office.
5. A copy will be sent to the Office of Policy and Legal Services (OPLS) (Slot S-260).

The petitioner or his or her representative will be advised by OAH that the DCO administrative hearing file can be reviewed at the county office.

L-112 Subpoenas

MS Manual 01/01/14

OAH will provide notice to the parties regarding the process by which subpoenas may be issued. Each party must provide to OAH the correct name and contact information for any witness for which a subpoena is requested.

At the time the county's administrative hearing file is sent, DCO must advise OAH of any witnesses to be subpoenaed to testify on behalf of DCO. The reverse side of the County Statement provides space for the caseworker to request subpoenas for witnesses. Department employees will attend hearings without the requirement of a subpoena. The caseworker will be advised by OAH of any witnesses for which the petitioner has requested subpoenas. DCO will have five (5) days from receipt of this notice to request subpoenas for rebuttal witnesses.

The Department of Human Services, Office of Policy and Legal Services, will issue the subpoenas, pursuant to the terms of agreement and authority of A.C.A. §20-76-103. Each subpoena must be served by the party requesting the subpoena.

L-120 Continuation of Assistance or Services during Appeal Process

MS Manual 01/01/14

If a petitioner files an appeal for a hearing within the ten (10) day notice period, or five (5) days in the case of probable fraud, the case will remain open at the petitioner's request until the hearing decision is received from OAH.

At the conclusion of the hearing, the hearing official will decide whether the case should be closed or services reduced prior to the rendering of the hearing decision. The criteria for determining whether adverse action is taken prior to the rendering of the hearing decision will be based on whether or not a fact or judgment situation exists. If it is determined that the sole issue is one of state or federal law or policy, the proposed action will be taken.

Examples of issues of fact:

- Verified earned or unearned income which caused net income to be in excess of the maximum income limitations.
- Protest of Agency Policy-The recipient agrees that his income or resources exceed the limitation but feels that the policy imposing these limitations is unreasonable.

If the sole issue is one of judgment relating to a state or federal law or policy, no adverse action is taken prior to the hearing decision.

Examples of judgment are:

- Disability in MRT cases.
- Value of real or personal property.

The petitioner will be advised at the beginning of the hearing that a decision will be made at the conclusion of the hearing regarding whether the benefits will be reduced or terminated prior to the rendering of the hearing decision. If the decision by the hearing official is to reduce or terminate benefits, a Notice of Action will be prepared by DCO and mailed for immediate action. This is not an additional ten (10) day notice.

If a subsequent change occurs that results in adverse action while the hearing decision is pending and the petitioner does not appeal such action within the ten (10) day notice period, appropriate action will be taken.

L-130 Scheduling, Place of Hearing and Assistance in Preparation of Appeal

MS Manual 01/01/14

OAH will schedule the hearing and send a letter to advise the petitioner of the time, date, and place of hearing, and the name of the hearing official who will conduct the hearing.

A hearing will be held by telephone at the DHS County Office in the county where the petitioner resides. The telephone hearing may be held in another location if, in advance of the hearing, the parties agree upon that location and notify OAH. Upon advance request, hearings may be held in OAH office at 7th and Main Street in Little Rock, Arkansas, or by video conference where available.

DCO will provide reasonable assistance to the petitioner in preparing for a hearing, if requested.

L-140 Abandonment of the Appeal

MS Manual 01/01/14

Regardless of whether the petitioner is represented, the petitioner must appear in person for all hearings regarding program eligibility or program services, or show good cause why he or she cannot be present. If any party fails to appear (either in person or by telephone) within fifteen (15) minutes after the hearing was scheduled to begin, OAH will confirm that the party had proper notice of the hearing and will attempt to contact the absent party. The hearing official may allow an additional fifteen minutes before beginning the hearing. When the hearing begins, the hearing official will identify for the record any party not present in person or by telephone. If the petitioner does not appear, the appeal shall be deemed abandoned, subject to reopening on a showing that the appellant exercised due diligence but was unable to appear due to circumstances beyond the petitioner’s control. If DCO does not appear, the hearing official may proceed with the hearing and may consider any hearing statements or other documents submitted by the agency.

L-150 Withdrawal of Appeal

MS Manual 01/01/14

If a petitioner advises DCO that he/she wishes to withdraw the request for a hearing, he/she will be requested to sign a statement to this effect or to sign a DHS-1201, Withdrawal of Request for Fair Hearing. DCO will provide this documentation to OAH and to OPLS.

L-160 DCO Hearing Responsibilities

MS Manual 01/01/14

It is the responsibility of the County Office to provide an office with privacy in which a hearing can be conducted as well as necessary telephone and/or computer equipment for hearings by telephone or by video conference.

It is also the responsibility of DCO to designate a County Representative prior to the time of the hearing in all cases except those that involve a disability determination by the Medical Review Team (MRT). The representative will be familiar with the case and able to answer pertinent questions from the petitioner, the petitioner's representative and the hearing official. The County Representative will be prepared to represent the county office at the scheduled time for the hearing to comply with all applicable time frames.

The County Representative will assure that all parties, representative, and witnesses who have arrived at the DHS county office or other designated hearing location are escorted to the designated hearing room by the hearing start time. When a hearing is held in the DHS county office, the County representative will ensure that the speaker telephone or video conferencing equipment is operational, and that the petitioner is comfortably seated in the room where the hearing will be held.

DCO may request legal assistance to prepare for the hearing and for representation at the hearing by OPLS.

L-170 Conducting the Hearing

MS Manual 01/01/14

The hearing will be conducted by a hearing officer from OAH. No person having any part in making the decision being appealed may serve as the hearing official.

The petitioner may be accompanied by friends or other individuals and may be represented by a friend, attorney, or other designated representative. DCO will be represented by the caseworker responsible for the case, the county DCO Program Eligibility Coordinator, or OPLS.

The hearing official may not review the case record or other material either prior to or during the hearing unless such material is made available to the petitioner or his or her representative.

The hearing will be conducted in an informal but orderly manner and is recorded. The hearing official will explain the hearing procedure to the parties. The County Statement will be read by the County Representative.

The proponent of an adverse action shall have the burden of proof. The party with the burden of proof will present his/her case first.

When the petitioner presents his/her case, he/she may do so alone or with the aid of others. The petitioner or petitioner's representative will be given the opportunity to present witnesses, advance arguments, offer evidence, and question or refute any testimony or evidence. If the petitioner is unable to present evidence in an effective manner, the hearing official will assist as necessary to assure that the petitioner's evidence is communicated on the record.

When DCO presents its case, it will be given the opportunity to present witnesses, advance arguments, offer evidence, question or refute any testimony or evidence.

Each party will be allowed to cross examine the other party and any witnesses. Questioning of all parties will be confined to the issues involved. Other eligibility factors may be reviewed when appropriate.

When all relevant information has been obtained, the hearing official will issue a Final Order which will include a Finding of Facts, Conclusions of Law, and a Decision. The Final Order will be mailed to the petitioner and a copy provided to DCO.

The parties will also be advised of their right to judicial review in the event of any adverse ruling.

L-171 Additional Medical Assessment

MS Manual 01/01/14

If the hearing involves medical issues, such as those concerning a diagnosis, an examining physician's report, or a medical review team's decision, and if the hearing official considers it necessary to have a medical assessment other than that of the individual involved in making the original decision, such a medical assessment must be obtained at agency expense and made part of the record.

L-172 Hearing Decision

MS Manual 01/01/14

The hearing official will prepare a Final Order based on the evidence accepted into the record and the sworn record of testimony of the proceedings. The format will include an Introduction, Findings of Fact, Conclusions of Law and a Decision. The final decision will be made by the hearing official who will sign the Final Order. Final administrative action must be completed within 90 days from the date of receipt of the appeal.

A client or representative or the DCO county office who would like reconsideration of the Final Order to correct a material misstatement of the record, a clear error of law, or both may request Reconsideration as outlined in DHS Appeals and Hearings Procedures Policy 1098.19-1098.23.

L-173 Judicial Review

MS Manual 01/01/14

When the hearing official has rendered a final agency action on a case and the petitioner or representative is not satisfied with the decision, he or she has the right to judicial review under Arkansas Administrative Procedure Act at A.C.A. § 25-15-212.

M-100 Overpayments

MS Manual 01/01/14

Any medical payment made on behalf of and to the benefit of an individual which is in excess (by at least $5.00) of the amount that should have been paid (if any) is an overpayment. It exists for each month that the individual received benefit of such payment.

An overpayment may result from an individual giving fraudulent information, withholding information, failing to report a change, etc. or from the Agency failing to exercise proper diligence, or a combination of factors.

The amount of overpayment will be determined using the budgetary procedures and allowances in effect at the time the overpayment occurred.

M-110 Overpayments Due to Ineligibility

MS Manual 01/01/14

When ineligibility of a case or member occurs, the potential for Medicaid overpayment is created. To determine if an overpayment has occurred, the ineligible case/members will be evaluated using Medically Needy criteria. A potential overpayment has occurred when the Medically Needy evaluation results in:

- Excess Income;
- Excess Resources; or
- Individuals who cannot be included in an MN determination.

For reporting of potential overpayments, refer to the following:

- When an understated liability exists in an LTC case, refer to MS M-120.
- When excess income exists, refer to MS M-130.
- When excess resources exist, refer to MS M-140.
- When individuals cannot be included, refer to MS M-160.

An overpayment occurs when medical payments have been made on behalf of individuals in any month the individuals are found not eligible.

In evaluating an overpayment and before submitting a report to the Overpayments Unit, the County Office should determine if the ineligible individual(s) would have been eligible in any other Medicaid category (e.g., a child found not income eligible for ARKids A would have been eligible in ARKids B). If eligibility would have existed in another category during the same period, document the electronic record, and do not submit information to the Overpayment Unit.

M-120 Overpayment Due to Understated Liability (LTC Cases)

MS Manual 01/01/14

When excessive payment has been made for the LTC vendor payment due to understated liability, the potential for Medicaid overpayment is created. To determine if an overpayment has occurred, it will be necessary to determine who received the benefit of the excessive payment.

When it is determined that the LTCF received the benefit of the excessive payment, there is no overpayment. An adjustment of vendor payment (to the effective date of change) will be keyed to WNHU instead of submitting an overpayment via a DHS-199.

When it is determined that the individual (his guardian, custodian or payee) received the benefit of the excessive payment (kept more than $30.00 (for SSI clients) and $40.00 (non-SSI client) per month for personal expense), an overpayment has occurred. The overpayment amount claimed for repayment is the amount of income that the individual received in excess of the $30/$40 per month personal expense allowance for the month(s) in which excessive payment was made. An adjustment of vendor payment will be made on WNHU to reflect the current income of the individual (if applicable).

M-130 Overpayment Evaluation - Excess Income

MS Manual 01/01/14

When an individual is ineligible due to income, the amount of excess income will be determined by deducting the appropriate MNIL (Re. Appendix N) for the month(s) of ineligibility from countable income for the period of ineligibility. The amount of the overpayment claimed for repayment will be determined by comparing the excess income for the period to the Medicaid payments for services obtained by the ineligible individual(s) during the period of ineligibility.

The amount claimed for repayment will be limited to the lesser of the amount of excess income or the cost of the medical services.

M-130 Overpayment Evaluation - Excess Income

For LTC cases, the amount claimed for repayment will be limited to the LTC vendor payments made during the period of ineligibility when the amount of the LTCF's private payment rate for the month(s) of ineligibility exceeds the excess income. If the private pay rate is less than the excess income, then the amount claimed for recovery will be the LTC vendor payment plus the Medicaid payment for all medical services received during the period.

The procedure for determining the amount of overpayment to be recovered is as follows:

1. The County Office will compute net countable income for the entire period of ineligibility. Net countable income for each month in the period will be determined by applying all exclusions and deductions which would be applicable if computing Medically Needy eligibility for the individual(s) (add together the net countable income received in each month in the period).

2. The County Office will compute the total MNIL for the entire period of ineligibility (add together the monthly MNILs for each month in the period).

3. The County Office will compute excess income by deducting the MNIL for the period (Re. 2, above) from the net countable income for the period (Re. 1 above).

4. The Overpayments Unit will compare the medical expenses incurred during the period of ineligibility to the excess income for the period.

   a. For LTC cases, if the total private pay rate for the period of ineligibility (add together the private pay rate for the patient's level of care for each month in the period) is more than the amount of excess income, the amount claimed for repayment will be limited to the total vendor payments.

   b. If the total private pay rate for the period of ineligibility is less than the amount of extra income, then the amount claimed for repayment will be the total vendor payment plus any medical expenses incurred.

   c. For non-LTC cases, the amount claimed for repayment will be the lessor of the excess income or the amount of payment for medical services received during the period.

Overpayments and potential overpayments due to excess income will be reported by the County Office on Form DHS-199. The report will identify each individual by name and Medicaid ID number, the total excess income for ineligible month(s), and each month/year of ineligibility.

EXAMPLE 1: **Excess Income –** An individual was ineligible for nursing home care for 4 months due to income. The individual had unearned income of $1,150.00/month for the period. The facility had a private payment rate of $1,500.00/month for the period.

Determine the amount of excess income for the period of ineligibility as follows:

1. Calculate net countable income.
   $1,150.00/month - $20.00 (general exclusion) = $1,130.00 x 4 months = $4,520.00

2. Calculate appropriate MNIL.
   $108.33 (1 person MNIL) x 4 months = $433.32

3. Calculate excess income.
   $4,520.00 (net income) - $433.32 (MNIL) = $4,086.68

4. Determine private payment rate for the facility as follows:

   $1,500.00/month x 4 months = $6,000.00

Since the private payment rate ($6,000) exceeds excess income ($4,086.68), the amount of overpayment claimed for repayment will be limited to the amount of the LTC vendor payment.

EXAMPLE 2: **Excess Income –** An individual was ineligible for nursing home care for 4 months due to income. The individual had unearned income of $1,150.00/month for the period. The facility had a private payment rate of $900.00/month for the period.

Determine the amount of excess income for the period of ineligibility as follows:

1. Calculate net countable income
   $1,150 - $20.00 (general exclusion) = $1,130 X 4 months = $4,520.00

2. Calculate appropriate MNIL.
   $108.33 (1 person MNIL) X 4 months = $433.32

3. Calculate excess income
   $4,520.00 - $433.32 (MNIL) = $4,086.68

4. Determine private payment rate for the facility as follows:

   $900.00/month X 4 month = $3,600.00

Since the excess income exceeds the private payment rate, the amount of overpayment claimed for repayment will not be limited to the vendor payment, but will include all medical payments for the period (the amount of the vendor payment plus the amount of payment for other services received during the period).

M-140 Overpayment Evaluation - Excess Resources

MS Manual 01/01/14

The County Office will evaluate the case to determine the months of ineligibility due to excess resources by comparing the level of resources for each month to the appropriate resource level. For non-nursing home cases, use the appropriate MNRL. For nursing home cases use $2,000 or $3,000, whichever is applicable.

The Overpayments Unit will compare the highest level of excess resources for an ineligible month(s) to the total medical payments made on behalf of case members in the ineligible month(s) to determine the amount claimed for overpayment.

When the LTC vendor payment in the month of receipt is an amount greater than the excess resources, the amount of overpayment claimed for repayment will be limited to the amount of the excess resources.

When the LTC vendor payment is an amount less than the excess resources, the amount claimed will be the lesser of the excess resources or the total amount of medical payments (includes vendor payments).

Overpayments and potential overpayments due to excess resources will be reported by the County Office on the DHS-199. The report will identify each individual by name and Medicaid ID number, the highest dollar amount of excess resources for an ineligible month, and each month/year of ineligibility.

NOTE: There is no resource limit for the Families and Individuals (MAGI) eligibility groups.

EXAMPLE: **Excess Resources –** An individual was ineligible for 5 months due to resources. The individual had resources of $2,100, $2,200, $2,300, $2,400, and $2,500 for months 1 through 5, respectively, for the period.

Determine the highest level of excess resources for an ineligible month as follows:

1. Select appropriate resource level.
   $2,000 (1 person)

2. Calculate excess resources for each ineligible month.
   $2,100 - 2,000 = $100

   $2,200 - 2,000 = $200

   $2,300 - 2,000 = $300

   $2,400 - 2,000 = $400

   $2,500 - 2,000 = $500

3. Select highest level of excess.
   +$500 (month 5)

The amount of overpayment claimed for repayment will be limited to the lesser of the highest level of excess ($500) or the amount of medical payments (includes LTC vendor payments, if applicable) made on behalf of the individual in the period of ineligibility.

M-150 Other Ineligibility

MS Manual 01/01/14

When the individual is ineligible due to other criteria (e.g., categorical relatedness, citizenship, residency, medical necessity, etc.), the amount of overpayment claimed for repayment will be the amount of medical payments (includes LTC vendor payment) made on behalf of the individual in the month of ineligibility. Refer to MS M-160.

M-160 Overpayment Evaluation - Ineligible Individuals (Non - LTC)

MS Manual 01/01/14

All payments made on behalf of individuals who are ineligible to be included in a financial eligibility determination for Medicaid will be considered overpayments.

Overpayments and potential overpayments for individuals totally ineligible will be reported on Form DHS-199. The report will identify each totally ineligible individual by name and Medicaid ID number and each month/year of ineligibility.

M-200 County Office Responsibilities

MS Manual 01/01/14

The following procedures outline county office responsibilities in reporting overpayments (includes potential overpayments), keeping the overpayments unit informed of any information that would have an effect on an established overpayment claim, and assisting clients or other persons with questions regarding the overpayment processes.

M-210 Record Information in Case Narrative

MS Manual 01/01/14

When an overpayment has occurred, enter the period of ineligibility/ understated liability, the reason(s) why the overpayment occurred, and any other pertinent information in the case narrative. All documents supporting the overpayment will be scanned into the electronic case file.

If the overpayment occurred because the individual provided false or incomplete information or failed to report a change, etc., the individual will be advised of the possible consequences (i.e., request for repayment and/or prosecution for fraud). The individual will be requested to explain his/her actions or failure to act and the explanation will be recorded in the electronic case file. Once recorded, the electronic case file will be referred to the Program Eligibility Coordinator for concurrence as to a reportable overpayment.

M-220 Referral to Central Office Overpayment Unit

MS Manual 01/01/14

All overpayments will be referred to the Central Office Overpayments Unit, Slot WG-2 on Form DHS-199. If fraud is suspected, Form DHS-1700 will be sent with the DHS-199.

The Overpayments Unit will register all referrals. After the DHS-1700 is registered, it will be sent to the Fraud Unit for investigation.

If the investigation indicates a prosecutable case, the Fraud Unit will refer the case to the Overpayments Unit (after the case has been adjudicated).

The Overpayments Unit will send a copy of the claim and any other pertinent information to the County Office.

M-230 Keeping Overpayment Unit Informed

MS Manual 01/01/14

The County Office will promptly report, by memorandum to the Central Office Overpayments Unit, any pertinent information (coming to its attention) which would have any effect on an established overpayment claim that has not been satisfied, such as, but not limited to:

1. Hardship situations (situation in which the clients is being deprived of basic subsistence needs – e.g., food, shelter, utilities, etc.);
2. Acquisition of resources or income that may increase the client's ability to repay;
3. Death;
4. Change of address;
5. Re-approval of case after closure.

M-240 Contacts with Clients

MS Manual 01/01/14

If clients or other interested persons have questions concerning recovery letters received directly from the Central Office, the County Office will refer them to the Central Office Overpayments Unit.

If clients wish to make arrangements for repayment, the County Office will explain that the final decision regarding recovery rests with the Central Office Overpayments Unit and give the mailing address:

Office of Finance and Administration
Attention: Overpayments Unit
P.O. Box 1437, Slot WG-2
Little Rock, AR 72203

M-300 Responsibilities of Overpayment Unit and Central Office Accounting Section

MS Manual 01/01/14

The Overpayments Unit will make the decision concerning the feasibility of repayment for all overpayments and ineligibles, whether they resulted from:

- Administrative error.
- Misunderstanding of state policies or laws by the client.
- Willful withholding or incorrect statement of factual information by the client.

The Overpayments Unit will:

1. Review information submitted by the County Office via DHS-199 and DHS-1700 (if applicable) and request additional information (as necessary).
2. Make a decision on the feasibility of seeking repayment from the client after reviewing available information.

M-310 Collections

MS Manual 01/01/14

The Central Office Overpayments Unit will make the determination relative to the disposition of the claim when collection and/or fraud referrals are indicated.

When an agreement is reached with the client either by the Fraud Unit or Office of Policy and Legal Services, the Central Office Overpayments Unit will be apprised of whether:

1. Client has been sentenced,
2. Client's sentence has been suspended contingent upon restitution by court order,
3. Voluntary agreement to repay has been reached,
4. Signed agreement to repay has been negotiated, or
5. Civil court action initiated and results.

M-320 Responsibility of Central Office Accounting Section

MS Manual 01/01/14

The Central Office Accounts Receivable Section will be responsible for receiving and processing all monies collected.

M-330 Recovery

MS Manual 01/01/14

Overpayments are subject to recovery action in accordance with federal regulations. The Overpayments Unit will decide if overpayments will be recovered. Recovery is regaining monies lost by the Agency as a result of overpayments. Restitution is securing payment (e.g., cashier's check or money order payable to the Agency) for overpayments received.

M-400 Willful Withholding of Information

MS Manual 01/01/14

Willful withholding of information is the deliberate misrepresentation or intentional concealment of information for the purpose of obtaining eligibility. Intentional concealment of information that affects eligibility must be clearly indicated. Overpayments resulting from "willful withholding" may be subject to prosecution for fraud.

"Willful" withholding of information includes:

- Willful misstatements, oral or written, made by a recipient in response to oral or written questions from the agency concerning the recipient's income, resources, or other circumstances that may affect eligibility. Such misstatements may include understatements of amounts of income or resources and omission of information regarding income and resources.

- Willful failure by the recipient to report changes in income, resources, or other circumstances that may affect eligibility if the agency has clearly notified the recipient of his obligation to report such changes.

- When a client signs the application/review form, he certifies that he understands that failure to fulfill his obligation to provide correct, complete information and to keep the agency informed of changes may be considered willful withholding of information and permit the agency to recover any overpayments.

- Willful failure by the recipient to report receipt of a payment (keying error and/or system error) which the recipient knew represented an overpayment.

M-500 State Income Tax Refund Interception (STRI)

MS Manual 01/01/14

Act 372 of 1983 as amended (Ark. Stats. Ann. § 84-4901 thru 84-4918) and Act 987 of 1985 authorizes the collection of debts owed the Department of Human Services (DHS) through the interception of State Income Tax Refunds.

The Office of Finance and Administration/Accounts Receivable will submit a list of households with a receivable balance of debts to the Department of Finance and Administration, Income Tax for State Tax Refund Intercept.

Act 987 requires notification to households who owe a debt to the State before this information is furnished to the Revenue Division of the Department of Finance and Administration. A notice of DHS intention to intercept refunds will be mailed by Central Office to the taxpayer prior to December 1 of each year.

The taxpayer has thirty (30) days from the date the notice is mailed to file a written request for a hearing. If no hearing is requested within (30) days, any refund determined to be available may be intercepted and mailed to the Office of Finance and Administration to be allocated within the Department of Human Services by priority.

M-510 Accounts Eligible for Interception

MS Manual 01/01/14

In order for an account to be submitted for State (Income) Tax Refund Intercept, the following conditions must be met:

- The amount owed the State must be certified by the Submitting Department.
- The taxpayer must have been notified of the debt in at least one demand letter.
- The debt must be at least $20.00.

M-520 Requesting the Hearing

MS Manual 01/01/14

The taxpayer has thirty (30) days from the mailing date of the Intent to Intercept Notice to file a written request for a hearing. All hearing requests should be sent to:

Collection Unit of Accounts Receivable
P.O. Box 1437, Slot #WG-2
Little Rock, Arkansas 72203

The Collection Unit will maintain a chronological register of the hearing requests to ensure that each is acted upon in a timely manner. The Appeals and Hearings Section will be notified of all hearing requests and is responsible for conducting hearings for STRI cases in which a Medicaid overpayment is involved.

M-521 Designation of a Representative

MS Manual 01/01/14

A household may designate a representative to act in its behalf during the hearing process by providing a signed statement naming a representative; this individual will receive a copy of all correspondence and materials mailed or provided to the household regarding the Administrative Hearing Proceedings.

M-530 Beginning the STRI Hearing Process

MS Manual 01/01/14

When the Appeals and Hearings Section receives a request for a hearing from the Overpayment Unit along with documentation relative to the overpayment, this information is forwarded to the County DHS Office in the county in which the taxpayer resides so that a County Statement can be prepared. The statement will contain the basis for establishing whether the claimed sum asserted as due and owing is correct. The purpose of the hearing is to determine the validity of the overpayment.

The STRI Hearing Statement should be prepared and returned to the Appeals and Hearings Section within seven (7) days of receipt of the memorandum from Appeals and Hearings. The reverse side of the STRI Hearing Statement contains spaces for the County Office to request the subpoena of witnesses. If the County Office needs assistance in preparing the County Statement or in presenting the case at the hearing, the office should contact the Office of Policy and Legal Services (OPLS) who will determine if OPLS assistance will be provided.

M-531 Subpoena of Witnesses by Taxpayer

MS Manual 01/01/14

DCO will forward copies of the County Statement and the information received from the Overpayment Recovery Unit to the taxpayer for review.

The taxpayer and/or his representative have the right to subpoena witnesses to testify at the STRI hearing. When the subpoena is issued by the Office of Policy and Legal Services, the taxpayer and/or his representative will be responsible for serving the subpoena.

M-532 Notification of the Hearing

MS Manual 01/01/14

The Appeals and Hearings Section will provide written notice to all parties involved at least 10 days prior to the date of the hearing to allow for adequate preparation of the case. The notice will contain:

1. The address and telephone number of the Appeals and Hearings Section to notify if the taxpayer and/or his representative will not be able to attend;

2. A statement that the Appeals and Hearings Section will abandon the hearing request if the taxpayer or his representative fails to notify this office 24 hours prior to the date of the hearing that he/she will be unable to attend.

M-533 Postponement of the Hearing

MS Manual 01/01/14

The hearing may be postponed one time at the taxpayer's request.

M-534 Place of the Hearing

MS Manual 01/01/14

The hearing will be conducted in the county of residence of the taxpayer unless it is determined by the Appeals and Hearings Section that another location would be more convenient for this individual.

M-535 Hearing Officer

MS Manual 01/01/14

The Appeals and Hearings Section will designate all Hearing Officers. The Hearing Officer must not have had any personal interest or involvement in the case and must not have been involved in the contested action either as a caseworker or in a supervisory capacity.

The Hearing Officer may not review the electronic record or other material either prior to or at the hearing unless such material is made available to the taxpayer or his representative.

M-536 Conducting the Hearing

MS Manual 01/01/14

A Hearing Officer will conduct the hearing. The taxpayer may be accompanied by friends or other persons and may be represented by a friend, attorney or designated representative. The Department of Human Services will be represented by a County Office representative from the County DHS Office in which the taxpayer resides.

The hearing will be conducted in an informal but orderly manner. The STRI Hearing Statement will be read by the County Representative. This includes presenting evidence and presenting the County's witnesses. The County Representative may be cross-examined by the taxpayer and/or his representative.

The taxpayer or his representative will then present his case which includes presenting witnesses, advancing arguments, offering additional evidence, and questioning or rebutting any testimony or evidence. The taxpayer or his representative will be allowed to question the County Representative. The taxpayer is subject to cross-examination by the County Office. If the taxpayer is unable to present his evidence, the Hearing Officer will assist him. Questioning of all parties will be confined to the issue involved.

When all relevant information has been obtained, the Hearing Officer will summarize the issues, the evidence, the agency policy, and will explain that he will recommend a decision to the Administrator, Appeals and Hearings Section, who will make the final decision.

The taxpayer will also be advised of his right to judicial review in the event of an adverse ruling.

M-540 Administrative Hearing Decision

MS Manual 01/01/14

Prompt, definitive, and final administrative actions must be taken within 60 days of receipt of a request for an Administrative Hearing. The hearing decision is based upon documentary evidence contained in the Administrative Hearing file and the testimony presented at the hearing.

M-541 Contents of the Administrative Hearing Decision

MS Manual 01/01/14

The hearing decision will contain the following information.

1. An Introduction - This part of the decision will summarize the reason for the appeal. Any pertinent information regarding the appeal is included. The date and location of the hearing must appear. The participants in the hearing must be named.

2. Findings of Fact - The facts upon which the decision is rendered are contained in this section.

3. Conclusions of Law - This section will summarize the appropriate program policy which will either validate or invalidate the overpayment.

4. Decision - This section contains the decision. Based upon the facts presented and the appropriate conclusions of law, a decision is rendered. The decision will determine if the overpayment is valid. If so, then the tax refund would be intercepted, if not, then it would be released.

M-542 Notification of Decision

MS Manual 01/01/14

The Final Order will be issued to the taxpayer, the appropriate County DHS Office, and the Overpayment Recovery Unit.

M-543 Judicial Review

MS Manual 01/01/14

Hearing decisions adverse to the household are sent via certified mail, return receipt requested. This procedure ensures that timely filing for judicial review may be ascertained.

Households not satisfied with an Administrative Hearing decision have the right to judicial review under the Administrative Procedures Act.

The household must file a petition in the Circuit Court of the county in which the household lives or does business or in the Circuit Court of Pulaski County within 30 days from the date the household received the Administrative Hearing decision. Copies of the petition are served to DCO and other parties of record by personal delivery or mail.

M-543 Judicial Review

Within 30 days from the date of the service of the petition to DCO (or additional time granted by the Court, not to exceed 90 days total), the Office of Policy and Legal Services must transmit to the Court the original or a certified copy of the entire record of the hearing under review.

The review will be conducted by the Court without jury and will be confined to the record unless a question of irregularity in procedure exists which is not indicated in the record. Testimony may then be taken before the Court.

N-100 Fraud Investigation

MS Manual 01/01/14

The Fraud Investigations Unit identifies, investigates, and refers for prosecution any individual accused of committing Theft of Property or Theft of Public Benefits as defined by state law. This includes Agency staff, recipients or other persons who deliberately violate the rules and regulations of DHS to defraud the state. Fraud Investigations prepares the Administrative Disqualification File on persons accused of committing an intentional program violation. The Fraud Investigations Unit is organizationally located within the Office of Quality Assurance.

N-110 Functions

MS Manual 01/01/14

The Fraud Investigations Unit has the following major functions:

- Review the case record and independently verify information contained in the file to determine if a criminal investigation is warranted.
- Investigate to gather evidence in cases where there is a probability that a fraudulent act was committed.
- Refer to the prosecutor if facts are obtained which indicate that the accused person, by deception, received DHS monies/benefits to which he/she was not entitled.

N-120 Referral Sources

MS Manual 01/01/14

Reports of suspected fraud may be received from any source within the Department of Human Services, the general public, public officials or other public agencies, or by the Fraud Investigations Unit, itself.

N-130 Reporting Suspected Fraud

MS Manual 01/01/14

Criteria for reporting suspected fraud:

- The suspected fraudulent act(s) resulted in a cumulative overpayment of $200 or more.
- Cases in which the client is receiving assistance in two or more names, counties or states.

Referrals from DHS sources in which an overpayment has not been established are referred to the Fraud Investigations Unit via DHS-1700.

N-140 Review of Case

MS Manual 01/01/14

When a referral is made to the Fraud Investigations Unit, the circumstances will be reviewed to determine if the case warrants investigation toward criminal prosecution.

If one or more of the following facts are present, the case will not be referred for prosecution:

- Total amount of the overpayment resulting from the alleged fraud is $200 or less;
- Age/education of the suspect is not conducive to proving criminal intent;
- Statute of limitations has run on all evidence referred;
- Recipient is permanently residing out of state.

If one or more of the following facts are present, the decision to investigate lies with the Director of Fraud Investigations:

- Fraud not evident in referred material;
- Fraud resulted from failure to report child support payments;

N-150 Case Accepted for Investigation

MS Manual 01/01/14

The following procedures will be completed for reports of suspected fraud that warrant criminal prosecution:

1. The case documentation and any other pertinent information concerning the suspected recipient will be reviewed and printed from the system. DHS Offices, Sections and Units must release any requested information to the Fraud Investigations Unit. Original documents will be retained by the Fraud Investigation Unit for evidence, and copies of those documents will be indexed in the electronic case record or furnished to the document source.

2. The investigator assigned to the case will:

a. Examine the electronic record and/or any other records on file within or outside DHS for suspected false statements of clients or other persons;

b. Conduct a systematic inquiry to determine validity of allegations of criminal conduct; such investigation may entail interviewing caseworkers with knowledge of the case, division staff, and the suspect for any accounts of alleged conduct;

c. After determination of a period of total ineligibility for Medicaid, request a Medicaid profile for purposes of establishing the Medicaid overpayment;

d. Prepare a written, documented report at the completion of the investigation for referral to the Prosecutor;

e. Administratively close the investigation if, at any stage of the inquiry, the investigative staff determines that the case is not suitable for prosecution;

f. Notify the DHS referral source of the disposition of the investigation and return copies of the case record to the County Administrator.

N-160 Disposition of Investigations

MS Manual 01/01/14

The Fraud Investigations Unit will notify the County Administrator of the initial disposition of each referral.

For cases referred for prosecution, the Fraud Investigations Unit will:

- Request the Prosecuting Attorney to file charges and send a copy of the request to the County Office.
- Advise the Overpayment Unit of the factual basis for the overpayment as well as overpayment calculation documents.

For cases administratively closed, the Fraud Investigations Unit will:

- Forward a memo to the County Office and the Overpayment Unit explaining the reason for the closure. If an overpayment has been calculated, these documents will be forwarded to the Overpayment Unit.

The final disposition of cases adjudicated by the court will be furnished to the County Administrator and the Overpayment Unit by the memorandum from the Director of the Fraud Investigation Unit.

N-170 Decision to Prosecute

MS Manual 01/01/14

The Director of the Fraud Investigations Unit will present to the Prosecuting Attorney of jurisdiction the original investigative report of those cases deemed worthy of prosecution. The prosecutor has sole discretion to prosecute, accept repayment in lieu of prosecution, or decline to prosecute.

O-100 Medically Needy Program

The Medically Needy Program is intended to provide medical services for categorically related individuals or families whose income and/or resources exceed the limits for cash assistance but are insufficient to provide medical care.

O-110 Extent of Medical Services for Medically Needy

MS Manual 01/01/14

Medicaid services outlined in the MS Section B, with the exception of Long Term Care and Personal Care, are available to eligibles under the Medically Needy Program. Family Planning Services and Child Health Services (EPSDT) will be offered.

0-120 Identification of Eligible Recipients

MS Manual 01/01/14

The term “Medically Needy” refers to categorically related individuals or families whose income and/or resources are too high to qualify as categorically needy individuals but insufficient to provide for all or part of their medical care.

Individuals not eligible for the Medically Needy Program are:

1. Those currently receiving Medicaid through a non-medically needy category, such as TEA Related Medicaid, ARKids, SSI, or are otherwise Medicaid eligible;
2. Aged and Blind individuals whose countable income and resources are below the SSI payment limitations;

   NOTE: Eligibility in the Medically Needy Categories for Aged, Blind and some individuals with a disability is limited to individuals with countable income in excess of SSI limitations, and deceased or other individuals for whom SSI retroactive eligibility cannot be completed (Re. MS O-141). Refer to MS F-120 for the consideration of AD-MN eligibility for certain individuals who allege a disability.

3. Individuals who allege a disability, whose countable income and resources fall below the SSI payment limitations, and whose disability has been denied by SSA (Re. MS F-120 for the criteria which govern the determination of disability by MRT and AD-MN Medicaid eligibility for an individual with a disability);
4. Persons age 21 and older who are inpatients of the Arkansas State Hospital or the Northeast Arkansas Community Mental Health Center formerly known as the George W. Jackson Center; and

5. Persons incarcerated under the penal system who have been charged with or found guilty of a criminal offense; this includes children under age 18 who are under the jurisdiction of the juvenile justice system and who are detained in juvenile detention centers or other alternative placements such as wilderness or boot camps. A person will be considered incarcerated or detained under the penal system until the indictment is dismissed or he is released from custody as not guilty or for some other reason (e.g. bail, parole or pardon). A person on furlough is still considered under custody of the penal system.

   Exception: An inmate in the custody of the Arkansas Department of Corrections or the Department of Community Corrections who has been admitted to and received treatment at an inpatient facility may be eligible for a Medicaid payment provided all eligibility requirements are met. Income, resources and categorical eligibility will be determined in accordance with MS 3310, MS 12000 and MS 16000. Only the income and resources of the applicant will be considered.

Individuals who may be eligible for the Medically Needy Program are:

1. Those who are categorically related to TEA Related Medicaid, ARKids, or SSI; and
2. Those who meet the income and resources criteria of the Medically Needy Program.

O-130 Medically Needy Group Designations

MS Manual 01/01/14

The two types of coverage within the Medically Needy Program are Exceptional Medically Needy (EC) and Spend Down Medically Needy (SD).

O-131 Exceptional Medically Needy

MS Manual 01/01/14

The Exceptional Medically Needy are those individuals or families whose income is within the Medically Needy Income Level and whose resources fall within the specified limits of the Medically Needy Program.

Eligibility for Exceptional Medically Needy continues as long as the individual or family meets the criteria for categorical relatedness and the income and resource requirements of the Medically Needy program.

Reevaluations are required every twelve months. The date for the initial reevaluation is counted from the date of case certification.

Note: Exceptional Medically Needy cases may be reevaluated along with a SNAP review.

O-132 Spend Down Medically Needy

MS Manual 01/01/14

The Spend Down Medically Needy are those individuals or families whose resources fall within the specified limits of the Medically Needy Program, but whose adjusted income is above the Medically Needy Income Level. Individuals or families qualify for Spend Down eligibility on the basis that their excess income (i.e., that above the MNIL for the determination period) is obligated or spent for medical services. Reevaluation of Spend Down Medically Needy individuals or families is not necessary. Spend Down Medically Needy cases have a "fixed" period of Medicaid Eligibility. Individuals or families may reapply for Spend Down Medically Needy after their eligibility period has ended.

O-140 Screening Applicants for Medically Needy Program

MS Manual 01/01/14

The caseworker will evaluate the individual or family circumstances to determine the proper category through which the individual or family may qualify for Medicaid services (Re. MS 0-210 - Multiple Applications).

O-141 Supplemental Security Income (SSI) Related Eligibility

MS Manual 01/01/14

Supplemental Security Income (SSI) Related Eligibility:

1. An individual or family receiving an SSI payment or covered by SSI is already eligible for Medicaid and need not apply for the Medically Needy Program.
2. An individual (or family) who seems likely to be eligible for Aged or Blind benefits through SSA and who has countable income and resources under the SSI payment limits will be referred to the Social Security Office. If a Medically Needy application has been made, it will be denied because SSI income and resource eligibles in the Aged and Blind categories are not eligible for the Medically Needy Program. This also applies to certain individuals with disabilities (Re. MS F-120).

EXCEPTIONS FOR THOSE WITH INCOME/RESOURCES WITHIN SSI PAYMENT LIMITS:

a. Retroactive eligibility will be determined for individuals whose SSI eligibility cannot be completed, i.e., deceased persons, etc.
b. Individuals in a Medicaid (non-LTC) institution who are subject to the $30.00 SSI countable income limit instead of the SSI full payment limit, with countable income greater than $30.00 but less than the MNIL, may be eligible as Medically Needy.
c. Individuals with disabilities with income and resources under the SSI limit may be found eligible for Medically Needy if one or more of the conditions listed at MS F-120 exist.

3. If an individual's countable income is above SSI limits and his resources are within the Medically Needy limits, the individual (or family) will be considered for Spend Down Medically Needy eligibility.

O-142 TEA Related Medicaid Eligibility

MS Manual 01/01/14

TEA Related Medicaid Eligibility:

1. An individual receiving TEA Related Medicaid is already eligible for Medicaid and need not apply for the Medically Needy Program.
2. An individual who seems likely to be eligible for TEA Related Medicaid may make an application.
3. An individual denied or apparently not eligible for TEA Related Medicaid will be considered for Medicaid eligibility under the Medically Needy Program first as AFDC Exceptional Medically Needy and, if not eligible under this group, as AFDC Spend Down Medically Needy.

O-143 Under 18 Category Related Eligibility

MS Manual 01/01/14

Under-18 Category Related Eligibility:

1. An individual receiving services under the ARKids category is already eligible for Medicaid and need not apply for the Medically Needy Program.
2. An individual who seems likely to be eligible for the U-18 category may make an application.

3. An individual denied or apparently not eligible for the U-18 category will be considered for Medicaid eligibility under the Medically Needy Program as “Spend Down”.
4. Foster children (Re. MS K-100) will be considered for eligibility in the Foster Care-EC, Foster Care MN-Spend down, if not eligible in Non-IV-E Foster Care, IV-E Foster Care or ARKids.

O-150 Special Cases - Medically Needy

MS Manual 01/01/14

Special Cases - Medically Needy

1. If an individual and spouse both qualify under the same or different SSI- related categories of the Medically Needy Program their categorical relatedness will be established separately; however, their income, resources, and medical expenses will be counted in each spouse’s case and eligibility established on that basis. Each individual will be certified in a separate case.
2. When a family unit includes an SSI recipient(s), the SSI recipient’s income, resources, and medical expenses are excluded from eligibility considerations. Only the income, resources, and medical expenses of the remaining family members are used in establishing Medically Needy eligibility. For purposes of Medically Needy eligibility the SSI recipient(s) is not included in the family count.
3. If there is a TEA cash ineligible child under the age of 18 living with a TEA cash family, the child can be considered for ARKids and if not eligible for ARKids, can be considered for U-18 Medically Needy.

O-160 Definition of Medically Needy Program Terms

MS Manual 01/01/14

The following sections of policy define terms that will be used within the Medically Needy policy section.

O-161 Medically Needy Income Level (MNIL)

MS Manual 01/01/14

The MNIL is the income standard used to determine an individual’s or family’s eligibility for Medically Needy program benefits. An individual or family is considered to be Exceptional Medically Needy if their net income is at or below the maximum specified for their family size.

Individuals or families whose income exceeds the MNIL will be considered for Spend Down Medically Needy. These individuals or families may qualify if their excess income (i.e., that above the MNIL) is obligated or spent for medical services.

O-162 Medicare Part B "Buy-In" Premium

MS Manual 01/01/14

The Medicare "Buy-In" Premium is the premium normally paid by insured Medicare individuals for Part B Medicare (medical insurance). The Department of Human Services (DHS) pays this premium for Exceptional Medically Needy individuals through a "Buy-In" agreement with the Social Security Administration. "Buy-In" is made on the basis of the individual's Social Security claim number (the Medicare number) which is entered in ANSWER at the time a case is certified. The Agency does not pay this premium for the Spend Down Medically Needy.

The cost of Part B Medicare will be treated as follows in Medically Needy determinations:

1. Exceptional Medically Needy - The cost of Part B Medicare will not be considered as a medical expense for the Exceptional Medically Needy since the Agency will assume the cost of the premium. If the premium has been withheld from the individual's Social Security check, it will be added back in for the eligibility determination.
2. Spend Down Medically Needy - The cost of Part B Medicare is considered a deductible expense for the Spend Down Medically Needy, since it is not paid by the Agency. The premium for Part B Medicare is included in the Spend Down as a non-covered medical expense.

Note: If the individual is receiving services through the Medicare Savings Programs that pays for the Part B premium, it will not be included as a non-covered medical expense as it is being paid by the Agency.

O-163 Excess Income

MS Manual 01/01/14

Excess income is the dollar amount by which the individual or family net income exceeds the Medically Needy Income Level.

O-164 Spend Down

MS Manual 01/01/14

Spend Down is the requirement that the individual or family obligate all excess income (i.e., that above the MNIL) for medical expenses before eligibility begins.

O-165 Spend Down Period

MS Manual 01/01/14

The Spend Down period is the three calendar months used in determining eligibility for the Medically Needy - Spend Down program.

The Spend Down quarter can be any continuous three calendar month period between the first day of the three month retroactive period (three calendar months prior to the application month) and the last day of the three month period beginning after the application month. The Spend Down quarter can be the three calendar months prior to the month of application; or two calendar months prior to the month of application and the application month; or one calendar month prior to the month of application, the application month, and one subsequent month; or the application month and two subsequent months; or the month after the application month and the two subsequent months.

EXAMPLE: The date of application is April 14, 2012. The Spend Down quarter can be: (1) January, February, and March; (2) February, March, and April; (3) March, April, and May; (4) April, May, and June; or (5) May, June and July.

The three months chosen for the Spend Down period should be the three months in which the applicant has the greatest medical expenses, or the three months in which he would receive the greatest benefit. A careful examination of dates and amounts of incurred medical expenses during the retroactive period and the application month will provide the facts necessary to select the quarter. The applicant will always be allowed to apply for the retroactive quarter if he chooses to do so.

Date specific eligibility has no effect on the three calendar months chosen for the Spend Down period, i.e., the three month period for consideration will always begin at the first of a calendar month and end on the last day of the third calendar month.

The only exception to a Spend Down period of less than three calendar months occurs when an individual did not qualify for reasons other than income during a portion of the period. For these cases, a one or two month determination will be made, as appropriate.

EXAMPLE: A man deserts his family on July 1st. His wife makes AFDC-MN application on July 21st for herself and their children. She requests medical assistance for June, July, and August. Due to a heavy workload, the caseworker does not complete the certification until September 2nd and, prior to certification, she learns the family moved from the state on September 1st. Given these circumstances, a 2 month Spend Down (July and August) will be worked, as eligibility does not exist for June (no deprivation) or for September (non-residence).

O-166 Spend Down Entitlement Period

MS Manual 01/01/14

The Spend Down entitlement period is a "fixed" period of Medicaid eligibility beginning either the first day of the Spend Down period if excess income is obligated by insurance premiums, copayments and/or uncovered incurred expenses (Re. MS O-742) or the day that the coverable medical expenses exceed the remaining excess income (Re. MS O-743) and ending the last day of the period. An entitlement period may cover up to one, two or three month(s).

Both beginning and ending dates of eligibility must be entered in ANSWER at certification.

The only effect date specific eligibility has on the entitlement period is that the end date for a period (last day of a month) may be changed after certification if a county worker becomes aware that an individual or family is no longer eligible for the remainder of the period, e. g., someone has inherited or has been awarded a large sum of money.

O-167 Unmet Liability (Date of SD)

MS Manual 01/01/14

The remaining excess income which is exceeded by deducting a daily total of incurred medical expenses included in the chronological spend down is the applicant's unmet liability (Re. MS O-741). This amount, rounded to the next lower dollar, is entered in ANSWER for the individual(s) who has medical expenses on the Spend Down date (Re. MS O-800). All claims for services incurred on the date of Spend Down will be processed against unmet liability until the liability has been satisfied (i.e., unmet liability is treated like a deductible).

The applicant is responsible for payment of the unmet liability amount.

O-168 Exceptional Medically Needy Duration of Eligibility

MS Manual 01/01/14

With date specific eligibility, an individual's or family's eligibility for exceptional Medically Needy may begin or end on any day of a month (Re. MS O-731). When found eligible, the certification period will begin on the day application was made, unless retroactive coverage is needed. If retroactive coverage is needed and if eligibility is established, the certification period may begin up to 3 months prior to the date of application (but not on the first day of a retroactive month, unless application was made on the first day of a month).

Exceptional Medically Needy eligibility continues until terminated at reevaluation or by reported changes that affect client eligibility. Any changes affecting eligibility must be reported within 10 days so that the caseworker can initiate necessary case action(s).

Termination of benefits does not affect the client's right to make subsequent applications.

O-170 Medically Needy Category Designations at Certification

MS Manual 01/01/14

Medically Needy cases are certified as one of the following categories:

Category	Description
AA(EC)	AA categorically related with income not greater than the MNIL. (see note below)
AA(SD)	AA categorically related with income greater than the MNIL
AFDC(EC)	AFDC categorically related with income not greater than the MNIL.
AFDC(SD)	AFDC categorically related with income greater than the MNIL.
AB(EC)	AB categorically related with income not greater than the MNIL. (see note below)
AB(SD)	AB categorically related with income greater than the MNIL
AD(EC)	AD categorically related with income not greater than the MNIL. (see note below)
AD(SD)	AD categorically related with income greater than the MNIL.
U-18(SD)	Under 18 categorically related with income greater than the MNIL
PW (EC)	Pregnant women with income not greater than the MNIL.
PW (SD)	Pregnant women with income greater than the MNIL.
UP (EC)	Unemployed Parent categorically related with income not greater than the MNIL
UP (SD)	Unemployed Parent categorically related with income greater than the MNIL.
RMA(EC)	Refugee under special eligibility period with income not greater than the MNIL.

Category	Description
RMA(SD)	Refugee under special eligibility period with income greater than the MNIL
FC(EC)	Foster child with income not greater than the MNIL
FC(SD)	Foster child with income greater than the MNIL

NOTE: Eligibility for AABD-EC is restricted to deceased individuals or other persons for whom SSI retroactive eligibility cannot be determined, and individuals in non-LTC institutions who are subject to the SSI $30.00 countable income limit (Re. MS O-141).

EXCEPTION: Some individuals may be found eligible for Cat.46-AD (EC) if certain conditions apply (Re. MS F-120).

O-200 Initial Requests for Medically Needy Services

MS Manual 01/01/14

Requests for Medically Needy Services must be made to DCO or to the Division of Children and Family Services (DCFS) for foster children. For SSI related categories (AABD) and emancipated minors, the individual, his legal guardian or his designated representative may apply. For AFDC related categories, the natural/adoptive parent, or specified relative or an individual, who has been awarded custody of a minor by court order, may apply. Applications for U-18 Medically Needy may be made by a parent or specified relative or by an individual who has been awarded custody of an un-emancipated minor by court order.

Applications will be accepted and processed for deceased persons. The application can be made by the person(s) responsible for medical debts of the deceased. The period of medical coverage cannot extend beyond the normal range of retroactive eligibility from the application date. With date specific eligibility, a Spend Down period can begin on the first day of the third month prior to the month of application, but eligibility for the Exceptional Medically Needy cannot begin more than 3 months prior to the date of application. Applications made for deceased person(s) whose date of death is prior to the limits of retroactive eligibility will be denied.

The Agency has the responsibility to follow up any request and to make arrangements for completion of the application. Medically Needy Services cannot be authorized until the application is approved.

Applications will be made in the county where the applicant resides. If a DCO employee or his relative applies for Medically Needy services in the Office where the employee works, the application will be processed by the next level supervisor.

Methods of verification used in eligibility determination will depend upon categorical relatedness.

All applications will be made on Agency documents. This requirement is necessary because: a legal document is needed to indicate the individual's intent to apply; the date of the application must be recorded; and a written application informs the applicant of his rights and responsibilities for giving the Agency accurate information for determination of eligibility. The application may be introduced in court in cases of fraud.

O-201 On-Site Applications

MS Manual 01/01/14

On-site applications are taken at Arkansas Children's Hospital (ACH) and the University of Arkansas for Medical Sciences (UAMS) from individuals residing in all counties of the State. Applications are also taken at numerous other hospitals and counseling centers around the state by out-stationed DCO workers.

O-210 Multiple Applications

MS Manual 01/01/14

Individuals applying for the Medically Needy Program who may be eligible for the Family Medicaid categories, such as TEA Related Medicaid, have the option of applying for these categories of Medicaid and/or the appropriate category under Medically Needy.

The caseworker has the responsibility of discussing the alternatives with the applicant in order that the applicant may make an informed decision. If there is more than one application for a family or individual, each application must be processed separately. All documents will be maintained in one electronic case file.

NOTE: There may be more than one case per household if there is more than one family in the home, or if there is a stepparent or grandparent in the home, etc. (Re. MS O-720).

O-220 Reapplication for Medically Needy Services

MS Manual 01/01/14

For the Medically Needy –Spend Down, application for services can be made every three months as needed. Application for a new quarter will be made in the same manner as the initial application. Previous documents will be reviewed.

O-230 Distinction between Application and Inquiry

MS Manual 01/01/14

Every person has the right to apply for Medically Needy Services. No application or inquiry may be ignored.

The distinction between an application and an inquiry is as follows:

1. An application is a signed request for payment of medical services by an individual or his authorized representative.
2. An inquiry is a request for information. An inquiry is distinguished from an application by the intent of the person to receive information rather than to apply.

O-240 Initial Contact with Applicant in Person

MS Manual 01/01/14

After an application is submitted to DCO, the caseworker will determine if a face-to-face or telephone interview is required or if the application can be processed using previous documentation.

O-250 Steps in Application Process

MS Manual 01/01/14

MS Sections O-250 through O-257 describe the required steps in the Medically Needy initial application process.

O-251 Application Interview

MS Manual 01/01/14

If a face-to-face or telephone interview is required, the tasks to be completed during the interview are as follows:

1. Explanation of the Medically Needy Program and the Agency regulations that affect the applicant. The explanation will be in terms the applicant can understand.
2. Explanation of the Agency's responsibility for carrying out policy in determining eligibility; of the applicant's responsibility for cooperating in the establishment of eligibility; of the mandatory assignment of rights to Medical support/third party liability (Re. MS D-500); of the obligation to file third party resource claims within a reasonable period of time; of the applicant's obligation to cooperate in Child Support Enforcement Activities (Re. MS F-130); of the information needed to establish eligibility; and of the confidential way in which the Agency treats information.
3. Explanation of the requirement that the applicant and each person included in the MNIL must have or apply for, a Social Security Number as a condition of eligibility (Re. MS D-400).

4. Explanation of the right to a hearing if the applicant is dissatisfied with the Agency's handling of the application or of the case.
5. Explanation of the Agency time limits for completion of applications.
6. Explanation of Child Health Services (EPSDT), Family Planning, SNAP, the Medical Assistance Program, and Service Programs.

O-252 Nondiscrimination

MS Manual 01/01/14

No person will be prevented from participation, be denied benefits or be subject to discrimination on the basis of race, color, national origin, age, religion, disability, sex, political affiliation, or veteran status. The Agency will be in compliance with provisions of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990.

The Agency has the responsibility for informing applicants, recipients, and clients that assistance and services are provided on a nondiscriminatory basis and of their right to file a complaint with the Agency or Federal Government if it is thought that discrimination has occurred on the basis of race, color, national origin, or handicap.

O-253 Securing Information to Determine Eligibility

MS Manual 01/01/14

The caseworker will secure essential social and financial information to determine eligibility.

The applicant will be relied upon as the primary source of information. However, when the applicant is unable to provide essential information and requests assistance, the caseworker will assist in obtaining the necessary verification.

If necessary, the caseworker will use form DHS-81, (Consent for Release of Information) to secure essential information from a collateral source. This form will be signed by the applicant so that information may be released to the Agency.

The caseworker will document each task completed during the interview and will also record in the narrative, and/or on the forms, essential social and financial information.

O-254 Completion of Application Forms

MS Manual 01/01/14

The applicant or his authorized representative will complete and sign the application form. If disability is to be established, the DHS-4000, DCO-106, DCO-107 (or DCO-701) and DCO-108 will be completed for MRT (Re. MS F-120 section). For SSN enumeration procedures, refer to

MS D-400. At the conclusion of the interview, the applicant or representative will be given a DCO-002 to indicate the documents needed for the eligibility determination. At least 10 days will be given for return of the items needed, or longer if the applicant requests.

O-255 Registering the Application

MS Manual 01/01/14

An application will be registered in ANSWER using the date it is received by the County Office. A register number will be system assigned to each application. The categories are:

- 1M for Aged Individual-Exceptional and Aged Individual-SD
- 2M for AFDC-Exceptional and AFDC-SD
- 3M for Blind Individual-Exceptional and Blind Individual-SD
  4M for Disabled Individual-Exceptional and Disabled Individual-SD
- 5M for U-18-SD
- 6M for Pregnant Woman-Exceptional and Pregnant Woman-SD
- 7M for Unemployed Parent-Exceptional and Unemployed Parent SD
- 8M for Refugee-Exceptional and Refugee-SD
- 9M for Foster Care-Exceptional and Foster Care-SD

Note: The Division of Children and Family Services (DCFS) Eligibility Unit will be responsible for completing and registering applications for Foster Care EC and Foster Care MN-SD.

O-256 Securing Information from Collateral Source

MS Manual 01/01/14

Collateral information is evidence provided by persons other than the applicant or by written documents. Items requiring collateral evidence are designated in sections dealing with specific eligibility requirements.

The caseworker will protect the rights of the applicant during collateral interviews and will give only the information necessary to enable the person interviewed to understand the need for the information requested.

When an original, photocopy, or certified copy of a document used as evidence is **not** a permanent part of the electronic case record, it will be necessary for the narrative to contain definitive information as follows:

1. The location of the document, (e.g., where or by whom the document is kept).
2. The pertinent facts which establish authenticity, when the document was made, where the document was registered or filed, registration or filing identification, serial number, etc.

Conflicting evidence will be resolved before approval of an application.

O-257 Time Limits to Dispose of Application

MS Manual 01/01/14

Except for those cases that require a disability determination, all Medically Needy cases will be disposed of within 45 days from the date of application by one of the following actions: approval, denial, or withdrawal.

AD Medically Needy cases, when an MRT disability determination is required, will be disposed of within 90 days from the date of application by one of the following actions: approval, denial, or withdrawal.

O-300 Disposition of Application

0-310 Approval

MS Manual 01/01/14

The caseworker will complete the following tasks when approving an application:

1. Record all pertinent information in the case narrative (information included on forms will not be repeated).
2. Process case approval in ANSWER. An existing case number should be used whenever possible.
3. Notify client by sending form DCO-700 or system generated notice. Approvals for Spend Down will include the amount of the recipient’s unmet liability on the day of Spend Down.

O-320 Denial and Withdrawal

MS Manual 01/01/14

The caseworker will complete the following tasks when denying an application.

1. Record pertinent information in the case narrative (information included on forms will not be repeated). The factor that makes the applicant ineligible will be narrated; however, if verification of other factors of eligibility has been obtained, these will be electronically scanned into the record.
2. Notify client of denial by sending form DCO-700 or system generated notice.
3. For withdrawal only, obtain a signed written statement from the applicant that indicates he/she wishes to withdraw the application.

O-330 Transfer to Another County

MS Manual 01/01/14

When an applicant moves out of the county in which the application was taken, the caseworker who receives the notification of the transfer will:

1. Obtain from the applicant the new address, the name of the county to which the applicant has moved and any other pertinent information regarding the move.
2. Deny the application and electronically transfer the case to the receiving county in ANSWER.

3. Upon notification of the transfer, the receiving county will register the application using the original date of application in ANSWER and continue the eligibility determination.

O-340 County Office Delay

MS Manual 01/01/14

When action on an application will be delayed because of the County Office or MRT, the County Office will notify the applicant with a DCO-700 to explain the reasons for the delay and of his or her right to an appeal.

O-350 Applicant Delay

MS Manual 01/01/14

If the applicant has been instructed by DCO-002 or DCO-191 to provide information to establish eligibility but fails to do so by the end of the specified time, the application will be denied and the applicant will be mailed a DCO-700 or a system generated notice of denial. If the applicant is having difficulty providing essential information and requests additional time, the caseworker will acknowledge the request by sending a DCO-700 that clearly specifies the extended time period and what information is needed by the end of the extended time period; and will also assist the applicant in obtaining the information, if possible. If the information has not been provided by the end of the extended time period, the application will be denied and the applicant will be mailed a DCO-700 or system generated notice of denial.

O-400 Medically Needy Eligibility Determination

MS Manual 01/01/14

O-410 Categorical Relatedness - Medically Needy

MS Manual 01/01/14

To be eligible for the Medically Needy Program, an applicant must meet the basic categorical eligibility requirements outlined in the following paragraphs for AFDC, SSI (AABD), or ARKids. If it is obvious the applicant cannot meet the requirements for any category, the application will be denied without further processing.

O-420 Medically Needy - AFDC Categorical Relatedness (AFDC-MN and UP-MN)

MS Manual 01/01/14

The individual or family must meet the following factors of eligibility to be certified as AFDC-Medically Needy or UP-Medically Needy.

1. Age Requirement – under 18 years old.
2. Citizenship or Alienage Requirement (MS D-200).
3. Residence Requirement (MS D-300).
4. Social Security Enumeration Requirement (MS D-400).
5. Assignment of Rights to Medical Support/Third Party Liability Requirement (MS D-500).
6. Deprivation of Parental Care and Support Requirement (deprived by reason of death, continued absence from the home, or physical or mental incapacity). For UP-MN, refer to MS O-421.
7. Cooperation in Child Support Enforcement activities (MS F-130). (DOES NOT APPLY TO UP-MN.)
8. AFDC Relationship Requirement and Living with Specified Relative (MS F-110).
9. <u>Standard of Need</u> - In determining eligibility, parents will be included in the need standard with their natural/adoptive children. Normally, all of the full siblings in the household will be included in the budget with their natural/adoptive parents. However, a parent may choose to exclude a child and that child's income from a case budget if inclusion of that child and the child's income would cause ineligibility for the other children. Children may also be excluded for other reasons, and the parent who applies need not state the reason. (Re. MS O-720 for additional information on need standards).

a. Income Computation - Income computation is as follows:

   1) The Lump Sum Payment treatment does not apply - a lump sum payment received in the determination period (i.e. in the month for EC cases or in the quarter for SD cases), will be considered as income in the period and, to the extent retained, a resource in the following period.

   2) The income of an alien sponsor is disregarded (Re. MS 6760).

   3) The net earned income (gross earnings minus earned income deduction($90) and child care) plus unearned income (minus the first $50 of child support paid) is compared to the Medically Needy Income Level to determine income eligibility or the Spend Down liability of the AFDC-Medically Needy. For UP-Medically Needy the work and child care deductions, when applicable, will also be given.

b. Resource Limitations and Computation - Resource eligibility for the AFDC-Medically Needy and UP-Medically Needy is determined by computing countable resources as specified in MS 2086 #8 and MS 11300 -11364 and comparing them with the Medically Needy Resource limitations specified under MS O-600. There is no applicable transfer of resource provision which applies to AFDC-MN or UP-MN, i.e., if uncompensated transfers have occurred, no periods of ineligibility will be imposed.

For AFDC-MN only (Not UP-MN), the Medical Review Team determination of disability or blindness will be required. Disability is verified based on submission to MRT of forms DHS-4000 and/or DCO-107 and DCO-108. Blindness is based on submission of forms DCO-701 (Report on Eye Examination of Applicant For or Receipt of Blind Assistance) and DCO-108. MRT reports its findings of approval or denial of disability on form DCO-109. Verification of disability based on receipt of an SSA or SSI disability payment or letter of entitlement may be used in lieu of the MRT procedure.

O-421 Factors Specific to Unemployed Parent Medically Needy

MS Manual 01/01/14

If a two parent family with dependent children meets all of the requirements for UP, except for income and/or resources, their income and resources should be compared to the Medically Needy standards for MN-SD eligibility.

O-422 Deprivation Due to Unemployment of the Principal Wage Earner

MS Manual 01/01/144

Deprivation due to unemployment must be based on the parent who has been the principal wage earner (PWE) for the past two years.

The PWE is the parent who earned the greater amount of income during the 24 month period which immediately precedes the month in which application for assistance is made. The earnings of each parent are considered in determining the principal wage earner regardless of when their relationship began. Only one parent can be the PWE.

Unemployed means:

1. The principal wage earner is not employed or is employed less than 100 hours a month; or
2. If 100 hours or more were worked in a particular month because the work was intermittent and the excess was temporary, the PWE must have been under the 100 hour standard for the two prior months and is expected to be under the standard for the following month.

The PWE must meet each of the following criteria at initial application, or during the month of application, in order for Medicaid coverage to begin in the month of application (see note below):

1. Must have been unemployed for at least 30 consecutive days or is employed less than 100 hours a month;
2. Must have had 6 quarters of work within any 13 calendar quarter period ending within 1 year prior to application or received unemployment compensation within 1 year prior to application. For the 6 quarters of work, education may be substituted for up to 4 of the 6 quarters;
3. Must not, without good cause, have refused a bona fide offer of employment or training for employment within the last 30 days;
4. Must not have refused to apply for or accept unemployment compensation if qualified.

NOTE: If an applicant does not meet the above criteria at application, or during the month of application, eligibility cannot begin until the first day of the month in which the criteria are met.

EXAMPLE: An individual loses his job on May 15th, and applies for UP-MN on May 16th. He worked 110 hours in May before losing his job. He will not have been unemployed for 30 consecutive days by the end of May; therefore, his family will not be eligible for Medicaid during May. He will have been unemployed for 30 days on June 14th, however. Assuming all other eligibility criteria are met, Medicaid benefits could begin June 1st.

O-423 Reporting Requirements

MS Manual 01/01/144

There will be no periodic reporting requirements for UP-MN.

O-424 Retroactive Eligibility

MS Manual 01/01/14

If all of the UP requirements are met in any of the 3 months prior to UP-MN application and if there are unpaid Medical bills, retroactive coverage may be given for any of the 3 retroactive months.

O-425 UP-MN Spend Downs

MS Manual 01/01/14

If all of the eligibility requirements with the exception of income are met, e.g., countable earnings (at less than 100 hours per month) are over the MNIL and if there are unpaid Medical bills, a Medically Needy Spend Down may be considered.

O-430 Medically Needy Pregnant Women Categories

MS Manual 01/01/14

Pregnant Women (Re. MS B-230) may be considered for Medically Needy-EC or SD, if they do not meet the need requirements for PW No-Grant. If a pregnant woman's income and/or resources exceed the limits for PW No-Grant, the PW's income and resources will be compared to the Medically Needy MNIL and MNRL to determine eligibility in PW-EC or SD.

If a pregnant woman has income above the MNIL but below 200% of Poverty Level, then SOBRA PW eligibility will be determined prior to determining eligibility for Spend Down.

O-440 Medically Needy - SSI (AABD) Categorical Relatedness

MS Manual 01/01/14

Individuals will meet the following SSI (AABD) factors of eligibility to be certified as AABD-Medically Needy.

1. Categorical eligibility by reason of “age”, “blindness” or “disability”.
    a. “Aged” is defined as 65 years old or older.
    b. “Blindness” is defined as central visual acuity of 20/200 or less with best correction or a limited visual field of 20 degrees or less in the better eye (Re. MS F-120).
    c. “Disability” is defined as a physical or mental impairment which prevents the individual from doing any substantial gainful work (for a child under 18, an impairment of comparable severity) and which has lasted or is expected to last for at least 12 months or is expected to result in death (Re. MS F-120).
2. Citizenship or Alien Status Requirement (Re. MS D-200).
3. Residence Requirement (Re. MS D-300).
4. Social Security Enumeration Requirement (Re. MS D-400).
5. Assignment of rights to Medical Support/Third Party Liability requirement (Re. MS D-500).
6. Cooperation in Child Support Enforcement Activities (Re. MS F-130).
7. Countable income equal to or greater than SSI payment limitations (Re. MS O-141 for exceptions).
8. SSI Countable Resource Limitations and Resource Treatment (countable resource limits are: $2,000 for an individual and $3,000 for a couple “living together”, one or both eligible. Re. MS O-600 for resource levels).

Methods of verification used for AABD Long Term Care cases apply to the AABD Medically Needy. Procedures used for verification of categorical relatedness is covered under MS G-100 through MS G-180; citizenship and alien status are covered under MS G-130; resource limitations and treatment are covered under MS E-500 through MS E-530; and computation of income is covered under MS E-400 through MS E-450.

O-450 Medically Needy - Under 18 Categorical Relatedness

MS Manual 01/01/14

The individual or family must meet the following factors of eligibility to be certified as U-18 Medically Needy.

1. Age Requirement - under 18 years old.
2. Relationship Requirement and Living with Specified Relative (Re. MS F-110). (These do not apply to individuals who are emancipated or who have been removed from the custody of their parents by court order).
3. Citizenship or Alienage Requirement (Re. MS D-200).
4. Residence Requirement (Re. MS D-300).
5. Social Security Enumeration Requirement (Re. MS D-400).
6. Assignment of rights to Medical Support/Third Party Liability Requirement (Re. MS D-500).
7. Cooperation in Child Support Enforcement Activities (Re. MS F-130).
8. Resource Limitations of the Medically Needy Program (Re. MS O-600).
9. Computation of Income - Earned and Unearned. Refer to MS O-420.)

Resource eligibility for the U-18 Medically Needy is determined by computing countable resources as specified under MS 11300-11364 and comparing them with the Medically Needy Resource limitations specified under MS O-600. There is no applicable transfer of resource provision which applies to U-18-MN, i.e., if uncompensated transfers have occurred, no periods of ineligibility will be imposed.

0-451 Medically Needy - Foster Care

MS Manual 01/01/14

Foster Children (Re. MS B-400) who do not meet the income and/or resource need requirements of State FC (U-18 criteria – Re. MS 0-143) or of Title IV-E-FC may be considered for Medically Needy FC - EC or SD by comparing income and resources to the Medically Needy MNIL and MNRL. The Division of Children and Family Services (DCFS) will determine IV-E and Medicaid eligibility for Foster Children.

Each child will be evaluated as a one person household unit against the appropriate criteria. Consideration of parental income/resources will cease effective the month a child enters Foster Care by the Court awarding custody to the Agency. A child taken into foster care on the basis of an emergency order only may be determined Medicaid eligible. If custody is later established by a judicial determination, the DCFS Worker will be required to include a copy of the order in the foster care Medicaid record.

If a Foster Child reenters his parent’s home, the child’s Medicaid eligibility redetermination will include parental income and resources, even if the reentry is a trial placement and the Agency retains custody.

O-500 SSI Related Treatment of Income (AABD-MN)

MS Manual 01/01/14

Income is defined as the receipt of assets by an individual in cash or in-kind during a month. To be considered as income, the assets received by the individual must be something of value for his own use and benefit in providing the basic requirements of food, clothing, and shelter. Lump sum or one time payments are considered as income for the month of receipt.

Income may be received in cash (including checks, money orders, etc.) or in- kind (including items such as free rent, free food, etc.). The cash value of items received in-kind must be determined. The value of infrequently and irregularly received items such as small gifts of clothing will not be considered as income.

O-510 Income Evaluation

MS Manual 01/01/14

Evaluations of income for the AABD Medically Needy will be made as follows:

1. Individuals with countable income less than the SSI payment limitations are not eligible for Medically Needy consideration unless they are: (a) deceased or other persons for whom SSI retroactive eligibility cannot be determined; (b) individuals in non-LTC institutions who are subject to the SSI $30.00 countable income limit (Re. MS O-141); or (c) individuals with disabilities who meet the requirements at MS F-120. The net monthly income of an individual in any of the above groups will be compared to the monthly Medically Needy Income Level to determine EC eligibility.
2. Those individuals whose countable income is greater than the SSI payment limitations will be evaluated on a quarterly basis to determine Medically Needy Spend Down (SD) eligibility. The individual or couple's net quarterly income in these cases will be compared to the Quarterly Medically Needy Income Level to determine SD liability and eligibility.

The specific process for determining Spend Down eligibility is found in MS O-740.

O-520 SSI Relatedness

MS Manual 01/01/14

The criteria for determining countable income for the AABD Medically Needy are contained in the Section E of this manual (MS E-400 through E-450).

1. MS E-400 - MS E-410 specifies the general consideration of income and how it is evaluated.
2. MS H-421 specifies the extent of consideration of income involving separated couples, (i.e. those not living together in the same household).
3. MS E-415 specifies the means for determining and verifying earned income.
4. MS E-420 – E-421 specifies the means for determining income from self- employment.
5. MS E-430 specifies sources of unearned income.
6. MS E-431 - MS E-434 specifies procedures for determination and verification of unearned income.
7. MS E-432 defines in-kind support and maintenance and other in- kind income, specifies the value determination for each type, and specifies items excluded (not considered as in-kind support and maintenance).
8. MS E-450 - MS E-451 specifies income exclusions applicable to the AABD Medically Needy for determination of net countable income.

O-530 Income of Other Persons (Deeming)

MS Manual 01/01/14

For any month or portion of a month that the applicant (eligible) resides with his ineligible spouse or parent(s) (if the applicant is a child who is blind or has a disability), deeming of income from the ineligible spouse or parent(s) is required.

Current SSI Standard Payment Amounts (SPA) and Living Allowance amounts can be found in the SSI Chart at Appendix S.

Deeming procedures are specified in MS O-531 through MS O-535:

O-531 Deeming of Income from Ineligible Spouse (AABD-MN)

MS Manual 01/01/14

When an applicant/eligible resides with his ineligible spouse, deeming of income from the ineligible spouse is required.

1. Determine the applicant's countable income (allow SSI exclusions – Re. MS E-450). Determine if the countable income is equal to, above, or less than the individual SSI Standard Payment Amount (SPA); then proceed to Step 2 of the deeming process.
2. Determine the total income of the ineligible spouse by types, earned and unearned, less any excluded from deeming (Refer to MS O-535 to determine income excluded from deeming). Proceed to step 3.
3. From the ineligible spouse's income, deduct a living allowance for each ineligible child in the home (i.e. those not receiving TEA Cash Assistance or SSI as a child who is blind or has a disability.

    NOTE: Any children under the TEA Cash family cap, not included in the TEA cash grant, are allowed the living allowance). Income of the child is used to reduce this allowance unless it is excluded as student earned income. Refer to MS O-535 #10 to determine whether any of the student earned income is used to reduce the living allowance. The living allowance is deducted from unearned income first, and any unused balance is then deducted from earned income; proceed to 4.

4. Total the ineligible spouse's remaining income by type, earned and unearned, with the applicant's gross earned and unearned income and treat the two totals of income as for an eligible couple:
    a. From unearned income, deduct the $20.00/mo. general exclusion (carry over any unused balance of the exclusion and deduct from earnings);
    b. From earned income, deduct the $65.00/mo. work expense allowance plus one-half (1/2) the remaining balance;
    c. Total remaining earned and unearned income to arrive at countable income; proceed to 5.
5. Compare the countable income, after deeming, to the two person SSI payment standard. If countable income is less than the two person SPA, and the applicant's own income in step 1 was less than the individual SPA, the applicant cannot be considered for Medically Needy. Referral will be made to SSA for SSI eligibility determination (Re. MS O-141 #2 for exceptions). Any other combination of individual SPA eligibility

(Step 1) vs. the couple's SPA eligibility (Step 5) may be considered for Medically Needy Spend Down. To illustrate:

a. If countable income is under the 1 person SPA and under the 2 person SPA - Refer to SSA.

NOTE: For individuals who allege a disability, refer to MS F-120 before referring to SSA. If MRT will make the disability determination, do not refer to SSA, consider AD-MN.

b. If countable income is under the 1 person SPA and over the 2 person SPA - Consider MN-SD

c. If countable income is over the 1 person SPA and under the 2 person SPA - Consider MN-SD

d. If countable income is over the 1 person SPA and over the 2 person SPA - Consider MN-SD

6. To determine Medically Needy - SD liability, the countable income will be compared to the two person MNIL. The excess over the two person MNIL is the applicant's Spend Down liability.

O-532 Deeming of Income from Ineligible Parent(s) to a Child Who is Blind or Has a Disability

MS Manual 01/01/14

For purposes of income deeming, a stepparent living in the home with an eligible child is not considered the same as a parent. Do not deem a stepparent's income.

1. Determine the gross monthly income of the ineligible parent(s) by type, earned and unearned less income excluded from deeming (Refer to MS O-535 to determine income excluded from deeming).
2. From the ineligible parent(s)' income, deduct a living allowance for each ineligible child in the home (i.e., those not receiving TEA cash or SSI as a child who is blind or has a disability). Any income of the child is used to reduce this allowance unless it is excluded as student earned income. Refer to MS O-535 #10 to determine whether any of the student earned income is used to reduce the living allowance. The living allowance is deducted from unearned income first, and any unused balance is then deducted from earned income.

3. Continue the deeming process as follows:
   a. From unearned income, deduct the $20.00/mo. general exclusion (carry over any unused balance of the exclusion and deduct from earnings);
   b. From earned income, deduct the $65.00/mo. work expense allowance plus one-half (1/2) the remaining balance;
   c. Total remaining earned and unearned income;
   d. From total remaining income, deduct a living allowance for the ineligible parent(s) equal to the SSI SPA.
   e. Remaining income (if any) is deemed to the child as unearned income. It is subject to the $20.00/mo. general exclusion in the child's countable income determination.
4. If parental income is deemed to more than one eligible child, prorate the deemed income equally to each child.

Examples
Deeming of income from Parent(s) to a child. (Examples reflect 1/1/2013 figures)

EXAMPLE #1: A child has gross unearned income of $35.00/month. His ineligible parents have gross earned and unearned income of $900.00/month and $223.00/month, respectively. There is one ineligible child. Deemed income is determined as follows:

a. The ineligible parents have gross monthly earned and unearned income of $900.00 and $223.00, respectively.
b. From the ineligible parents' unearned income, deduct the living allowance for the ineligible child i.e., $223.00 - $356.00 = $00.00; $900.00 earned income - $133.00 (the remainder of the living allowance for the ineligible child) = $767.00. Since remaining income is earned only, income computation will be as follows:
   1) From remaining income, deduct the $20.00 general exclusion and the $65.00 earned income deduction ($767.00 - $85.00 = $682.00).
   2) From the remainder of $682.00 deduct 1/2 ($682.00 - $341.00 = $341.00); then deduct the SSI SPA for a couple ($341.00 - $1,066.00 = $0.00).
   3) $0.00 is deemed to the child as unearned income. If the computation had resulted in an amount greater than zero, it would be added to the child's own income as unearned income for his eligibility determination.
   4) From the child's gross income deduct the $20.00 general exclusion ($35.00 - $20.00 = $15.00) to determine the child's countable income for eligibility.

EXAMPLE #2: A child has gross unearned income of $130.00/month. His ineligible parents have gross unearned income of $800.00/month. There is one ineligible child. Deemed income is determined as follows:

a. The ineligible parents have gross monthly unearned income of $800.00.

b. From the ineligible parents income, deduct the living allowance for the ineligible child ($800.00 - $356.00 = $444.00). Since remaining income is unearned only, computation will be as follows:

   1) From remaining income, deduct the general exclusion ($444.00 - $20.00 = $424.00).

   2) From remaining income, deduct SSI SPA for the ineligible parents ($424.00 - $1,066.00 = $0.00).

   3) $0.00 is deemed to the child as unearned income. This amount would be added to the child's own income for his eligibility determination.

   4) From the child's gross income deduct the $20.00 general exclusion ($130.00 - $20.00 = $110.00) to determine the child's countable income for eligibility.

EXAMPLE #3: A child has gross unearned income of $35.00 monthly. His ineligible parent has gross earned and unearned income of $685.00 monthly and $300.00 monthly, respectively. There are no ineligible children. Deemed income is determined as follows:

a. The ineligible parent has gross monthly earned and unearned income of $685.00 and $300.00, respectively.

   1) From unearned income deduct the general exclusion ($300.00 - $20.00 = $280.00).

   2) From earned income, deduct the work expense allowance plus one-half (1/2) the remaining balance ($685.00 - $65.00 = $620.00 divided by 2 = $310.00).

   3) Total remaining earned and unearned income ($310.00 + $280.00 = $590.00).

   4) From the total remaining income deduct the SSI SPA for the ineligible parent ($590.00 - $710.00 = $0.00).

   5) $0.00 is deemed to the child as unearned income. This amount would be added to the child's own income as unearned income for his eligibility determination ($0.00 + $35.00 = $35.00 less the $20.00 general exclusion leaves $15.00 as countable income to the child).

NOTE: If the child's countable income is under the SSI/SPA, refer to MS F-120 to determine whether SSA or MRT will make the disability determination, and whether or not to refer to SSA. If the allegation is blindness and the countable income is under the SSI/SPA, refer to SSA.

O-533 Deeming of Income to Individual Who Would Be Eligible Except for Excess Income to Eligible Child Who is Blind or Has a Disability

MS Manual 01/01/14

When there is a child who is blind or has a disability living in the home with his parents and one parent is categorically eligible (i.e., acceptable evidence exists that proves that the parent would qualify as aged, blind or disabled except for income), income of the ineligible parent is deemed first to the categorically eligible spouse and then to the eligible child. Deemed income to a child who is blind or has a disability under these circumstances is determined as follows:

1. Complete Steps 1 through 4 of Spouse to Spouse deeming as indicated in MS O-531 Deeming of Income from an Ineligible Spouse;
2. Compare the result derived from Step 4 of MS O-531 to the couple's SSI SPA.
3. If the couple's income determined under Spouse to Spouse deeming is equal to or less than the couple's SSI SPA, there is no income to deem to the child;
4. If the couple's income exceeds the couple's SSI SPA, all of the countable income above the SPA is deemed to the child as unearned income. If more than one eligible child is in the home, divide the income equally to each child. The amount deemed to the child as unearned income is subject to the $20/mo. general exclusion in his eligibility determination.

NOTE: If the child's countable income is under the SSI/SPA, refer to MS F-120 to determine whether SSA or MRT will make the disability determination, and whether or not to refer to SSA. If the allegation is blindness and the countable income is under the SSI/SPA, refer to SSA.

O-534 Deeming of Income to Eligible Child from Parent/Parents Who Would Be Eligible Except for Excess Income

MS Manual 01/01/14

When there is a child who is blind or has a disability in the home with a parent/parents who is/are eligible except for excess income (i.e., acceptable evidence exists that proves that the parent/parents would qualify as aged, blind, or disabled except for income), only income above the parent(s)' SSI SPA is deemed to the child. Deemed income is determined as follows:

1. Determine the parent/parents' countable income as if no children were involved (allow SSI exclusions listed in MS E-450);
2. If the countable income is equal to or less than the SSI SPA, there is no income to deem to the child. If the countable income is greater than the SSI SPA, the amount above the SSI SPA is available for deeming to the child;
3. Reduce the excess income amount by the living allowance for each ineligible child in the home (i.e., those children who are not blind or disabled). If this reduces excess income to zero, there is no income to deem to the eligible child. If not proceed to 4.
4. If excess income remains after deduction of living allowances, it is deemed to the child's unearned income. If more than one eligible child is in the home, divide the income equally to each child. The amount deemed to the child as unearned income is subject to the $20/month general exclusion in his eligibility determination.

NOTE: If the child's countable income is under the SSI/SPA, refer to MS F-120 to determine whether SSA or MRT will make the disability determination, and whether or not to refer to SSA. If the allegation is blindness and the countable income is under the SSI/SPA, refer to SSA.

O-535 Items (Income) Not Included in Deeming

MS Manual 01/01/14

The items listed below are excluded from income of the ineligible spouse or ineligible parent(s) before determination of deemed income.

1. Assistance or Income based on Need - Excludes payments by any Federal Agency, State or political subdivision, SSI payments and any income which was taken into account in determining such assistance. Exclusion applies to V.A. Pension but not to V.A. Compensation. Also excludes TEA cash payments and income which was taken into account in determining assistance (including all income of a stepparent in households where there is a stepparent).
2. Portions of Grants, Scholarships or Fellowships used to pay tuition and fees at an educational institution or the cost of Vocational Technical training which is preparatory for employment.
3. Foster Care Payments received for an ineligible child.

4. Supplemental Nutrition Assistance Program (SNAP) benefits and Department of Agriculture donated foods.
5. Home produce grown for personal consumption.
6. Refund of income taxes, real property taxes, or tax refunds on food purchased by the family.
7. Income used to comply with the terms of court-ordered support and Title IV-D support payments.
8. The value of In-Kind Support and Maintenance provided to ineligible members of the household.
9. Income excluded by other Federal Statutes.
10. Earned income of an ineligible child who is a student unless the child makes such income available (contributes) to the family. This income would not be used to offset the living allowance which is deducted from parental income in the deeming process. If a contribution is being made by the student, consider only the amount contributed as available income.
11. Income necessary for a plan to achieve self-support (i.e., Approved Plan through Rehabilitation Services).

O-600 Medically Needy Resource Limitations and Resource Determination

MS Manual 01/01/14

The following countable resource limitations are in effect for the Medically Needy Program from 1/1/86.

O-610 Medically Needy Resource Limitations

MS Manual 01/01/14

Medically Needy Resource Limitations – Resource Limits

Household Size	1/1/86-12/31/86	1/1/87-12/31/87	1/1/88-12/31/88	From 1/1/89
1	$1,700	$1,800	$1,900	$2,000
2	$2,550	$2,700	$2,850	$3,000
3	$2,650	$2,800	$2,950	$3,100
4	$2,750	$2,900	$3,050	$3,200
5	$2,850	$3,000	$3,150	$3,300
6	$2,950	$3,100	$3,250	$3,400
7	$3,050	$3,200	$3,350	$3,500
8	$3,150	$3,300	$3,450	$3,600
9	$3,250	$3,400	$3,550	$3,700
10	$3,350	$3,500	$3,650	$3,800

NOTE: For Household Sizes Above 10, Add $100 For Each Additional Member.

1. Determination of Household Size for Medically Needy Resource Consideration
   Household size for MN Resource determination is made according to categorical consideration.
   a. SSI cash assistance recipients and their resources are excluded from AFDC and U-18 related cases. They cannot be considered in a second eligibility determination.
   b. AFDC and U-18 Related - Determination of household size for AFDC and U-18 related MN cases is made as follows. The resources of non-SSI individuals may be considered in more than one MNRL.

1) The eligible children and the natural/adoptive parent(s) in the home will be included in the MNRL unit. However, a parent may choose to exclude a child and that child's resources if inclusion of that child and that child's resources would cause ineligibility for the other children in the MNRL. A parent's needs will always be included when determining eligibility for his/her children.
2) The resources available only to a stepparent will be disregarded in the MNRL of his/her stepchild and his/her spouse (the stepchild's natural/adoptive parent) if that spouse requests assistance as caretaker relative of her deprived child. The stepparent will not be counted in their MNRL.
3) The resources available only to a grandparent, or any relative other than a parent, who is not included in the assistance unit, will be disregarded.

   If the grandparent, or other relative other than a parent, chooses to be included in the assistance unit, his/her resources will be included in full in determining resource eligibility for all those included in the MNRL.

   When the grandparent or other relative chooses to be included and when the grandparent/other relative has a spouse in the home, the resources available only to that spouse will be disregarded in determining resource eligibility.
4) In dependent child/minor parent/grandparent households, the rules in (3) above will apply, i.e., if the grandparent is to be included as an eligible, the grandparent's resources will be counted; and if the grandparent is not to be included, the grandparent's resources will be excluded.

NOTE: In U-18-MN cases, the resources of a parent(s) will always be counted in full in his/her child's MNRL and that parent(s) will be included in the MNRL, even though the parent(s) may be over age 18 and will not be a Medicaid eligible member(s) of the unit.
However, in dependent child/minor parent/grandparent households, even though the grandparent's resources must be counted toward the minor parent, they will be disregarded in the resource eligibility determination of the grandchild.

c. SSI Related (AABD) - The household size determination for SSI related is as follows:

1) Household Size 1 ($2,000) limit: The one person or individual limit is used for AABD individuals not living with a spouse, and for a child who is blind or has a disability.
2) Household Size 2 ($3,000) limit: The two-person limit is used for AABD couples and for individual AABD determinations when there is an ineligible spouse.

2. Medically Needy Resource Determinations
   Countable resources for Medically Needy are determined as follows according to categorical consideration.
   a. AFDC and U-18 Related - Countable resources are determined and verified in accordance with TEA Related Medicaid policy. However, there is no applicable transfer of resource provision which applies to AFDC and U-18 related Medically Needy cases.
   b. SSI Related (AABD) - Countable resources are determined and verified in accordance with SSI related policy (Re. MS 3330 - 3339). However, there is no applicable transfer of resource policy which applies to the AABD-MN categories.
   c. All resources are to be verified on the first day for each month of eligibility.

O-620 Resources of Other Persons (Deeming)

MS Manual 01/01/14

When an AABD applicant/eligible resides with his ineligible spouse or ineligible parent(s) (if the applicant is a child who is blind or has a disability), deeming of resources from the ineligible spouse or parent(s) is required.

1. Resources of Ineligible Spouse
   The applicant and his ineligible spouse are permitted a couple's countable resource limit of $3,000 (Allow SSI Exclusions); there is no actual deeming.
2. Resources of Ineligible Parent(s)
   For purposes of resource deeming, a stepparent living in the home with an eligible child is not considered a parent. Do not deem a stepparent's resources to his stepchild.
   a. Determine the child's countable resources (allow SSI exclusions). If countable resources exceed the one person Medically Needy Resource Limit (MNRL) the child is ineligible. If countable resources are less than or equal to the one person MNRL, proceed to b.
   b. Determine the ineligible parent(s) countable resources (allow SSI exclusions). If countable resources are less than or equal to the appropriate MNRL there are no resources to be deemed and the child is eligible. If countable resources exceed the appropriate MNRL, deem the excess (i.e., countable resources above $2,000 or 3,000) to the child, and proceed to c.
   c. Compare the child's countable resources, after deeming, to the one person MNRL. If countable resources exceed the one person MNRL, the child is ineligible. If

countable resources are less than or equal to the one person MNRL, the child is eligible.

O-700 Income Determination for Medically Needy Program

MS Manual 01/01/14

Income is the third consideration for Medically Needy applications. Categorical relatedness and resource eligibility should be reasonably established before income eligibility is considered.

Income is treated differently for the Exceptionally Needy (EC) and Spend Down (SD) groups; however, eligibility for both groups (EC and SD) is determined using the Medically Needy Income Levels below. All cases will first be considered for Exceptionally Needy and, if necessary, for Spend Down.

O-710 Medically Needy Income Levels

MS Manual 01/01/14

Size of Family Unit	Monthly Income	Quarterly Income	Annual Income
1	$108.33	$ 325.00	$ 1300
2	$ 216.66	$ 650.00	$ 2600
3	$ 275.00	$ 825.00	$ 3300
4	$ 333.33	$1000.00	$ 4000
5	$ 383.33	$1150.00	$ 4600
6	$ 441.66	$1325.00	$ 5300
7	$ 500.00	$1500.00	$ 6000
8	$ 558.33	$1675.00	$ 6700
9	$ 616.66	$1850.00	$ 7400
10	$ 675.00	$2025.00	$ 8100

Add $58.33 per month to the monthly income level or $175.00 per quarter to the quarterly income level for each additional member above family size 10.

O-720 Determination of Household Size Used for MN Income Consideration

MS Manual 01/01/14

Determination of Household Size Used for MN Income Consideration:

1. Household size for MN income determination is made as follows according to categorical consideration.

a. SSI cash assistance recipients and their income are excluded. They cannot be considered in a second eligibility determination.

b. AFDC and U-18 Related - Determination of household size for AFDC and U-18 related MN is made as follows. The income of non-SSI individuals may be considered in more than one MNIL.

1) The eligible child(ren) and the natural/adoptive parent(s) in the home will be included in the MNIL unit. A parent may choose to exclude a child and that child's income from a case budget if inclusion of that child and the child's income would cause ineligibility for the other children. Children may also be excluded for other reasons, and the parent who applies need not state the reason.

2) Step-parents may be included in the MNIL with their stepchildren as long as the step-parent's income does not cause ineligibility for the step-children.

3) If the step-parent is not included in the MNIL, the step-parent's income will be disregarded in the MNIL of his/her step-child. If the step-parent's spouse who is the natural/adoptive parent of the step-child requests assistance, the step-parent's income will be deemed to the spouse.

EXAMPLE: A husband and wife have living in their home a child by his former marriage. Both the man and his child request assistance.
MNIL #1: To determine the child's eligibility use the 2 person MNIL to include the father and child and their income only. Disregard the wife's income.
MNIL #2: To determine the man's eligibility, use again the 2 person MNIL (father and child) with their income included. The income of the wife would be deemed to the unit.

4) A step-child can be in the same MNIL with children of his/her step-parent.

5) In step-parent households when a natural/adoptive parent of the stepchild requests assistance and when the natural/adoptive parent and the step-parent have a child of their own, they all can be budgeted in the same case as long as the step-parent's income does not cause Medicaid ineligibility for the step-child(ren).

EXAMPLE: A husband and wife have a child, and the wife has a child by a former marriage. Assistance is requested for both children and the wife.
MNIL #1: Eligibility for their child in common will be determined in a 3 person MNIL, with all the income of the husband, wife, and their child considered. Only the child can be found eligible in U-18-MN, assuming that both parents are over age 18.

MNIL #2: Eligibility for the stepchild will be determined in a 2 person MNIL that includes only the stepchild and the natural/adoptive parent. Their income will be considered in full. The stepparent's and half-sibling's income will be disregarded.

MNIL #3: Eligibility for the natural parent of the stepchild will be determined in an MNIL that includes only the natural parent and the stepchild, with their income considered along with the deemed income of the step- parent. Disregard the half-sibling's income.

If there is a step-child who resides in an UP-MN household, the step-child would be set up in the case with his/her natural parent, step-parent and step-siblings. The UP-MN case will include the step-child, the step-child's natural parent, that parent's spouse, and their child(ren) in common. If the stepparent's income cause ineligibility for the step-child, the step-child can then be set up in a separate Medicaid case, other than UP-MN, with his/her natural parent included in the budget in closed status. The UP-MN case would be set up to include the step-child's natural parent, that parent's spouse, and their child(ren) in common but not the stepchild. There is no deeming of income in UP-MN determinations.

6) In minor parent households, deeming of the income of a grandparent not included in the assistance unit to a grandchild in the unit is prohibited. However, the grandparent's income will be deemed to the minor parent. Therefore, in minor parent situations where the grandmother is not included, there will be 2 MNIL's, and 2 Medicaid cases.

EXAMPLE: A grandmother applies for AFDC-MN for her minor daughter and the daughter's infant.

MNIL #1: For infant eligibility, the MNIL unit of 2 will include the minor parent and the infant, with only their income considered. Disregard the grandparent's income.

MNIL #2: For the minor parent's eligibility, include the minor parent and infant in a 2 person MNIL, with their income, plus the deemed income of the grandparent.

When the grandparent chooses to be included in the unit, the grandparent and the grandparent's full income will be included in the MNIL with the minor parent and infant and their income - one MNIL for 3 persons and one case.

If there are 2 grandparents in the home and one grandparent chooses to be included in the medical assistance unit, income of the excluded grandparent will be deemed to the MNIL that determines eligibility of the included grandparent/minor parent but will not be deemed to the MNIL that determines eligibility of the grandchild. In this situation, there will be 2 MNIL's and 2 Medicaid cases.

MNIL #1: For infant eligibility, the MNIL unit will include the grandparent, minor parent, and infant. Totally disregard the excluded grandparent's income, but include all other income.

MNIL #2: For grandparent and minor parent eligibility include the same 3 members as above, and their income. Also include the deemed income of the excluded grandparent.

The above rules will also apply to other relatives who care for a dependent child/ren, e.g., an aunt and uncle.

NOTE: In U-18-MN cases, a parent's income is always counted in full in his/her own child's case, i.e., there is no deeming of income from a parent to a minor parent in U-18-MN eligibility determinations. However the parent's income will be disregarded in the eligibility determination of the minor parent's child.
For certification instructions when there are multiple cases in one household, refer to MS 7700.

c. SSI Related (AABD) - The size of family unit for SSI related cases is as follows:

- One person unit: The one person or individual income level is used for AABD individuals not living with a spouse, or with a child who is blind or has a disability.
- Two person unit: The two person level is used for AABD couples and for individual AABD determinations when there is an ineligible spouse. If the ineligible spouse is an SSI recipient, that spouse's income is excluded from deeming. (Re. MS O-535)

O-730 Income Eligibility Determination for Exceptional Medically Needy

MS Manual 01/01/14

Income eligibility determinations for the Exceptional Medically Needy will be completed as follows:

O-730 Income Eligibility Determination for Exceptional Medically Needy

Determine the monthly income level applicable to the case according to the Medically Needy Income Levels from MS O-710.

Determine the net monthly income to be considered as follows:

1. For AABD-MN, determine net monthly income according to AABD policy (allow SSI exclusions in MS E-450 and E-451) as follows:
   a. From the unearned income of an individual or the combined unearned income of an eligible couple, deduct $20/month (general SSI exclusion). Do not allow the exclusion from income based on need (e.g. V.A. pension).
   b. Where there is no unearned income for the case or unearned income is less than $20/month, deduct the $20 exclusion or remainder thereof from gross earned income of the case before deducting the SSI earned income exclusion.
   c. From the earned income of an individual or the combined earned income of an eligible couple, deduct $65/month plus 1/2 of the remainder (SSI exclusion).
   d. Total remaining unearned and earned income to arrive at net income.
   e. If the net income is less than the SSI payment level, the individual or couple cannot be considered for Medically Needy, and referral will be made to SSI (Re. MS O-141 for exceptions). If the net income equals or exceeds the SSI payment level, a Spend Down eligibility determination will be made.
2. For AFDC-MN, UP-MN, PW-MN, and U-18-MN, determine net monthly income according to AFDC policy (see exceptions in MS O-420) as follows:
   a. Determine the unearned income for the case.
   b. From earned income, deduct $90 and child care expense.
   c. Total unearned and remaining earned income to arrive at net income.
   d. If the determined net income is less than the monthly Medically Needy Income Level at this point, the individual or family is eligible as Exceptionally Medically Needy and no further computation is necessary. If the net income exceeds the monthly Medically Needy Income Level, it will be necessary to make a Spend Down eligibility determination.

O-731 Establish Duration of Eligibility - Exceptional Medically Needy Cases

MS Manual 01/01/14

With date specific eligibility, eligibility for Exceptional Medically Needy cases begins on the day of application (current) and/or as far back as three months prior to the date of application (retroactive), provided eligibility requirements are met and there are incurred medical expenses for each month of the retroactive period of certification.

EXAMPLE: If application is made on May 3rd, eligibility may be given retroactively to February 3rd, if there are incurred medical expenses in each of the three months and if income/resources requirements are met in each of the months. A shorter retroactive period could be given if the only medical bill in the retroactive period was incurred on April 16th. In that case, eligibility would begin on April 16th.

Eligibility for the Exceptional Medically Needy continues until terminated by the County Office. Termination may occur at the time of reevaluation or at any other time that changes affect eligibility.

The end date of eligibility will be the last day of the 10 day advance notice period, unless a recipient requests a hearing within the advance notice period.

The recipient is required to report all changes within 10 days so that the County Office can initiate necessary case actions.

O-740 Income Determination for Spend Down

MS Manual 01/01/14

Income eligibility for Spend Down cases is determined on a quarterly basis. Use actual quarterly income when available. When actual quarterly income is not available, project income for the quarter as follows:

1. Determine average income per pay period (divide actual total income by actual total pay periods). When available use 8 pay stubs if paid weekly, 4 pay stubs if paid bi-weekly or twice a month, or 2 pay stubs if paid monthly.
2. Determine projected income for the remaining month(s) or portion thereof- (multiply average income per pay period by projected number of remaining pay periods).
3. Determine monthly income (total actual and/or projected income for each month).

Net monthly income, determined according to MS O-730, will be totaled to arrive at quarterly income. The amount of net quarterly income available to the individual/family is measured against the appropriate Medically Needy Income Level (MNIL) (MS O-710) to determine "excess income."

When eligibility cannot be determined for a full quarter (Re. MS O-165), the determination will be made for the balance of the retroactive period (i.e., one or two months). Net income for the shortened period as determined in MS 0-730 will be measured against the appropriate MNIL (MS O-710) to determine excess income.

O-741 Eligibility Based on Incurred Medical Expenses (Spend Down)

MS Manual 01/01/14

The eligibility determination based on incurred medical expenses is a two-step process:

1. Incurred medical expenses (i.e., those which were incurred at the time of application) which cannot be covered by Medicaid are deducted from excess income, first. When these expenses obligate all excess income, the individual is eligible beginning the first day of the Spend Down quarter being considered. When these expenses do not obligate all excess income, proceed to item #2. A list of these non-covered expenses is specified in MS O-742.
2. When excess income remains following deduction of incurred non-covered expenses, a chronological listing (by date of service) of coverable medical expenses must be prepared to determine Spend Down eligibility. Daily totals of these expenses will be deducted from remaining excess income. When remaining excess income is exceeded by a daily total, the Spend Down date (i.e., beginning date of eligibility) is established. The last excess income that was exceeded by the daily total on the Spend Down date is the applicant's "unmet liability". When excess income remains after deducting all coverable medical expenses, the application will be denied.

NOTE: When the applicant has incurred medical expenses which have been paid or will be paid within a reasonable period of time by a third party resource (i.e., insurance, etc.) refer to MS O-750.

O-742 Incurred Medical Expenses Not Coverable Under Medically Needy Program

MS Manual 01/01/14

Incurred medical expenses which are not coverable under the Medically Needy Program will be deducted in the following order. These expenses may include the expenses of an ineligible individual whose needs cannot be included in the MNIL, but whose expenses are the liability of the eligible individual (e.g. the expenses of a deceased spouse).

1. The cost of Health Insurance premiums, including the Part B Medicare premium, for the Spend Down period for all individuals whose needs are included in the MNIL.

2. The cost of any required copayments and/or deductibles for the Spend Down period for all ineligible individuals whose needs are included in the MNIL. Only the cost of required copayments or deductibles on Medicare Part B (non-assigned) claims for the Spend Down period can be deducted for the eligible individual(s) (See Note B).

3. The cost of remaining incurred medical expenses for the Spend Down period for all ineligible individuals whose needs are included in the MNIL. This includes the expenses of an ineligible spouse (AABD related) and the expenses of the ineligible parent(s) (U-18 related) (See Note B).

4. The cost of any uncovered incurred medical expenses for the Spend Down period for the eligible individual(s).

5. The cost of any medical expenses which were incurred during the month of application and the three (3) preceding retro months for all individuals whose needs are included in the MNIL.

   Expenses incurred during the month of application and the three (3) preceding retro months must be deducted from excess income unless they have been paid by or are subject to payment by a legally liable third party, such as a health insurance plan. If the expenses have already been paid by the individual, family or legally responsible relative, the deduction will be allowed. This is true regardless of whether the expenses were incurred during the spend down period. Expenses incurred before the spend down period, but within the retro period, paid or unpaid, will be deducted as non-covered expenses. Any expenses incurred before the retro period, that have been paid cannot be deducted.

6. The cost of any unpaid medical expenses which were incurred outside the Spend Down period for all individuals whose needs are included in the MNIL.

   Proof of current liability (at the beginning of the Spend Down period) must be provided by the applicant for expenses incurred outside the period or the expenses cannot be used in Spend Down. When the applicant has made arrangements to repay any medical expenses, only the payments due in the Spend Down period can be deducted as non-covered, unless the bill was incurred during the Spend Down period. In that case, the bill may be used in the chronological Spend Down, rather than using the monthly payment amount to be made under the contract. Expenses sold or turned over to collection agencies may be deducted if they are verified to be from a medical source.

   When there is no formal agreement to pay non-coverable medical expenses, but regular payments are being made, only those payments made during the Spend Down quarter may be deducted as non-coverable. If payments are being made irregularly or only occasionally, then the entire expense may be deducted as non-coverable.

   NOTE A: Incurred medical expenses used to achieve eligibility cannot be used in future Spend Down determinations, with the following exception. When only a portion of an incurred medical expense is used to achieve eligibility, the unused balance is available for use in the future Spend Down determinations if the applicant can prove continued liability.

   NOTE B: In households with multiple cases, the medical expenses of an individual may be used in the Spend Down of each case in which he/she is included in the budget, whether the individual is eligible or not in the case. In households where a parent and child are eligibles in separate cases, the medical expenses of the parent and child will be considered as covered expenses in each other's Spend Down determination. If an application is made for the child only, and the parent does not qualify for Medicaid, the parent's expenses will be considered as non-covered in the child's Spend Down determination.

O-743 Incurred Medical Expenses Included in Chronological Spend Down

MS Manual 01/01/14

When excess income is not eliminated after deduction of non-covered incurred expenses, it will be necessary to conduct a daily Spend Down (i.e., eliminate remaining excess income through chronological deduction of incurred expenses coverable in the Spend Down quarter). These expenses would be comprised of all services incurred during the Spend Down quarter for individuals potentially eligible for Medically Needy services and apparently coverable under the program (includes the cost of Medicare copayments and/or deductibles) on assigned claims and the cost of any prescribed drug(s) covered by the Medicaid program (name brand drugs must be certified by the physician as medically necessary if lower cost generic equivalent drugs are available).

For maternity expenses, any payments will be deducted on the date of such payments and the balance will be deducted on the date of delivery (if applicable).

NOTE A: Incurred medical expenses used to achieve eligibility cannot be used in future Spend Down Determinations, except as noted in MS O-742 #5.

NOTE B: Medical expenses paid by a credit card or loan within the spend down period and the client is still liable for the loan may be used in the chronological spend down to reduce excess income. Medical expenses incurred before the spend down period that were paid by a credit card or loan can be used as a non-coverable expense.

O-750 Treatment of Third Party Resources

MS Manual 01/01/14

A third party resource is insurance or some other form of entitlement which helps defray the cost of medical services. Third party resources recognized by the Medicaid program include Medicare, private health insurance, public and private liability insurance, workman's compensation, veteran's insurance, CHAMPUS, etc. Third party resources make specific payment for medical services and/or are assignable to a medical provider. Insurance which makes nonspecific payments (i.e., pay whether or not medical services are rendered) and is non-assignable to a medical provider (i.e., pays to the individual only) is not considered a third party resource. Payments from this type of insurance are considered as unearned income. However, insurance which makes nonspecific payments and is assignable will be considered a third party resource (Re. MS O-753).

Payments which are received from third party resources within a reasonable period of time will be applied to the cost of incurred medical expenses to determine the liability of the individual. Any portion of incurred medical expenses paid by third party resources is not the liability of the individual and cannot be deducted from excess income. Any portion of incurred medical expenses not paid by third party resources is the liability of the individual and can be deducted from excess income.

Statements which are received from third party resources within a reasonable period of time can be used to determine the liability of the individual if they indicate either the amount of payment to be made or that no payment is to be made. When statements indicate the amount of payment to be made, the indicated amount of payment will be applied to the cost of incurred medical expenses to determine the liability of the individual (i.e., it will be treated as if it were an actual payment). When statements indicate that no payment is to be made, the total amount of incurred medical expenses is the liability of the individual and can be deducted from excess income.

When a third party resource has not made payment, does not indicate the amount of payment to be made, or indicates that no payment is to be made within a reasonable period of time, the actual liability of the individual cannot be determined and the incurred medical expenses cannot be deducted from excess income.

NOTE: For administrative ease, the time limit imposed for the disposition of the applicable Medically Needy application (45 or 90 days) will be considered to be "a reasonable period of time" to obtain verification of medical expenses paid by a third party.

The most common third party resources are Medicare and private health insurance. To facilitate an accurate determination of an individual's liability, these resources should be treated as follows:

O-751 Medicare Coverage Types

MS Manual 01/01/14

Medicare consists of two types of coverage:

1. Part A - Hospital Insurance - coverage is provided for inpatient hospital care, post hospital extended care and post hospital home health care and skilled nursing care. Part A pays Medicare per diem rate, less any unmet deductible(s) and/or coinsurance.

   Under Part A - Medicare pays direct to the hospital/supplier. The hospital/supplier agrees to accept the Medicare per diem rate. The actual liability of the individual is limited to the following, where applicable:

- Inpatient Deductible, and/or
- Blood Deductible, and/or
- Coinsurance.

NOTE: Medicare provides an unlimited number of hospital days after the annual Part A deductible.

2. Part B, Medical Insurance - coverage is provided for physician services, supplies, home health care, outpatient hospital services, therapy and other services. Part B pays 80 per cent of the Medicare amount approved, less any unmet deductible.

   Non-assignment - Under the non-assignment method, Medicare pays 80 per cent of their amount approved, less any unmet deductible, direct to the individual. The actual liability of the individual, (i.e., the difference between the amount billed by the physician/supplier and the amount paid by Medicare), is limited to the following, where applicable:

   - Difference between amount billed and amount approved, plus
   - Deductible, and/or
   - 20 per cent coinsurance.

   Assignment - Under the assignment method, Medicare pays 80 percent of their amount approved, less any unmet deductible, direct to the physician/supplier. The physician/supplier agrees to accept the amount approved by Medicare, (i.e., he discounts the difference between the amount billed and the amount approved by Medicare). The actual liability of the individual is limited to the following, where applicable:

   - Deductible, and/or
   - 20 per cent coinsurance.

NOTE: Some services are not covered under Part B. Where Medicare disallows a charge in its entirety (e.g. $10.00 billed, $0.00 allowed), the individual is liable for the full charge regardless of assignment.

O-752 Private Health Insurance

MS Manual 01/01/14

Private Health Insurance, like Medicare, consists of two types of coverage, Hospital and Medical.

For hospital care, private insurance makes reimbursement by means of per diem payments, percent of charge payments or a combination of the two.

Under the per diem method, the insurance will apply a fixed amount for each day of hospitalization, regardless of the total charges for the hospitalization.

EXAMPLE: A child is hospitalized for 4 days; daily charges are $1200, $1100, $900 and $650 for days 1-4, respectively. The child's parents have insurance which pays a $600 per diem less any unmet deductible. The insurance payment and client's liability are determined, as follows:

Days	Charges	-	Per Diem Payment	=	Liability
7/1	$1200	-	$600	=	$600
7/2	$1100	-	$600	=	$500
7/3	$900	-	$600	=	$300
7/4	$650	-	$600	=	$50
Total 4	$3850		$2400		$1450 (Plus any unmet deductible)

Under the percent of charge method, the insurance will specify a fixed percent to be applied to the total charges for the hospitalization.

EXAMPLE: Mr. Doe is hospitalized for 4 days, daily charges are $1200, $1100, $900 and $650 for days 1-4, respectively. Mr. Doe has insurance which pays 80 percent of total charges, less any unmet deductible. The insurance payment and Mr. Doe's liability are determined as follows:

Days	Charges	-	Per Diem Payment	=	Liability
7/1	$1200	-	$960	=	$240
7/2	$1100	-	$880	=	$220
7/3	$900	-	$720	=	$180
7/4	$650	-	$520	=	$130
Total 4	$3850		$3080		$770 (Plus any unmet deductible)

The following is an example of a combination of the per diem and percent of charge methods:

EXAMPLE: Mr. Doe is hospitalized for 4 days; daily charges, less room charge, are $1325, $1000, $900 and $700 for days 1-4, respectively; the room charge is $250 a day. Mr. Doe has insurance which pays 80 per cent of total charge, less room charge, less any unmet deductible. The insurance also pays a $200 per diem on room charge. The insurance payment and Mr. Doe's liability are determined as follows:

	Unit Charges		-	Unit Payments		=	Unit Liability	
Days	**Room**	**Other**	**-**	**Room**	**Other**	**=**	**Room**	**Other**
7/1	$250	$1325	-	$200	$1060	=	$50	$265
7/2	$250	$1000	-	$200	$800	=	$50	$200
7/3	$250	$900	-	$200	$720	=	$50	$180
7/4	$250	$700	-	$200	$560	=	$50	$140
Unit Total 4	$1000	$3925		$800	$3140		$200	$785 (Plus any unmet Deductible)
Grand Total 4		$4925			$3940			$985 (Plus any unmet Deductible)

Some private insurance (e.g., Medipak, which only covers the deductible and coinsurance charges that Medicare does not pay) provides limited coverage only.

Although private insurance offers an infinite variety of coverage plans, most companies make payment using one of the methods described or a similar method.

Nonmedical charges (e.g., charge for telephone, television, etc. while hospitalized) cannot be deducted from excess income even though the charges are a liability of the individual.

O-753 Nonspecific Assignable Payments

MS Manual 01/01/14

When a third party resource makes or indicates that it will make a nonspecific assignable payment (method of calculating payment is not known), the payment will be applied in the following manner.

O-753 Nonspecific Assignable Payments

Divide the nonspecific payment by total charges to determine the percent of payment. For cases in which the charges are not itemized (i.e. only a total summary of charges is available), it will be necessary to divide the charges by the dates of service to determine an average daily charge. Apply the percent of payment to each daily charge to determine the amount of charge covered by the payment. The balance of each daily charge (if any) is the liability of the individual.

O-800 County Office Certification

MS Manual 01/01/14

0-810 County Office Certification Responsibility

MS Manual 01/01/14

When all factors of Medically Needy eligibility have been established, the case will be certified in ANSWER.

With date specific eligibility, the beginning date of medical eligibility for Exceptional Medically Needy cases (EC) will be the day of application unless retroactive eligibility is authorized. Retroactive eligibility may be authorized as far back as three months prior to the date of application, provided the individual or family meets the eligibility requirements for the retroactive period, and medical expenses were incurred during the period. Eligibility may be authorized for any one or all of the months during the retroactive period. Each period of retroactive eligibility must be keyed in ANSWER. Refer to ANSWER Desk Guide.

No termination date will be entered for Exceptional Medically Needy cases. Eligibility will continue until closure is authorized by the caseworker. With date specific eligibility, an end date can be entered to terminate coverage on any day of a month, after appropriate 10 day advance notice. For example, if a county is informed of an income increase on 10/13/2012 which makes an individual ineligible, the case may be closed effective 10/23/2012 after advance notice.

Both the beginning and end dates of eligibility are shown for Medically Needy Spend Down cases. The beginning date listed in ANSWER will always be the day of Spend Down. The ending date for Spend Down cases listed in ANSWER is the last day of the third month of the Spend Down quarter used. Once the entitlement period has been established and the certifying document has been submitted, no additional medical expenses can be considered for the entitlement period. The "unmet liability" amount will be rounded to the next lower dollar and entered in ANSWER. Date Specific Eligibility will not change the consideration of the Begin and End dates for the Spend Down certification period.

The begin and end dates will also be shown for fixed eligibility cases. If certifying for fixed eligibility, the begin and end dates may be any day of a month. For example, an individual who applies 5/15/2012 needs coverage for April and May, and is income/resource eligible for those months. Bills were incurred April 18th, and May 5th through 10th. The fixed eligibility period for this individual will begin April 18th and end May 10th.

O-800 County Office Certification

0-810 County Office Certification Responsibility

In AFDC-MN and U-18 households that require separation of the eligible members into different cases (Re. MS O-710) each eligible member will be entered in open status in his/her case, and the other eligible members of the unit will be entered in closed status.

When an eligible member is entered in closed status in another eligible's case, the member's status will be "active" in the budget of the eligible's case to show that the income of the closed member is included in the budget.

EXAMPLE: In a stepparent household where a man, his wife, and her child live, if there are separate cases for the child and his/her natural/adoptive parent, with an open and closed member in each case, "active" will be entered for the natural/adoptive parent that is in closed status to show that the income of the closed member (the natural/adoptive parent) in this case is included in the budget.

In UP-MN cases, the principal wage earner will be added to the child's parent tab with the deprivation reason "unemployed".

When only one member of an AABD couple has expenses on the date of Spend Down, enter the unmet liability amount in ANSWER of that member. Where both members of an AABD couple had expenses on the date of Spend Down, prorate the unmet liability amount to each member on the basis of their percent of expenses on the date of Spend Down. For example, an AABD couple has $200 in unmet liability and $250 in expenses (i.e. $150 - Member A and $100 - Member B) on the date of Spend Down. The amount of unmet liability to be entered in ANSWER of each member is determined as follows:

1. Divide the expenses of each member by total expenses.

   Member A - $150 divided by 250 = 60%

   Member B - $100 divided by 250 = 40%

2. Multiply the unmet liability amount by each member's percent of expenses.

   Member A - $200 x 60% = $120

   Member B - $200 x 40% = $80

In AFDC or U-18 related cases when more than one member had medical expenses on the date of Spend Down, the total unmet liability will be prorated for each member and each individual's prorated unmet liability will be shown in the member segment in ANSWER.

EXAMPLE A: In an AFDC-SD case containing 3 members, medical expenses were incurred on the date of Spend Down by only one member and totaled $300.00. The unmet liability on the date of Spend Down was $100.00 The total unmet liability should be entered in ANSWER for the member who had medical expenses on the date of Spend Down.

EXAMPLE B: In a U-18-SD case, three members had medical bills on the date of Spend Down. Child 201 incurred $150.00 on the date of Spend Down, child 202 incurred $75.00, and child 203 incurred $275.00. The total unmet liability was $100.00 on the date of Spend Down. To determine each member's unmet liability:

For each case:

1. Divide the expenses of each member by the total expenses.

   Member 201-$150 divided by $500 = 30%

   Member 202-$75 divided by $500 = 15%

   Member 203-$275 divided by $500 = 55%

2. Multiply the total unmet liability by each member's percent of the expenses.

   Member 201-$100 x 30% = $30.00

   Member 202-$100 x 15% = 15.00

   Member 203-$100 x 55% = 55.00

O-900 Medically Needy Case Controls

MS Manual 01/01/14

All applications for Medically Needy will be registered in ANSWER. Dispositions of applications will also be noted, as well as the date of disposition.

The DCO/OFO Web Reports (Mainframe Reports) will provide a monthly statistical application report to each County Office for reconciliation of pending and disposed applications on the register as well as overdue applications.

O-910 Time Schedule for Reevaluation of Eligibility for Exceptional Medically Needy Cases

MS Manual 01/01/14

Reevaluation of Exceptional Medically Needy cases will be completed twelve months from the month of certification or the last completed reevaluation. To insure that reevaluations are completed by the end of the twelfth month, they will be scheduled for the eleventh month.

For an AABD-EC reevaluation, the caseworker will mail a DCO-215 and the other forms required to the recipient specifying exactly what is needed (e.g., completed application, check stubs, collateral statement, etc.) and a date by which the forms and verification should be returned. For a Family Related-EC reevaluation, a DCO-136 will be system generated to the recipient. A worker may also use telephone contact along with mail service to obtain additional information or to clarify any questionable information, etc.

The county offices and processing units will use the reevaluation lists that are on Share in the area folders to determine when a reevaluation is due for AABD-EC categories.

The County Office is responsible for completing the reevaluation and making any necessary changes in ANSWER at the time the reevaluation is completed.

At the time of reevaluation, the factors verified will vary according to the categorical relatedness of the case. Particular attention will be given to verification of items subject to frequent change such as income.

The caseworker will:

1. For AABD-EC cases, review the statements on the DCO-215.

2. For Family Related-EC cases, obtain a completed DCO-136, and sufficient information to verify all income, resources, and any income related expenses and deductions. Other forms will be completed, as appropriate (Re. MS O-254).
3. Recompute income eligibility.
4. If additional information/verification is needed to establish continuing eligibility, the recipient will be given a DCO-700, Notice of Action, which will list the information that needs to be returned and the date it should be returned.

If the recipient fails to provide any information necessary to redetermine continued eligibility as requested, the caseworker will close the case at the end of the specified time. If the recipient requests additional time to provide the information, the caseworker will send a second DCO-700 that clearly states what information is needed by the end of the extended time period. “Failure to provide” by the end of the extended period will result in case closure.

O-920 Medically Needy Case Actions - Exceptional and Spend Down

MS Manual 01/01/14

Changes in Exceptional Medically Needy Cases may be made in ANSWER prior to reevaluation or between scheduled reevaluations. Changes in Spend Down cases can only be effected if they are completed before the expiration of the Spend Down entitlement period. Such changes can include the dropping or adding of a family member (for example, a newborn child) or a change in address.

O-930 Change Notification to Medically Needy Recipient by County Office

MS Manual 01/01/14

The ten day advance notice requirement applies to all categories of Medically Needy and is given in all instances of adverse action with the following exceptions.

Advance notice is not required when:

1. The agency has factual information confirming the death of the recipient.
2. The agency receives a written statement signed by a recipient that he or she no longer wishes assistance, or that gives information which requires termination or reduction of assistance, and the recipient has indicated that he understands the consequences of supplying such information.
3. The recipient has been admitted or committed to an institution thereby making him ineligible except when special conditions are met. (Re. MS J-130).

4. The recipient's location is unknown and agency mail directed to him has been returned by the Post Office indicating no known forwarding address. The recipient's Medicaid card must be made available to him if his whereabouts becomes known during the eligibility period covered by the returned ID card.
5. A recipient has been accepted for assistance in a new jurisdiction (another state) and that fact has been established by the jurisdiction that previously granted assistance.
6. A child is removed from the home as a result of a judicial determination or voluntarily placed in foster care by his legal guardian.

The caseworker will notify the recipient by sending form DCO-700 or system generated notice regarding ineligibility of a member and/or closure of the Medically Needy case.

O-940 Medically Needy Case Closures

MS Manual 01/01/14

The system will automatically affect closure of current open Spend Down cases and all cases which are converted to SSI eligibility. The County Office will affect all other closures by input into ANSWER.

With the exception of closed past Spend Down and Fixed Eligibility Certifications, the ten day advance notice applies to all categories. Recipient notifications will be made on form DCO-700 or system generated notice.

The reason for closure will be made in the narrative of each closed case and a copy of the Notice of Action will be filed electronically in the case file.

Eligibility for Medicaid ceases at the end of the 10 day advance notice period. Under date specific eligibility, eligibility may be terminated on any day of a month for Exceptional Medically Needy cases and for Spend Down cases.

O-950 Medically Needy Case Record

MS Manual 01/01/14

The Medically Needy electronic case record will contain the following items required for proof that all conditions of eligibility are met.

1. Documentation of the eligibility factors that correspond with the Medically Needy category to which the case is related. (Refer to the section regarding categorical relatedness).

2. All medical bills/statements/receipts (and/or photo copies) used in determining Spend Down eligibility. Each bill must be:
   - Itemized by the date of medical services
   - Identified with the individual/family name(s)

Burial Fund Guide

Life Ins. with No CSV is Not Resource or Burial	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6	Case 7
1a. Ins. Face $1500 or Less Disregard CSV	$250 Face ($200 CSV)	$1500 Face ($3000 CSV)				$1400 Face ($500 CSV)	
1b. Ins. Face More than $1500 CSV=Res.			($2000 Face) $500 CSV	($5000 Face) $3000 CSV	($3000 Face) $3000 CSV		($2000 Face)
$500 CSV							
2. Irrevocable Contracts (Burial Assn., Some Prepaid incl. Those funded with annuities and insurance)	$500	$2000 OK to here	$5000		$6000		
3. Revocable Contracts A. Prepaid B. Insured Bur. Contracts	A. $500	B. $500 CSV (Resource)					A. $3200
4. Cash—Includes CSV from 1b	$250	$2000 (Resource)	$500 (CSV from above)	$3000 (CSV from above)	$3000 (CSV from above)	$1600	$500 (CSV from above)
Treatment	$1500 Burial <u>OK</u>	$3500 Burial <u>OK</u> $2500 Resource	$5000 Burial <u>OK</u> $500 Resource	$1500 Burial $1500 Resource (OK If $3000 Split)	$6000 Burial OK $3000 Resource	$1500 Burial $1500 Resource (OK If $1600 Split)	$1500 Burial $2200 Resource (If $3200 Split)

01/01/14

Transportation Services

Federal regulations require that non-emergency transportation services be provided to certain Medicaid recipients:

- When necessary for medical care (diagnosis or treatment);
- When transportation is otherwise not available;
- In the least expensive means suitable to the recipient's medical needs; and
- To transport recipients to qualified providers who are generally available and used by other residents of the community.

Transportation services cannot be used by individuals enrolled in ARKids B, Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SMB), and Qualified Disabled Working Individuals (QDWI).

ICF/MR, nursing home facilities, and the Hot Springs Rehabilitation Center are responsible for transporting their clients.

If a nursing home facility administrator believes that unusual circumstances place transportation services outside the scope of his responsibility and requests assistance, the administrator should call the Office of Long Term Care (**501-682-8430**) for assistance.

Services for Which Transportation is Paid

Transportation may be provided when a recipient needs to travel to and from a medical facility that provides medical services covered by Medicaid. A medical facility is defined as a place where medical examinations and treatment are received. Medical facilities include hospitals, doctors' offices, dentists' offices, clinics, independent laboratories, X-ray facilities, Developmental Day Treatment Clinics, pharmacies and drug stores (for purchase of prescription drugs and prescription medical supplies), and the Health Department.

Medicaid transportation will not be provided for a non-Medicaid-covered service (e.g., transportation would not be authorized to a psychologist for an individual over age 21, since this is not a covered service). "Arkansas Medicaid, ARKids First & You" handbook lists the services covered by Medicaid.

Primary Care Physicians

Some Medicaid recipients are required to choose a primary care physician (PCP) to take care of their medical needs, and can generally obtain other medical services only upon a referral from their PCP. If a recipient is required to have a PCP, transportation only to the PCP or to a physician or the medical services referred to by the PCP when a referral is required, will be provided.

Some individuals are excluded from PCP selection. They are nursing home and ICF/MR, Home and Community Based Waiver, Medicare, DDS Children's Services, Medically Needy Spend Down recipients, and those who have retroactive eligibility only or who are temporarily absent from the state (e.g., a foster child placed out of Arkansas).

There are some Medicaid services a recipient can receive without a referral from a PCP (e.g., dental services for children under age 21). For a list of services that do not need a PCP referral, see DCO-2613.

Freedom of Choice (Non-PCP Recipients)

When a recipient is not required to have a PCP or a PCP referral to obtain a Medicaid covered service, a recipient may go to any enrolled Medicaid provider he/she chooses.

Transportation for non-PCP recipients may also be provided for a recipient if a referral has been made by a physician or other health care specialist (e.g., an RN at the Health Department) to a provider who is not the nearest qualified provider.

Methods of Transportation and Payment

Medicaid transportation is provided and paid for as follows:

1. The NET (Non-Emergency Transportation) Program - The NET brokers give Medicaid recipients rides (free of charge) to and from doctor appointments or other covered Medicaid services. It is the responsibility of the Medicaid recipient to call the transportation broker (the company that provides the ride) to schedule a ride. To find the broker in his/her region, the recipient can call the Medicaid Transportation Helpline at 1-888-987-1200 or visit **mmcs.afmc.org** and select Medicaid Beneficiaries & Families, Non-Emergency Transportation (NET) Program. The transportation broker must be called 48 hours (two full business days) before the scheduled appointment. Weekends and recognized state holidays are not business days. Rides are offered Monday through Friday, 8 am to 5 pm.
2. Ambulance Transportation- Ground and air ambulance transportation providers must be licensed by the Arkansas State Ambulance Board and enrolled in the Title XVIII (Medicare) Program. Ambulance service for eligible Medicaid recipients is covered by Medicaid when a physician certifies that the ambulance transportation is medically necessary. It is the responsibility of the transportation provider to obtain prior authorization for non-emergency transportation from the Division of Medical Services (DMS) Utilization Review Section.

All of the above enrolled as Medicaid transportation providers bill Medicaid directly for their services. County offices do not authorize or pay for Medicaid transportation in any situation.

Loaded Miles

Medicaid transportation costs cannot be reimbursed for loaded miles.

Meals, Lodging and Incidental Expenses

A Medicaid recipient's meals and lodging may be paid for only when domiciliary care is required (See below).

Domiciliary Care

Domiciliary care is a covered service under the Arkansas Medicaid Program and is defined as the provision of meals and lodging for a Medicaid recipient who must be fed and housed during a period of receiving medical treatment. Medicaid covers domiciliary care for the Medicaid eligible beneficiary only. It is not available for family members or friends who accompany the patient receiving medical care. It is not a commonly used Medicaid service. The county offices do not authorize or pay for this service.

Therapeutic Visits

A therapeutic visit is defined as a meeting of a child with his parents, guardian or foster parents as a part of a treatment plan to help reunite a family whose members have been separated due to the necessity of inpatient psychiatric care for the child.

Three (3) therapeutic visits (either for the child to visit the parents or for the non-Medicaid eligible parents, etc. to visit the child) in a calendar year may be authorized by the Division of Medical Services (DMS) Utilization Review Section for a family whose child is in an out-of-state facility when a psychologist or psychiatrist has recommended in writing that the visits are medically necessary as a part of the recipient's therapeutic treatment plan (See section below for out-of-state travel). NET should be contacted for information and for transportation arrangement.

If the facility is in Arkansas, a parent, foster parent or guardian is eligible for transportation by NET to visit a minor Medicaid recipient. There is a limit of one (1) trip to and from the facility per episode of care. The parent, foster parent, or guardian contacts NET to schedule the appointment.

Only one (1) round transportation trip will be authorized by the DMS Utilization Review Section for parents who take their child home from a facility (e.g., weekend visit) and later return the child back to the facility.

Emergency Transportation

When an emergency occurs and the attending doctor advises the client to obtain medical care immediately, the doctor will call the NET transportation broker and informs the broker that the client has an "urgent medical situation." The broker will provide transportation without 48 hour notice.

Emergency ambulance services may be covered only when provided by an ambulance company that is licensed by the Arkansas State Ambulance Board and is an enrolled provider in the Arkansas Medicaid Program. Medicaid will cover the ambulance transportation only when the Medicaid recipient is admitted to the hospital or when the patient's condition is an emergency.

Visits for Prolonged Treatment

When it is necessary for a client to see the doctor at the same time each week (e.g., for dialysis or radiation therapy), the client should contact the broker and ask if a regular schedule can be setup for that time period.

Out-of-State Transportation

The Division of Medical Services (DMS) Utilization Review Section authorizes all out of state transportation including air travel.

The provider must obtain prior authorization from the DMS Utilization Review Section for ground ambulance trips to a medical facility outside the State of Arkansas, unless the medical facility is within a 50-mile trade area and is the nearest hospital or nursing home from the point of pick-up.

All requests which require authorization by Utilization Review should be submitted at least 2 weeks in advance of the scheduled departure date. Requests for travel should be made to:

> **Division of Medical Services**
> **Utilization Review**
> **P.O. Box 1437, Slot S413**
> **Little Rock, AR, 72203-1437.**

In cases of extreme emergency or when further information is needed concerning a request, Utilization Review may be contacted at **501-682-8340.**

Transportation of Former Recipients for Utilization Review

Transportation may not be authorized to former Medicaid recipients.

Medical Services – Appendix C, Verification of Citizenship, Alien Status and SSN Enumeration

I. Citizenship Verification - Acceptable Documents for Proof of Citizenship

When citizenship cannot be verified through the Federal Data Services Hub (FDSH) or the SSA match, the worker must access Vital Records through ARFinds for verification of birth. If citizenship documentation cannot be obtained through Vital Records, specific forms of documentation may be acceptable evidence of citizenship. If an individual presents evidence from the listing of Primary Documentation, no other information is required.

To establish U.S. citizenship, the document must show a U.S. place of birth and that the person is a U.S. citizen. The documents must be original or certified copies. Copies of documents already obtained will be accepted as assumed made from the original unless questionable (e.g. stamped "copy", or unreadable).

In general, the caseworker should obtain primary evidence of citizenship before using the secondary documentation or tertiary list. The following forms of documentation may be accepted:

Primary documentation– The highest reliability that conclusively establishes identification and citizenship.

- A U.S. Passport.
- A Certificate of Naturalization (Department of Homeland Security (DHS) Forms N-550 or N-570).
- A Certificate of U.S. Citizenship (DHS Forms N-560 or N-561).

Secondary documentation– Secondary evidence of citizenship is documentary evidence of satisfactory reliability that is used when primary evidence of citizenship is not available.

- A U.S. birth certificate.
- A Certification of birth issued by the Department of State (Form DS-1350).
- A Report of Birth Abroad of a U.S. Citizen (Form FS-240).
- A Certification of Birth Abroad (FS-545).
- An American Indian Card issued by the Department of Homeland Security with the classification code "KIC". (Issued by DHS to identify U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border).
- Final adoption decree.
- Evidence of civil service employment by the U.S. government before June 1976.
- An official military record of service showing a U.S. place of birth.
- A Northern Mariana Identification Card (issued by the INS to a collectively naturalized citizen of the United States who was born in the Northern Mariana Islands before November 4, 1986.

Third level documentation– Third level evidence of U.S. citizenship is documentary evidence of satisfactory reliability that is used when neither primary nor secondary evidence of citizenship is available. This documentation includes:

- Extract of U.S. hospital record of birth established at the time of the person's birth, created at least 5 years before the initial application date and indicating a U.S. place of birth.
- Life or health or other insurance record created at least 5 years before the initial application date showing a U.S. place of birth.
- Religious records recorded in the U.S. within 3 months after the birth which show that the birth occurred in the U.S. showing the date of the birth of the individual or the individual's age at the time the record was made. These must be official records recorded with the religious organization (e.g., baptismal certificates). Entries in a family bible are not considered recorded religious records.
- Early school records which show the name of the child, the date of admission to the school, the date of birth (or age at the time the record was made), a U. S. place of birth, and the name(s) and place(s) of birth of the applicant's parents.

Fourth level documentation – Fourth level evidence of U.S. citizenship is documentary evidence of the lowest reliability. This level should **only** be used in the rarest of circumstances. This level of evidence is used only when primary evidence is not available, both secondary and third level evidence do not exist or cannot be obtained within the reasonable opportunity period, and the applicant alleges a U.S. place of birth. This documentation includes:

- Federal or State census record showing U.S. citizenship or a U.S. place of birth, as well as the applicant's age.
- Birth records that were recorded with vital statistics 5 years after a birth (a delayed birth record).
- Institutional admission papers from a nursing home, skilled nursing care facility or other institution created at least 5 years before the initial application date and which indicate a U.S. place of birth.
- Medical (clinic, doctor, or hospital) record which was created at least 5 years before the initial application date and indicates a U.S. place of birth unless the application is for a child under 5.
- Other document that was created at least five years before application for Medicaid. These documents are Seneca Indian tribal census record, Bureau of Indian Affairs tribal census records of the Navaho Indians, U.S. State Vital Statistics official notification of birth registration, an amended U.S. public birth record that is amended more than 5

years after the person's birth or a statement signed by the physician or midwife who was in attendance at the time of birth.

- The Roll of Alaska Natives maintained by the Bureau of Indian Affairs.
- Written affidavit. This should be in rare circumstances when the applicant or recipient cannot provide evidence from another listing.

Written affidavits may be used in circumstances when the state is unable to secure evidence of citizenship from another listing. The affidavits must be supplied by at least two individuals, one of whom is not related to the recipient. Each must attest to having a personal knowledge of the event(s) establishing the recipient's claim of citizenship. Those making affidavits will be subject to prosecution for perjury. If the persons claiming knowledge of another's citizenship has information, which explains why documentary evidence establishing the claim of citizenship does not exist or cannot be readily obtained, the affidavit should contain this information as well.

A second affidavit from the recipient or other knowledgeable individual explaining why documentary evidence does not exist or cannot be readily obtained must also be requested.

II. Alien Status Verification - Using SAVE (Systematic Alien Verification for Entitlement)

When an individual's INS documentation appears valid but does not have the necessary coding to show the alien's status, or the entry or admission date is missing, verification of the alien's status can be obtained through SAVE's automated database, the Alien Status Verification Index (ASVI).

To access the ASVI:

- Using a touch-tone phone, dial the toll-free system number, 1-800-365-7620.
- Enter the access code, then press the pound (#) sign when instructed by the recorded message.
- Enter the alien registration number when instructed by the recorded message. The alien registration number is a series of digits preceded by the letter "A." Do not enter the "A." If the number is less than nine digits, use zeros at the beginning of the number to make it nine digits. (E.g., if the number is "A12345" enter it as "000012345.")

If a record for the alien is found, the ASVI system will give the alien's:

- Registration number.

- Verification number.
- Last and first name, spelled out.
- Date of birth.
- Status code.
- Country of birth code.
- Social Security number.
- Date of entry.

If no record is found for the alien, the ASVI system will instruct you to "institute secondary verification." When this message is received, use form G-845, *Document Verification Request*, to request information from INS.

Secondary Documentation of Alien Status

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Secondary documentation is the process for obtaining status information from the INS when using form G-845, Document Verification Request, and its supplement.
Obtain secondary documentation only when:

- SAVE instructs you to do so.
- The documentation the individual provided shows an eligible status, but the document itself is expired or appears questionable or not genuine.
- The documentation is a receipt showing that the alien has an eligible status but has applied to INS for a replacement card.
- The INS documentation appears to be genuine and the alien claims to have an eligible status, but necessary codes or dates are missing from the card.

Until verification is received from the INS indicating the individual is a qualified alien, the individual should be treated as a nonqualified alien.

III. Alien Documentation Chart

The chart below shows the types of documentation that can be used to verify alien status, and additional verification that certain aliens must provide to verify that they are eligible for Medicaid (e.g., the date they were admitted to the U.S., or the date a particular alien status was granted or adjusted).

Alien Status	Acceptable Documentation of Alien Status	Medicaid Status
Amerasian Immigrant	• INS Form I-551, Permanent Resident Card, annotated AM6, AM7 or AM8. • Unexpired temporary I-551 stamp in a foreign passport annotated AM1, AM2 or AM3. • INS Form I-94, Arrival/Departure Record, annotated AM1, AM2 or AM3.	Eligible Regardless of U.S. entry date
Asylee	• INS Form I-94, Arrival/Departure Record, noting admittance under section 208 of the INA. • INS Form I-94, Arrival/Departure Record, annotated AS-1, AS-2 or AS-3. • INS Form I-94, Arrival/Departure Record, with Visa 92 or V-92. • Order of an immigration judge granting asylum. • Written decision letter from the Board of Immigration Appeals. • INS Form I-688B, Employment Authorization Card, annotated "274a.12(a)(5)." • INS Form I-730, Approval Letter. • INS Form I-766, Employment Authorization Document, annotated "A5."	Eligible as of date asylum is granted.

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Alien Status	Acceptable Documentation of Alien Status	Medicaid Status
Battered Alien	Proof of admission of entry date and one of the following documents: • I-360 or I-130 petition with proof of filing (a file-stamped copy of the petition, an I-797 or I-797VC, or another document demonstrating filing, such as a signed certified return receipt or cash register or computer-generated receipt). • INS Form I-797 or I-797C indicating approval or prima facie validity of an I-360 petition. • INS Form I-797 or I-797C indicating filing or approval of an I-130 petition. • Order or document from the Immigration Court or Board of Immigration Appeals granting suspension of deportation under INA section 244(a)(3), or cancellation or removal under INA section 204A(b)(2). • Application for cancellation of removal (Form EOIR 42B) or suspension of deportation (Form EOIR 40) with proof of filing (a file-stamped copy of the application or another document demonstrating filing, such as a signed certified return receipt or cash register or computer-generated receipt). • A document from the Immigration Court or Board of Immigration Appeals indicating that the applicant has established a prima facie case for suspension of deportation under INA section 244(a)(3), or cancellation of removal under INA section 204A(b)(2).	Barred for five (5) years if entered U.S. on or after 8/22/96. Eligible if entered U.S. before 8/22/96.
Canadian-born American Indian	• INS Form I-551, Alien Registration Receipt Card, coded S13. • I-551 stamp in a Canadian passport coded S13. • INS Form I-94, Arrival/Departure Record, coded S13. • Proof of tribal membership or a tribal document showing the individual has at least 50% American Indian blood. Proof of membership can be a tribal membership card, other tribal documents showing membership, or collateral contact with the tribe's government.	Eligible Regardless of U.S. entry date
Conditional Entrant	Proof of admission or entry date and one of the following documents: • INS Form I-94, Arrival/Departure Record, with stamp showing admission under section 203(a)(7) of the INA. • INS Form I-688B, Employment Authorization Card, annotated "274a.12(a)(3)." • INS Form I-766, Employment Authorization Document, annotated "A3."	Barred for five years if entered U.S. on or after 8/22/96. Eligible if entered U.S. before 8/22/96

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Alien Status	Acceptable Documentation of Alien Status	Medicaid Status
Cuban or Haitian Entrant	• INS Form I-551, Permanent Resident Card, annotated CU6, CU7 or CH6. • Unexpired temporary I-551 stamp in a foreign passport annotated AM1, AM2 or AM3. • INS Form I-94, Arrival/Departure Record, annotated CU6 or CU7, or with a stamp showing parole as "Cuban/Haitian Entrant" under section 212(d)(5) of the INA.	Eligible regardless of U.S. entry date
Deportation or removal withheld	• INS Form I-688B, Employment Authorization Card, annotated "274a.12(a)(10)." • INS Form I-766, Employment Authorization Document, annotated "A10." • Order of an immigration judge showing deportation withheld under section 243(h) or removal withheld under section 241(b)(3) of the INA and date of grant.	Eligible Regardless of U.S. entry date
Lawfully admitted for permanent residence	• INS Form I-551, Permanent Resident Card. • Unexpired "Temporary I-551" stamp in a foreign passport. • INS Form I-94, Arrival/Departure Record, with a temporary I-551 stamp.	With proof of 40 qualifying quarters, eligible regardless of U.S. entry date. Without 40 qualifying quarters: • Barred for five years if entered U.S. on or after 8/22/96. • Eligible if entered U.S. before 8/22/96.
Paroled into U.S. for at least one year	Proof of admission or entry date and INS Form I-94, Arrival/Departure Record, showing admission for at least one year under section 212(d)(5) of the INA. NOTE: The applicant cannot use admission periods for less than one year to meet the one-year requirement.	Barred for five years if entered U.S. on or after 8/22/96 Eligible if entered U.S. before 8/22/96
Refugee	• INS Form I-94, Arrival/Departure Record, showing entry under section 207 of the INA. • INS Form I-688B, Employment Authorization Card, annotated "274a.12(a)(3)." • INS Form I-766, Employment Authorization Document, annotated "A3." • INS Form I-571, Refugee Travel Document. NOTE: Refugees who have adjusted to lawful permanent resident status are still considered refugees for Medicaid eligibility. If a refugee has a Form I-551, Permanent Resident Card*, it will be annotated RE-6, RE-7, RE-8, RE-9 or R8-6.	Eligible regardless of U.S. entry date

Medical Services – Appendix C, Verification of Citizenship, Alien Status and SSN Enumeration

Alien Status	Acceptable Documentation of Alien Status	Medicaid Status
Veteran or active duty military personnel lawfully admitted for permanent residence (and families)	To verify alien status: • INS Form I-551, Permanent Resident Card. • Unexpired "Temporary I-551" stamp in a foreign passport. • INS Form I-94, Arrival/Departure Record, with a "Temporary I-551" stamp. To verify military status: • Honorably discharged veteran: Original or notarized copy of form DD214 (discharge papers). NOTE: This verification is sufficient when the veteran is a U.S. citizen, and the spouse or unmarried dependent children (or surviving spouse and unmarried dependent children of a deceased veteran) are aliens. • Active duty: Original or notarized copy of the current orders showing the person is on full-time duty in the U.S. Army, Navy, Air Force, Marine Corps, or Coast Guard, or a DD form 2 military ID card (active duty papers).	Eligible regardless of U.S. entry date
Other (legal or illegal)	Documents that indicate the person's alien status is one other than those specifically listed under **Aliens Subject to Five-Year Bar** (MS D-223) or under **Aliens Exempt from Five-Year Bar** (MS D-224).	Ineligible regardless of U.S. entry date

*In 1998, the INS changed the name of Form I-551 from "Alien Registration Receipt Card" to "Permanent Resident Card" because the new name more appropriately identifies the individual as having permanent resident status.
If the documentation provided does not contain all the information needed to establish the alien's eligibility, additional verification can be obtained from the INS by contacting them in writing, using form G-845, or by contacting SAVE by phone.

If the documentation provided appears questionable, contact INS in writing using form G-845 to attempt verification of the document, rather than using SAVE.

IV. Social Security Number (SSN) Enumeration

SSNs that have mismatched through the electronic verification process will be submitted to the queue with a message that the SSN could not be verified.

To resolve the mismatch, first check for obvious mismatches, (e.g., errors in keying the SSN, sex, name or date of birth). Next check SOLQ to determine if a correction can be made in the system from the SSA data on SOLQ.

Other methods of resolving a mismatch include:

- Viewing the social security card. The name in the system must match the name on the social security card; and
- Viewing a copy of the birth certificate or other proof of age or date of birth mismatch.

Household Cooperation in Clearing the Mismatch

When declared SSNs are returned by SSA as unverified, it is often necessary for the household to furnish the information necessary to resolve the mismatch.

A request for contact must be issued by the caseworker to advise the recipient of the mismatch, what caused the problem (e.g., name is incorrect) and what information must be provided to resolve the problem. The recipient will be given 10 days to furnish the information. If the household does not furnish the needed information by the end of the designated 10-day period an advance notice of adverse action will be issued.

The notice will specify that:

1. the recipient has 10 days to furnish the information needed to clear the SSN mismatch;
2. failure to provide the information will result in terminating eligibility for the individual whose SSN has not been verified or closure of the case if applicable; and
3. If there are problems in obtaining the needed material the recipient should contact the DCO county office at once.

If the recipient claims that the information needed to clear the mismatch report cannot be furnished, the caseworker must substantiate the inability to provide the needed information. For example, a household may claim it cannot verify a name change because official records were destroyed in a fire. The case worker would attempt to verify the occurrence of the fire because SSA records cannot be corrected without the missing documentation. If the caseworker verifies that the recipient cannot provide the information needed to verify the SSN, the individual may continue to participate if otherwise eligible.

All actions taken to clear SSN mismatches must be fully documented in the system.

Medical Services – Appendix C, Verification of Citizenship, Alien Status and SSN Enumeration

Monitoring

The DCO Supervisor, or designee in the absence of the supervisor, will be responsible for monitoring the mismatch notifications.

01/01/14

Generally, there is no limit on benefits to individuals under age 21 who are enrolled in the Child Health Services Program (EPSDT). There may be benefit limits to individuals over age 21. Consult “Arkansas Medicaid, ARKids First and You” (PUB-040) for specific information. Below is a description of some of the benefits available either through Medicaid or ARKids First.

Alternatives for Adults with Physical Disabilities –This service is for adults (aged 21 through 64) with physical disabilities (as determined by SSI/SSA or DHS Medical Review Team) living in the community who would need nursing home care if they did not have home and community-based services. Refer to MS B-314 for additional information about this program.

Ambulatory Surgical Center (ASC) Services – Ambulatory surgical centers provide surgeries that do not require an overnight hospital stay. Recipients of ARKids B have to pay a co-payment for these services.

Autism Services – One-on-one intensive early intervention treatment for Medicaid recipients ages eighteen (18) months through six (6) years with a diagnosis of autism. Refer to MS B-316 for additional information about this program.

Child Health Management Services (CHMS) – Medicaid or ARKids A will pay for many different services for a child under 21 that is found to have a health problem or is not developing normally. These services can include medical, psychological, speech and language pathology, occupational therapy, physical therapy, behavioral therapy and audiology.

Child Health Services (CHS) Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

CHS is a free comprehensive health care service for eligible recipients from birth to age 21. This program is administered through the Division of Medical Services (DMS).

Chiropractic Services - Chiropractic services are limited to manipulation of the spine.

Dental Services – Dental care is covered for children under age 21 with ARKids A and Medicaid. There is limited dental care for children with ARKids B.

DDS Alternative Community (ACS) Waiver Services – The service offers certain “home and community-based services” as an alternative to institutionalization for recipients who have a developmental disability and need special care no matter how old they are. Refer to (MS B-317).

Developmental Day Treatment Clinic Services (DDTCS) – Services provided to adults and children with developmental disabilities, such as autism or severe learning disabilities.

Domiciliary Care – Medicaid will pay to provide meals, lodging and transportation en route to and from a medical care facility for eligible recipients receiving daily medical treatment.

Durable Medical Equipment (DME) – Medicaid and ARKids will pay for some durable medical equipment. A prescription and a referral from the PCP are required.

ElderChoices Services – Services provided to individuals aged 65 or older who need special care to live at home or in the community instead of in a nursing home. Refer to (MS B-313) for additional information about this program.

Emergency Services – Medicaid will pay for services provided in a hospital emergency room only if the services meet the Medicaid emergency criteria.

Family Planning Services – Medicaid pays for these services for recipients who are of childbearing age.

Federally Qualified Health Center – Medicaid pays for a range of medically necessary procedures provided in a certified Federally Qualified Health Center.

Hearing Services – Medicaid covers hearing tests and hearing aids for children under age 21 who are enrolled in the Child Health Services (EPSDT) Program.

Home Health Care - Home health services are provided in the eligible person's home.

Hospice – Services for recipients who are terminally ill and not expected to live for a long period of time.

Hyperalimentation Services - Fluids, equipment and supplies necessary for the administration of fluids in the recipient's home for parenteral and enteral nutrition therapy are covered by Medicaid.

Injections – Allergy shots and immunizations for recipients under age 21 are covered through the Child Health Services (EPDST) Program, if medically necessary. Although some other injections are covered by Medicaid, coverage is limited for adults.

Inpatient Hospital Services – Medicaid pays for hospitalization when it is medically necessary.

Inpatient Psychiatric Program - Coverage of Inpatient Psychiatric Services for individuals under age 21.

Laboratory and X-Ray Services – Labs and x-rays are covered if requested by the doctor. There is a limit on the number of tests and x-rays for recipients age 21 or older.

Living Choices Assisted Living (ALF) – Medicaid pays for apartment-styled housing for recipients (age 65 or older or age 21 through 64 determined as meeting a disability by SSA or

DHS Medical Review Team) who are at risk of being placed in a nursing home or who already live in a nursing home and want more independence. Refer to MS B-312 for more information about this program.

Long Term Care (Nursing Facility) – Medicaid pays for nursing home care in a Medicaid-certified nursing home. Nursing home care must be recommended by a doctor. Refer to MS B-311 for more information about this program.

Nurse-Midwife Service – Medicaid will pay for a certified nurse-midwife trained to deliver babies in a hospital, birthing center or clinic, or in the patient's home, and to care for a woman while she is pregnant and just after she has the baby. ARKids B recipients have to pay a co-payment for each visit.

Nurse Practitioner Services – Nurse practitioners are nurses with special training that can do some of the things a doctor can do. Medicaid will pay for a certain number of visits with a nurse practitioner. A doctor's referral may be required. ARKids B recipients may have to pay a co-pay.

Organ Transplants - Medicaid will pay for services required for certain organ transplants. Prior authorization is required.

Outpatient Hospital Services – Most outpatient hospital care is covered, however there may be some charges the recipient may have to pay. There is a limit on the number of visits for adults aged 21 or older. ARKids B coverage requires a co-payment.

Personal Care Services - Personal care services will be paid if they are prescribed by a physician and provided according to a plan of care in the recipient's home.

Physician Services - Medicaid will pay for a limited number of physician services for recipients aged 21 or older each year.

Podiatrist Services – A podiatrist specializes in problems of the feet. Recipients age 21 or older have a limit number of visits Medicaid will pay for. ARKids B requires a copayment.

Prescription Drugs – Medicaid and ARKids cover most prescription drugs. Some prescriptions will require prior approval. ARKids B recipients may have to pay a copay.

Private Duty Nursing Services (PDN) - Nursing services may be covered for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of a hospital or skilled nursing facility.

Prosthetics - A range of prosthetic services is available to Medicaid recipients based on the age of the recipient.

Psychology Services – A broad range of psychology services for recipients under age 21 is provided through the Child Health Services (EPDST) Program.

Rehabilitative Services for Persons with Mental Illness (RSPMI) – Medicaid will pay for some rehabilitative services for mental illness.

Rehabilitative Services for Persons with Physical Disabilities (RSPD) – Medicaid pays for rehabilitation services for children under age 21 with physical disabilities, if services are recommended by a doctor or other licensed medical worker. The child must have had a severe brain injury or a spinal cord disorder or injury.

Rural Health Clinic Services – Medicaid will pay for a limited number of visits to a rural health clinic for individuals aged 21 or older.

Targeted Case Management – Targeted case managers help patients find and get the medical services needed as prescribed by a doctor. The patient may be able to get this service if younger than 21 and referred as a result of a well-child check-up; has ARKids A or regular Medicaid; has a developmental disability; is aged 60 or older; or is pregnant.

TEFRA Services – Medicaid pays for services in the home for certain children (aged 18 or younger) with disabilities if they would qualify for Medicaid as residents of an ICF/MR facility.

Therapy Services – Occupational, physical, and speech therapy services are provided to recipients under age 21 through the Child Health Services (EPDST) Program. Therapy services for individuals aged 21 and older are only covered when provided through the following Medicaid Programs: Developmental Day Treatment Clinic Services (DDTCS), Hospital/Critical Access Hospital (CAH)/End-Stage Renal Disease (ESRD), Home Health, Hospice and Physician/Independent Lab/CRNA/Radiation Therapy Center.

Transportation – Medical transportation may be covered for certain Medicaid recipients needing to travel to and from a medical facility that provides medical services covered by Medicaid. Refer to (MS Appendix B) for a description of Transportation Services.

Ventilator Equipment – Equipment in the recipient's place of residence (own dwelling, a relative's home or a nursing facility) may be covered only when determined to be medically necessary and prescribed by a physician. Ventilator equipment is not covered in a boarding home or a residential care facility.

Vision Care Services – Medicaid will pay for services that include a limited number of vision examinations, eyeglasses, replacements and repair of eyeglasses.

MS Manual 01/01/14

Example 1: <u>Grandmother claiming daughter and granddaughter as tax dependents</u>

Bertha is a working grandmother who claims her daughter Audrey, age 20 and a full-time student, and granddaughter Chloe (Audrey's daughter), age 2, as tax dependents. The household consists of these three only. All are applying for medical assistance.

Bertha's Household			
1.	Does Bertha expect to file a tax return?	Yes	Continue to Question 1a.
1a.	Does Bertha expect to be claimed as a tax dependent by anyone else?	No	
Bertha's household:			Bertha (applicant and taxpayer) Audrey (tax dependent) Chloe (tax dependent)

Audrey's Household			
1.	Does Audrey expect to file a tax return?	No	Continue to Question 2.
2.	Does Audrey expect to be claimed as a tax dependent?	Yes	Continue to Question 2a.
2a.	Does Audrey expect to be claimed as a tax dependent of someone other than a spouse or biological, adopted or step-parent? Is Audrey under age 19 living with both parents but the parents do not expect to file a joint tax return? Is Audrey under age 19 and expecting to be claimed by a non-custodial parent?	No No No	
Audrey's household:		Audrey (applicant) Bertha (taxpayer) Chloe (tax dependent)	

Chloe's Household			
1.	Does Chloe expect to file a tax return?	No	Continue to Question 2.
2.	Does Chloe expect to be claimed as a tax dependent?	Yes	Continue to Question 2a.

2a.	Does Chloe expect to be claimed as a tax dependent of someone other than a spouse or a biological, adopted or step-parent?	Yes	See MS 5135 Chloe is claimed by her grandmother Gloria. Since she falls into one of the exceptions under 2a, we look to the rules of non-filers to determine Chloe's household

Chloe is under age 19 and is claimed as a tax dependent by her grandmother, Bertha.	
Chloe's household includes the person or persons who live in the home with her:	
Spouse	No
Children (biological, adopted and step children) under age 19	None
Parents (biological, adopted and step-parents)	Yes
Siblings (biological, adopted and step siblings) under age 19	None
Chloe's household is : Chloe Audrey (Chloe's parent living in the home with her)	

Bertha's and Audrey's Household Composition (which determines whose income is counted)

Members	Income Type	Counted
Bertha	Full-time Earnings	Yes
Audrey	Part-time Earnings	No – Audrey is not required to file a tax return and is Bertha's child and tax dependent. Therefore, her income is not counted in either Bertha's or her own household.
Chloe	Child Support	No – Chloe is Bertha's tax dependent; child support income is not counted.

Chloe's Household

Members	Income Type	Counted
Audrey	Part-time Earnings	Yes – Although Audrey is not required to file a tax return and is claimed as a tax dependent, her income does count in this household because she is not the

		child nor tax dependent of any of the other members of this household, i.e., Chloe.
Chloe	Child Support	No – Chloe is Audrey's child; child support income is not counted.

Bertha works full time as the vice president of The High Rise Corporation. She reported that the annual income amount returned from the Federal Data Services Hub ($96,000) was reflective of her current salary and that she receives the same amount each month. Therefore, the annual income amount can be divided by 12 months to arrive at her current monthly income ($8,000).

Audrey just started working part time (10 hours per week) at the daycare center where Chloe attends. She earns $7.25 per hour. Her current monthly income is determined as follows: $7.25 x 10 = $72.50 $72.50 x 4.334 = $314.22 monthly income

Bertha and Audrey's household are the same which includes Bertha, Audrey & Chloe.

- Bertha earns $8,000.00 per month which equals $96,000 annually.
- Audrey earns $314.22 per month which equals $3,770.64 annually.
- Audrey is the child and tax dependent of Bertha. Audrey is not required to file taxes; therefore, her income doesn't count. Bertha's income is counted.
- Bertha's household size is 3.
- Compare the $8,000.00 monthly income to the 138% standard for 3, $2,245.95.
- Bertha and Audrey are not eligible for the Healthcare Independence Program; therefore, the agency will electronically transfer their account to the Exchange for possible eligibility for premium tax credits and cost sharing reductions.

Chloe's household includes Chloe and her mother, Audrey.

- Audrey earns $314.22 per month which equals $3,770.64 annually.
- Audrey's income will be counted because neither her mother, nor father is included in this household. Chloe's child support income is disregarded.
- Chloe's household size is 2.
- Compare the $314.22 monthly income to the ARKids A standard of 142% for 2, $1,835.35.
- Chloe is eligible for ARKids A.

Example 2: Single parent and child

Gloria is 47 years old. She is a single mother that has a 13 year old daughter, FeFe. Gloria claims FeFe as her tax dependent when filing her taxes. Gloria is applying for Medical assistance for herself and her daughter.

Gloria's Household			
1.	Does Gloria expect to file a tax return?	Yes	Continue to Question 1a
1a.	Does Gloria expect to be claimed as a tax dependent by anyone else?	No	
Gloria's household:		Gloria(taxpayer) FeFe (tax dependent)	

FeFe's Household			
1.	Does FeFe expect to file a tax return?	No	Continue to Question 2.
2.	Does FeFe expect to be claimed as a tax dependent by someone else?	Yes	Continue to Question 2a.
2.a.	Does FeFe expect to be claimed as a tax dependent by someone other than a spouse or a biological, adopted or step-parent?	No	
	Is FeFe under age 19 living with both parents but the parents do not expect to file a joint tax return?	No	
	Is FeFe under age 19 and expect to be claimed as a tax dependent by a non-custodial parent?	No	
FeFe's household: Since all the answers to Question 2a are "No", FeFe's household is the same as Gloria's household, that is the household of the taxpayer claiming her as a dependent.		Gloria (taxpayer) FeFe (tax dependent)	

Gloria works full time at Rising Boutique and earns $7.25 per hour. She is paid weekly. Gloria receives $500.00 per month in child support for FeFe. Her monthly earned income is $1,256.86. • $7.25 x 40 = $290.00. • $290.00 x 4.334 = $1,256.86. Child support income is disregarded.

Gloria and FeFe's households are the same: Gloria and FeFe.

- Gloria earns $1,256.86 per month which equals $15,082.32 annually.
- FeFe is the tax dependent of Gloria.
- FeFe’s child support income is not counted.
- Gloria’s household size is 2.
- Compare the $1,256.86 monthly income to the $220.00 (parent/caretaker relative) standard for 2.
- Compare the $1,256.86 monthly income to the $1,719.03 Healthcare Independence Program (HCI).
- Compare the $1,256.86 monthly income to the ARKids A standard of 142% for 2, $1,835.35.
- FeFe is eligible for ARKids A.
- Gloria is eligible for the HCI without applying the 5% disregard.

Example 3: Single adult who files taxes

Linda is 21 years old and lives at home with her parents. Linda files income taxes and her parents do not claim her as a tax dependent. Linda is applying for Medical assistance because she does not have health insurance.

<table>
<tr><td colspan="4">Linda’s Household</td></tr>
<tr><td>1.</td><td>Does Linda expect to file a tax return?</td><td>Yes</td><td>Continue to Question 1a.</td></tr>
<tr><td>1a.</td><td>Does Linda expect to be claimed as a tax dependent by someone else?</td><td>No</td><td></td></tr>
<tr><td colspan="2">Linda’s household:</td><td colspan="2">Linda (taxpayer)</td></tr>
<tr><td colspan="4">Linda works full time at the Hardware Store and earns $8.50 per hour. She is paid bi-weekly. Her monthly earned income is $1,473.56.
• $8.50 x 80 = $680.00
• $680.00 x 2.167 = $1,473.56</td></tr>
</table>

- Linda earns $1,473.56 per month which equals $17,682.72 annually.
- Linda is expected to file a tax return.
- Linda household size is 1.
- Compare the $1,473.56 monthly income to the $1,321.35 (with 5% disregard) HCI Program standard for 1.
- Linda is not eligible for the HCI Program; therefore, the agency will electronically transfer their account to the Exchange for possible eligibility for premium tax credits and cost sharing reductions.

Example 4: Single adult claimed as tax dependent

Willis is 27 years old, attending college and living with his parents, Gary and Rose. Willis is not filing a tax return because he hasn't worked in the last 5 years. The parents file joint tax returns and claim Willis as a tax dependent. The household consists of Gary, Rose and Willis. Willis is applying for medical assistance.

<table>
<tr><td colspan="4">Willis' Household</td></tr>
<tr><td>1.</td><td>Does Willis expect to file a tax return?</td><td>No</td><td>Continue to Question 2.</td></tr>
<tr><td>2.</td><td>Does Willis expect to be claimed as a tax dependent?</td><td>Yes</td><td>Continue to Question 2a.</td></tr>
<tr><td>2a.</td><td>Does Willis expect to be claimed as a tax dependent of someone other than a spouse or a biological, adopted or step-parent?

Is Willis under age 19 living with both parents but the parents do not expect to file a joint tax return?

Is Willis under age 19 and expecting to be claimed by a non-custodial parent?</td><td>No

No

No</td><td></td></tr>
<tr><td colspan="2">Willis' household:</td><td colspan="2">Willis (tax dependent)
Rose (taxpayer)
Gary (taxpayer and Rose's spouse)</td></tr>
<tr><td colspan="4">Rose works full time as a registered nurse and Gary works full time as a licensed practical nurse. Rose earns $35.00 per hour and Gary earns $20.00 per hour. Both are paid once a month. Their monthly earned income is $8,800.00.
• $35.00 x 160 (40 hours per week) = $5,600.00.
• $20.00 x 160 (40 hours per week) = $3,200.00.</td></tr>
</table>

- Willis earns no income.
- Willis parent's income will be counted because he lives with them and they carry him as a tax dependent.
- Willis household size is 3
- Compare the $8,800.00 monthly income to the $2,245.95 (with 5% disregard) HCI Program standard for 3 people.
- Willis is not eligible for the Healthcare Independence Program; therefore, the agency will electronically transfer his account to the Exchange for possible eligibility for premium tax credits and cost sharing reductions.

Example 5: Single adult with a child who is claimed as a tax dependent by the non-custodial parent

Crissy is 27 years old and has an 11 year old daughter, Hanna. Crissy is filing taxes this year but Hanna is being claimed as a tax dependent by her father who doesn't live in the home with Crissy and Hanna. Crissy is applying for medical assistance for herself and Hanna.

Crissy's Household			
1.	Does Crissy expect to file a tax return?	Yes	Continue to Question 1a
1a.	Does Crissy expect to be claimed as a tax dependent	No	
Crissy's household:			Herself (taxpayer) Because she doesn't have a spouse living with her and she doesn't expect to claim anyone else as a tax dependent, she is the only member of her household for Medicaid purposes.
Hanna's Household			
1.	Does Hanna expect to file a tax return?	No	Continue to Question 2
2.	Does Hanna expect to be claimed as a tax dependent?	Yes	Continue to Question 2a
2a.	Is Hanna expected to be claimed as a tax dependent of someone other than a spouse or a biological, adopted, or step-parent? Is Hanna under age 19 living with both parents but the parents do not expect to file a joint tax return? Is Hanna under age 19 and expects to be claimed by a non-custodial parent?	No No Yes	See MS 5135 Hanna is claimed by her non-custodial parent. Since she falls into one of the exceptions under 2a, we look to the rules of non-filers to determine Hanna's household.
3.	Hanna's household includes the person or persons who live in the home with her: Spouse Children (biological, adopted, and step) under age 19 Parents (biological, adopted, and step)	 No No Yes	Hanna (tax dependent of non-custodial parent) Crissy (Hanna's mother)

	Siblings (biological, adopted and step) under age 19	No	

Crissy works part time at the Grocery Store and earns $10.50 per hour. She is paid bi-weekly. Crissy's monthly earned income is $1,365.21. • $10.50 x 60 = $630.00 • $630.00 x 2.167 = $1,365.21

1. Crissy earns $1,365.21 per month which equals $16,382.52 annually.
2. Hanna's child support is disregarded.
3. Crissy's household size is 1.
4. Compare the $1,365.21 monthly income to the $220.00 parent/caretaker relative standard for 1 person.
5. Compare the $1,365.21 monthly income to the $1,321.35 (with the 5% disregard) HCI Program standard for 1 person.
6. Compare the $1,365.21 monthly income to the 142% ARKids A standard for 2 people, $1,835.35.
7. Crissy is not eligible for the HCI Program.
8. Hanna is eligible for ARKids A.

Example 6: Single adult who doesn't file tax

Brenda is 26 years old, unemployed and lives alone. Brenda has exhausted all her unemployment benefits because she has been unemployed for the last 3 years and for the last 12 months she has not received any unemployment benefits. Brenda is applying for medical assistance.

Brenda's Household		
1.	Does Brenda expect to file taxes?	No
2.	Does Brenda expect to be claimed as a tax dependent?	No
Brenda's Household:		Brenda Because she is neither a taxpayer, nor is she claimed as a tax dependent nor is she expected to file a federal income tax return for the current year, so her household is based on the non-filer rules and will include herself only because she doesn't have a spouse, nor any biological, adopted or step children nor her biological, adopted or step-parent living with her.
Brenda does not have income.		

Brenda's household consists of herself only.

- Brenda doesn't receive any income.
- Brenda is eligible for the HCI Program without applying the 5% disregard.

Example 7: Jonathan and Shelia have legal guardianship of their nephew, Mason. They are applying for Medical assistance for Mason.

Mason's Household			
1.	Does Mason expect to file taxes?	No	Continue to Question 2
2.	Does Mason expect to be claimed as a tax dependent?	Yes	Continue to Question 2a
2a.	Is Mason expected to be claimed as a tax dependent by someone other than a spouse or a biological, adopted or step- parent?	Yes	See MS 5135 Mason is claimed as a tax dependent by his uncle and aunt who have legal guardianship of him. Since he falls into one of the exceptions under 2a, we look to the rules of non-filers to determine Mason's household
Mason's household: Includes the following persons who live in the home with Mason: Spouse Children (biological, adopted and step children) under age 19 Parents (biological, adopted and step) Siblings (biological, adopted and step) under age 19		 None None None None	Mason (tax dependent)
Mason doesn't receive any income.			

Mason's household consists of himself only.

- Mason doesn't have any income.
- Mason is eligible for ARKids A.

Example 8: Martha is applying for Medicaid for her son Matthew. Martha is pregnant with twins. Martha works fulltime as an elementary school teacher. She has health insurance for herself.

1.	Does Matthew expect to file a tax return?	No	Continue to Question 2	
2.	Does Matthew expect to be claimed as a tax dependent?	Yes	Continue to Question 2a	
2.a.	Does the Matthew meet any of the following exceptions? Expects to be claimed as a tax dependent of someone other than a spouse or parent (biological, adoptive or step-parent)? Is a child under age 19 living with both parents but the parents do not expect to file a joint tax return? Is a child under age 19 who expects to be claimed by a non-custodial parent?	 No No No		
Matthew's household is: Martha (the tax payer) Matthew (the tax dependent) The twins Martha is expecting				
Martha earns $2,900.00 per month.				

Matthew household consists of himself.

- Matthew doesn't have any income. Martha's income is counted.
- Matthew is a tax dependent of Martha, his mother.
- Martha earns $2,900.00 per month which equals $34,800.00 annually.
- Compare the $2,900.00 monthly income to the 2,884.88 (with the 5% disregard) ARKids A standard for 4 people.
- Matthew is not eligible for ARKids A.
- Compare the $2,900.00 monthly income to the $4,140.88 (without the 5% disregard) ARKids B standard for 4 people.
- Matthew is eligible for ARKids B.

Monthly Levels (October 1, 2013 through March 31, 2014)

10/01/13

Families and Individuals Medicaid Categories

Family Size	Health Care Independence 133%	Health Care Independence with 5% Disregard 138%	ARKids A 142%	ARKids A with 5% Disregard 147%	ARKids B 211%	ARKids B with 5% Disregard 216%	Arkansas Health Care Access 150%	Full Pregnant Women & Parent Caretaker Relative	Transitional Medicaid 185%	Limited PW/Unborn Child 209%	Limited PW/Unborn Child with 5% Disregard 214%
1	1273.48	1321.35	1359.65	1407.53	2020.33	2068.20	1436.25	124.00	1771.38	2001.18	2049.05
2	1719.03	1783.65	1835.35	1899.98	2727.18	2791.80	1938.75	220.00	2391.13	2701.33	2765.95
3	2164.58	2245.95	2311.05	2392.43	3434.03	3515.40	2441.25	276.00	3010.88	3401.48	3482.85
4	2610.13	2708.25	2786.75	2884.88	4140.88	4239.00	2943.75	334.00	3630.63	4101.63	4199.75
5	3055.68	3170.55	3262.45	3377.33	4847.73	4962.60	3446.25	388.00	4250.38	4801.78	4916.65
6	3501.23	3632.85	3738.15	3869.78	5554.58	5686.20	3948.75	448.00	4870.13	5501.93	5633.55
7	3946.78	4095.15	4213.85	4362.23	6261.43	6409.80	4451.25	505.00	5489.88	6202.08	6350.45
8	4392.33	4557.45	4689.55	4854.68	6968.28	7133.40	4953.75	561.00	6109.63	6902.23	7067.35
9	4837.88	5019.75	5165.25	5347.13	7675.13	7857.00	5456.25	618.00	6729.38	7602.38	7784.25
10	5283.43	5482.05	5640.95	5839.58	8381.98	8580.60	5958.75	618.00	7349.13	8302.53	8501.15
Each addl member add:	445.55	462.30	475.70	492.45	706.85	723.60	502.50	9 and greater 618.00	619.75	700.15	716.90

AABD Medicaid Categories

	ARSeniors Equal to or Below 80%	QMB Equal To or Below 100%	SMB Between 100% & 120%	QI-1 At least 120% but Less Than 135%	QDWI Equal To or Below 200%
Individual	766.00	957.50	1149.00	1292.63	1915.00
Couple	1034.00	1292.50	1551.00	1744.88	2585.00

Extent of Services

Both ARKids A and ARKids B provide basic health insurance coverage. Infants and children found eligible for benefits under ARKids A are entitled to the full range of services that Medicaid provides, including Child Health Services (EPSDT). There are no copayments in ARKids A for individuals under the age of 18.

Participants in ARKids B are not eligible for the full range of Medicaid services. Co-payments and coinsurance will apply, as appropriate, for all services with the exception of immunizations, preventive health screenings, family planning, and prenatal care. There is no co-pay for dental checkups. Child Health Services (EPSDT) are not offered.

Based on the family's countable income and size, eligibility will be determined in the appropriate ARKids category. Below is a chart that shows a summary comparison of the two ARKids benefit packages:

Coverage Type	Description	ARKids A	ARKids B
Basic Coverage	Physician, prescription drugs, hospital, ambulance (emergency only), dental, medical equipment, medical supplies, emergency department services, eye glasses, family planning, health screens, home health services, laboratory and x-ray, mental health – outpatient only, podiatry, speech therapy and vision, chiropractor, immunizations, nurse midwife and nurse practitioner.	Yes	Yes
Additional Coverage	Audiology, child health management services, developmental day treatment clinic services, domiciliary care, end stage renal disease services, hearing aids, hospice, hyperalimentation, inpatient psychiatric, nursing facilities, orthotics, personal care, transportation (non-emergency), private duty nursing, prosthetics, therapy (occupational and physical), ventilator services, and targeted case management.	Yes	No
Screenings (through Child Health Services)	If the child receives periodic Child Health Services checkups, benefits are unlimited for covered services that are medically necessary.	Yes	No
Co-Payments	ARKids B requires co-pays as follows: \$5.00 per prescription drug, \$10.00 per medical visit, \$10.00 per emergency ambulance trip, 10% of the 1st day of inpatient hospitalization, 10% of Medicaid allowed amount for each item of durable medical equipment. A co-payment is not required for preventative health screens, family planning services and dental checkups. ARKids B families will have an annual cumulative cost-sharing (co-payments & coinsurance) maximum of 5% of the family's gross annual income. The annual period is the state fiscal year (SFY) of July 1 through June 30th. The annual cost-sharing maximum will be recalculated and the cumulative cost-sharing counter will be reset each July 1. **Note**: A co-pay of \$.50 to \$3.00 for prescription drugs and a small percentage of the first day cost in a hospital will be required for an 18 year old receiving ARKids A.	No	Yes

01/01/14

Treatment of resource transfers for less than fair market value made by an applicant/recipient, his/her eligible spouse, or their representative are governed by the date of transfer, the institutional or waiver status of the applicant/recipient, and whether the transfer was to the applicant/recipient's spouse. Prior to 9/1/81 there was no applicable transfer of resources policy for Medicaid applicants/recipients.

Look Back Date

The look back period is the time frame for which the caseworker determines whether an individual transferred resources for less than fair market value. The caseworker will look at all transfers made during the look back period.

9/1/81 through 6/30/88 (through 9/30/89 for Inter-Spousal Transfers)

The look back date for the period of 9/1/81 through 6/30/88 (through 9/30/89 for Inter-Spousal Transfers) was 24 months prior to the month of application/redetermination.

7/1/88 through 8/10/93

The look back date for the period of 7/1/88 through 8/10/93 was 30 months prior to the date of institutionalization or entry into the Waiver program for Medicaid recipients. If the individual was not a Medicaid recipient on the date of institutionalization or application for the Waiver program, the look back period will be the 30 months prior to the date of application.

8/11/93 through 2/8/06

The look back date for 8/11/93 through 2/8/06 was 36 months from the date on which an individual was both in an institution and had applied for medical assistance or, in the case of a Waiver individual, from the date on which the individual applied for Waiver assistance.

The 36 month look back date was effective with enactment of OBRA, 1993, for transfers occurring 8/11/93 and later. However, county workers could not begin asking "Have you transferred resources in the past 36 months?" until 36 months had passed since enactment of OBRA, 1993. Therefore, the following dates were utilized in investigating transfers by NF and Waiver applicants/recipients:

- 8/11/93 through 2/10/96 - Inquire about transfers in the last 30 months
- 2/11/96 through 8/10/96 - Inquire about transfers made 8/11/93 or later
- 8/11/96 and later - Inquire about transfers in the last 36 months.

If an institutionalized or Waiver individual was not eligible when he first applied for assistance and later reapplied, the county worker would ask about transfers in the appropriate look back period from the date of the second application, or the dates of subsequent applications if not eligible at the second application.

Imposition of Penalty Period

When Transfer Occurred 9/1/81 through 6/30/88 (through 9/30/89 for Inter-Spousal Transfers)

The value of uncompensated transfers occurring within 24 months prior to the month of application/redetermination will be divided by $1000 to determine the number of months of ineligibility for all Medicaid services. Any remainder will count as an additional month. For example, an uncompensated transfer of $41,500 divided by $1000 equals 41.5 months, or 42 months of ineligibility. The first month of ineligibility will be the month following the month of transfer.

When Transfer Occurred 7/1/88 through 8/10/93

The length of the period of ineligibility will be the lesser of:

a. 30 months, or
b. A number of months equal to the total uncompensated value of the transferred resources (the difference between the FMV of the resources at the time of transfer and the value of compensation received for the resources) divided by $1500.00. Any remainder from the division will be dropped.

EXAMPLE: A $15,500 uncompensated transfer would result in 10 months of ineligibility ($15,500 divided by $1500 equals 10, with $500 remaining. The $500 would be disregarded, and would not count for an additional month of ineligibility.

For uncompensated transfers made 7/1/88 or later, the period of ineligibility will begin in the same month that the transfer was made, NOT in the month following the month of transfer;
AND
When uncompensated transfers are made 7/1/88 or later and an individual applies for nursing facility or Waiver services, that individual will not be eligible for a vendor payment or Waiver services until the period of ineligibility has expired. An individual in a nursing facility WILL be eligible to receive a Medicaid card during the period of ineligibility, provided he/she is otherwise eligible. However, an individual who has applied for Waiver Services will NOT be eligible for a Medicaid card only, unless that individual is found eligible in some category other than a Waiver category.

When Transfer Occurred 8/11/93 through 9/30/93

If an individual had transferred resources during the period of 8/11/93 through 9/30/93, the period of ineligibility would have begun in August or September, 1993, but the agency was not allowed to withhold vendor payments until October 1, 1993, for transfers occurring during those two months.

Determination of Period of Ineligibility for Resource Transfers 8/11/93 through 2/8/06

The number of months of ineligibility for facility/Waiver services was determined by dividing the uncompensated value of all resources transferred by the individual or spouse on or after the look back date by the current divisor (see Appendix R).

If the client was not currently receiving LTC or Home and Community Based Waiver Medicaid, but reapplied and was under a previously imposed penalty, the penalty period was reassessed using the current divisor. If eligible, the case was approved with coverage not granted before April 1st or before the three-month retro period based on the most recent application, whichever was later.

There was no cap on the total number of months of ineligibility. Any fraction remaining after dividing the total uncompensated value by the divisor was dropped. The period of ineligibility began on the first day of the first month during which resources were transferred.

Multiple Transfers Made That Do Not Result in Overlapping Penalties 8/11/93 through 2/8/06

If an individual made multiple transfers that did not result in overlapping penalty periods, a separate penalty period was assigned to each transfer.

Multiple Transfers Made That Do Result in Overlapping Penalties 8/11/93 through 2/8/06

The sum total of all transfers made was divided by the current divisor to determine the period of ineligibility.

Medical Services – Appendix I, Application Form Chart

Eligibility Group	DCO-151 or 152	DCO-645	DCO-777	DCO-215	DCO-808	DCO-950	DCO-9700	DCO-81	DCO-237	DCO-662	DCO-702	DCO-704	DCO-710	DCO-712	DCO-713	DCO-727	Pub 405	Pub 407	Pub 408	DCO-106	DCO-107	DCO-108 or 108C	DMS-2602	DHS-4000	DHS-3330	DCO-2603
Families & Individuals																										
ARKids A	🟢																	🟢	🟢							
ARKids B	🟢																	🟢	🟢							
Newborns		🟢																🟢	🟢							
Parents & Caretakers	🟢																	🟢	🟢							
Pregnant Women	🟢																	🟢	🟢							
Pregnant Women Low Income	🟢																	🟢	🟢							
Unborn Child	🟢																	🟢	🟢							
Former Foster Care	🟢																	🟢	🟢							
Health Care Independence	🟢																	🟢	🟢							
Aid to Aged, Blind or Disabled																										
Long Term Services and Supports																										
Nursing Facility			🟢					🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢		🟢	🟢	🔴	🔴	🔴		🔴		
Assisted Living Facility			🟢					🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢		🟢	🟢	🔴	🔴	🔴		🔴	🟢	
ElderChoices			🟢					🟢	🟢	🟢	🟢	🟢		🟢	🟢	🟢		🟢	🟢						🟢	
AAPD Waiver			🟢					🟢	🟢	🟢	🟢	🟢		🟢	🟢	🟢		🟢	🟢	🔴	🔴	🔴		🔴	🟢	
DDS Waiver			🟢					🟢	🟢	🟢	🟢	🟢		🟢	🟢	🟢		🟢	🟢	🔴	🔴	🔴		🔴	🟢	
Medicare Savings Program																										
ARSeniors					🟢													🟢	🟢							
QMB					🟢													🟢	🟢							
SMB					🟢													🟢	🟢							
QI-1					🟢													🟢	🟢							
QDWI					🟢													🟢	🟢							
Waivers																										
TEFRA							🟢	🟢	🟢	🟢		🟢					🟢	🟢	🟢	🔴	🔴	🔴	🔴	🔴		🟢
Autism							🟢	🟢	🟢	🟢		🟢						🟢	🟢	🔴	🔴	🔴		🔴		
Workers with Disabilities						🟢		🟢	🟢	🟢								🟢	🟢	🔴	🔴	🔴		🔴		

A green dot signifies this form will be needed for an application.

A red dot signifies this form will be needed for an application if a disability determination from MRT is needed.

Medical Services – Appendix I, Application Form Chart

Appendix I - Application Table

Eligibility Group	DCO-MAGI	DCO-645	DCO-777	DCO-215	DCO-808	DCO-950	DCO-9700	DCO-81	DCO-237	DCO-662	DCO-702	DCO-704	DCO-710	DCO-712	DCO-713	DCO-727	Pub 405	Pub 407	Pub 408	DCO-106	DCO-107	DCO-108 or 108C	DMS-2602	DHS-4000	DHS-3330	DCO-2603
Miscellaneous																										
Spend Down U-18 & PW				🟢				🟢	🟢	🟢								🟢	🟢							
PACE			🟢					🟢	🟢	🟢	🟢	🟢		🟢				🟢	🟢	🔴	🔴	🔴		🔴		
Foster Care																		🟢	🟢							
SSI Medicaid	**Must be an SSI Recipient**																									
Pickle (COLA)			🟢						🟢	🟢								🟢	🟢							
Disabled Adult Child (DAC)			🟢						🟢	🟢								🟢	🟢							
Widows or Widowers (OBRA)			🟢						🟢	🟢								🟢	🟢							

A green dot signifies this form will be needed for an application.

A red dot signifies this form will be needed for an application if a disability determination from MRT is needed.

Medical Services - Appendix J, Eligibility Table

Eligibiltiy Group	General	Age	Disability	Income	Resources	Med Necessity	Relationship	OCSE Coop	Other
Policy Reference	**Section D**	**MS F-110**	**MS F-120**	**MS E-100**	**MS E-500**	**MS F-151**	**MS F-110**	**MS F-130**	**Section F**
Families & Individuals									
ARKids A	●	●		●			●		
ARKids B	●	●		●			●		No Ins Coverage
Newborns	●	●					●		Medicaid Mom
Parents & Caretakers	●			●			●	●	
Pregnant Woman	●			●					Must Be Pregnant
Pregnant Woman Low Income	●			●					Must Be Pregnant
Unborn Child				●					No Creditable Coverage
Health Care Independence	●	●		●					Not Medicare Eligible
Aid to Aged, Blind or Disabled	**To qualify for one of these categories, the individual must be aged or blind or have a disability.**								
Long Term Services and Supports									
Nursing Facility	●	●	●	●	●	●		●	Cost Effective
Assisted Living Facility	●	●	●	●	●	●		●	Cost Effective
ElderChoices	●	●		●	●	●			Cost Effective
AAPD Waiver	●	●	●	●	●	●			Cost Effective
DDS Waiver	●		●	●	●	●			Cost Effective
Medicare Savings Program	**Must be a Medicare beneficiary**								
ARSeniors	●	●		●	●				
QMB	●	●	●	●	●				
SMB	●	●	●	●	●				
QI-1	●	●	●	●	●				
QDWI	●	●	●	●	●				

A green dot signifies that there is an eligiblity criteria in that column that must be met for the indicated Medicaid category to be approved.
General heading includes: Citizenship, Residency, Social Security Enumeration and TPL Assignment.
(Relationship = Living with a Specified Relative) (Medicaid Mom = Mother eligible for Medicaid coverage at child's birth)

Medical Services - Appendix J, Eligibility Table

Eligibility Group	**General**	**Age**	**Disability**	**Income**	**Resources**	**Med Necessity**	**Relationship**	**OCSE Coop**	**Other**
Policy Reference	**Section D**	**MS F-110**	**MS F-120**	**MS E-100**	**MS E-500**	**MS F-151**	**MS F-110**	**MS F-130**	**Section F**
Waivers									
TEFRA	●	●	●	●	●	●			
Autism	●	●	●	●	●	●			
Workers with Disabilities	●	●	●						Must Be Working
Miscellaneous									
Spend Down U-18	●	●		●	●				
Spend Down Pregnant Woman	●			●	●				Must Be Pregnant
PACE	●	●				●		●	
Foster Care	●	●		●	●				
Former Foster Care	●	●							Fmr Foster Care Status
SSI Medicaid	**Must be an SSI Recipient**								
Pickle (COLA)	●			●	●				
Disabled Adult Child (DAC)	●	●	●	●	●				
Widows or Widowers (OBRA)	●	●	●	●	●				Not Medicare Eligible

A green dot signifies that there is an eligiblity criteria in that column that must be met for the indicated Medicaid category to be approved.

General heading includes: Citizenship, Residency, Social Security Enumeration and TPL Assignment.

(Relationship = Living with a Specified Relative) (Medicaid Mom = Mother eligible for Medicaid coverage at child's birth)

01/01/14

The PACE provider is Total Life Healthcare which is located in Jonesboro in Craighead county. The provider service area includes specific zip codes in Craighead, Cross, Greene, Lawrence, Mississippi, Poinsett and Randolph counties. Below is the list of the counties and the zip codes:

Craighead		**Cross**		**Greene**	
Jonesboro	72401	Cherry Valley	72324	Paragould	72450
Jonesboro	72404	Wynne	72396		
Bay	72411	Vanndale	72387		
Black Oak	72414	Parkin	72373		
Bono	72416				
Brookland	72417				
Cash	72421	**Lawrence**		**Mississippi**	
Caraway	72419	Hoxie	72433	Blytheville	72315
Egypt	72427	Sedgwick	72465	Gosnell	72319
Lake City	72437	Walnut Ridge	72476	Manila	72442
Monette	72447			Leachville	72438
State College	72467				
Poinsett		**Randolph**		**Sharp**	
Harrisburg	72432	Pocahontas	72455		
Lepanto	72354				
Marked Tree	72365				
Trumann	72472				

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Table 1: Male		Table 2: Female	
Age	Average Number of Years of Life Remaining	Age	Average Number of Years of Life Remaining
0	75.38	0	80.43
10	66.08	10	71.04
20	56.40	20	61.20
30	47.13	30	51.50
40	37.84	40	41.91
50	28.99	50	32.69
60	20.92	60	23.97
61	20.16	61	23.14
62	19.40	62	22.31
63	18.66	63	21.49
64	17.92	64	20.69
65	17.19	65	19.89
66	16.48	66	19.10
67	15.77	67	18.32
68	15.08	68	17.55
69	14.40	69	16.79
70	13.73	70	16.05
71	13.08	71	15.32
72	12.44	72	14.61
73	11.82	73	13.91
74	11.21	74	13.22
75	10.62	75	12.55
76	10.04	76	11.90
77	9.48	77	11.26
78	8.94	78	10.63
79	8.41	79	10.03
80	7.90	80	9.43
81	7.41	81	8.86
82	6.94	82	8.31
83	6.49	83	7.77
84	6.06	84	7.26

Table 1: Male		Table 2: Female	
Age	**Average Number of Years of Life Remaining**	**Age**	**Average Number of Years of Life Remaining**
85	5.65	85	6.77
86	5.26	86	6.31
87	4.89	87	5.87
88	4.55	88	5.45
89	4.22	89	5.06
90	3.92	90	4.69
100	2.07	100	2.39
110	1.15	110	1.22

Source: SSA, Office of the Actuary

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The Family Support Act of 1988 (Public Law 100-485), requires that certain AFDC families (Category 20) who lose eligibility April 1, 1990, or later, due to earned income must be given six (6) months of Initial Transitional Medicaid benefits without an application for such assistance. These families may also qualify for an Additional 6 Months Transitional Medicaid Extension.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 extended this requirement to certain Medicaid families following replacement of the AFDC program with the TANF program. In Arkansas, families who lose eligibility for TEA Medicaid due to earnings are eligible for this extension.

Extent of Services

Individuals approved for Transitional Medicaid will be eligible for the full range of Medicaid services, including services under the Children's Health Services Program.

Eligibility Requirements

In addition to the standard Medicaid eligibility requirements of citizenship, enumeration and child support enforcement, the following requirements must be met in determining eligibility for the Initial 6 Months TM Extension period:

1. The family must have become ineligible for TEA Medicaid due to increased wages or increased hours of employment (Re. MS Appendix M).
2. The family must have received TEA Medicaid in at least 3 of the 6 months immediate preceding the first month of TEA Medicaid ineligibility. Retroactive months count for this purpose (Re. MS Appendix M).
3. The family members must have been residents of Arkansas in the last month of TEA Medicaid eligibility, and must continue to reside in Arkansas.
4. There must be a dependent child under age 18 in the home (Re. MS Appendix M).

In addition to the eligibility criteria stated above, the following eligibility requirements must also be met in the Additional 6 months TM extension period:

1. The family must have received TM in each month of the Initial 6 Months TM extension period.
2. There must continue to be a dependent child under age 18 in the home.
3. The parent (or non-parent specified relative) must have met the reporting requirements in the 1st and 4th months of the Additional TM Extension period (Re. MS 2061.7 and MS 2062.1).
4. The parent (or non-parent specified relative) must continue to be employed and receive earnings in each month preceding the 2nd and 3rd report periods of the additional TM extension period, unless good cause exists.

The average monthly gross earnings of the eligible members (less paid child care costs) cannot exceed 185% of the Federal Poverty Level (Re. FPL Chart at Appendix F).

Resources, deprivation, and unearned income are not eligibility factors for TM.

A re-referral to OCSE is not required.

TEA Medicaid Case Closure - Due to Earnings

The Tea Medicaid case closure must be due solely to increased wages or increased hours of employment. If a TEA Medicaid family becomes ineligible due to earnings and for another reason in the same month, the family will be ineligible for Transitional Medicaid. For example, if the absent parent of all the TEA Medicaid children returns home and the caretaker parent becomes employed in the same month, the family will not be eligible for TM since earned income is not the sole reason for ineligibility. If, however, the TEA Medicaid family began receiving unearned income and earned income (of the caretaker parent) in the same month, a budget will be worked without the earned income. If the TEA Medicaid case remains eligible without the earned income and the inclusion of the earned income is the sole reason for TEA Medicaid closure, this requirement for TM has been met.

The increased earnings must be of the child's parent (or non-parent specified relative) who was included in the TEA Medicaid case as an eligible member in the last month of eligibility. The client's declaration of earnings will be accepted to determine continued Medicaid eligibility when the TEA cash assistance case closes due to employment. If at the first quarterly report the caseworker determines that the family should have remained in the TEA Medicaid, the case will be converted back to TEA Medicaid.

When it is determined that the family is ineligible for TEA Medicaid, and eligible for the Initial 6 Months Transitional Medicaid Extension, the caseworker will manually issue Form DCO-123 to notify the family of their TEA cash case closure; and to inform them of their eligibility for Transitional Medicaid and of the reporting requirement in the Initial 6 Months Transitional Medicaid Extension Period.

The TEA Medicaid case will be closed using "Convert to TM" and the appropriate reason will be entered in ANSWER. The earnings that resulted in TEA Medicaid ineligibility will be entered in ANSWER. The Transitional Medicaid case will be keyed to the WATM screen, using Form DCO-125, and the TEA Medicaid case number.

The Initial 6 Months TM Extension will begin with the first month following the last month of TEA Medicaid eligibility. The begin date will be entered in the Transitional Medicaid Begin Date on WATM. Individuals included in the budget group in the last month of TEA Medicaid eligibility will be entitled to the Initial 6 Months TM Medicaid Extension. Night Edit will convert the case to Category 25 for all open members if the income keyed, when calculated by the system, shows the case to be ineligible for TEA Medicaid.

Received TEA Medicaid in 3 of the last 6 Months

The family must have received TEA Medicaid in at least 3 of the 6 months immediately preceding the first month of TEA Medicaid ineligibility in order to qualify for TM. Eligibility for retroactive TEA Medicaid can count toward the 3 months. This requirement must always be met. For example, after receiving TM for 4 months or longer, if the parent (or non-parent specified relative) loses employment, receives TEA Medicaid for two months, than loses TEA Medicaid eligibility again due to employment, the family will not be eligible for TM, as they did not receive TEA Medicaid in 3 of the last 6 months immediately preceding the first month of TEA Medicaid ineligibility.

If a family received TEA in another state at any time during the 6 months immediately preceding the first month of TEA ineligibility, this period can be used to determine eligibility for TM.

The family will not be eligible for Transitional Medicaid if it is determined that the family was ineligible for TEA Medicaid at any time during the 6 months immediately preceding TEA Medicaid ineligibility due to fraud (under current policy, only a court can make a determination of fraud).

Residence

The family members must be residents of Arkansas at the time they became ineligible for TEA Medicaid, and must continue to reside in Arkansas throughout the Transitional Medicaid period. Residence is not affected by temporary absence from the state (e.g., on vacation). The TM case will be closed if the family moves out of Arkansas. Subsequently, if the family returns to Arkansas after the TM case has been closed, the TM case cannot be reopened. The family will have to make an application, and eligibility will be determined in another category.

Dependent Child

"Dependent Child" is defined, for TM purposes, as a child who is under age 18 who was living in the home in the last month of TEA Medicaid eligibility, and whose presence in the home helped establish TEA Medicaid eligibility. As a condition of TM eligibility, there must be a dependent child in the home in each month of TM. Eligibility for TM will terminate at the end of the first month in which the family ceases to include a dependent child. If the only dependent child leaves home and later returns after the TM case has been closed, the TM case may not be reopened, even if a portion of the 12 month TM period remains.

Reporting Requirements in the Initial 6 Months Transitional Medicaid Extension Period (First Six Months)

<u>First Report</u>

On the 6th workday from the end of the 3rd month of the Initial 6 Months Extension Period, the system will generate a notice and report form, DCO-124, to the family to be returned to the County Office by the 5th day of the 4th month. The parent (or non-parent specified relative) must report the household composition, the amount of gross earnings received, the amount of child care paid, and other circumstances which existed in the first 3 months of the Initial 6 Months TM Period. The DCO-124 will inform the family of its option for an additional 6 months period of TM which will be, in part, dependent upon the return of the DCO-124 report form in the 4th month of the Initial 6 Months TM Extension Period.

Upon receipt of a complete DCO-124, the County will key a "Y" in the "Report Received by County" field on WATM and will enter the date the report was received. This must be keyed to WATM no later than the 7th workday from the end of the 4th month. The earnings will be keyed into the income section in ANSWER, but continuing eligibility is not based on the amount of earnings received in the first 3 months of the Initial Extension Period. If there is any unearned income in the budget fields, it should be removed with zeros (00s). Zeros should also be entered in the deduction fields. The only entries needed in the budget fields are gross earned income and child care. The system will compute the net earned income.

If the DCO-124 has not been received in the County Office by the 5th day of the report month (or the following workday if the 5th falls on a non-workday) or, if an incomplete DCO-124 is received, the following procedures will be used:

1. Notice DCO-126 and Form DCO-124 will be manually issued to the parent (or non-parent specified relative) no later than the 1st workday following the 5th day of the report month. The DCO-126 will advise the parent (or non-parent specified relative) that the DCO-124 must be returned in 10 days, or eligibility will not be granted for the Additional 6 months TM Extension period.
2. If the client returns an incomplete DCO-124, the caseworker will mail the incomplete form back with the DCO-126 and advise the client in the space provided on the DCO-126 which questions must be completed or what verification is required. The client will also be advised that failure to return the completed DCO-124 in 10 days will result in ineligibility for the Additional 6 Months TM Period.

A "complete" DCO-124 is defined as one in which each "Yes or No" question is answered, the explanations related to a "Yes" response are completed, and required verification is attached. Part I, Household Information, will be considered complete if sufficient information is shown to determine household composition.

If the county has not keyed a "Y" to WATM by the 7th workday from the end of the month, the system will close the case with a Medicaid end date effective the last day of the 6th month and will send a closure notice to the family. If the client returns a complete report form after the 7th workday from the end of the 4th month and good cause for an untimely report is established, or the County failed to key a "Y" by the 7th workday from the end of the month, the County will reinstate the case in ANSWER and key "Y" in the Override Indicator" field on WATM and the date the report was received. The original Med Begin Date will be rekeyed and the Med End Date zeroed out. When the County reopens a case in this situation, it will not be necessary to register a new application.

NOTE: Good Cause for untimely reports (DCO-124): An untimely DCO-124 is one which is received after the 10 day notice period specified on the DCO-126. The client must establish good cause for an untimely report in order for the report requirement to be met. The determination as to whether good cause exists for returning an "untimely" report will be left to the judgment of the caseworker, with approval by the Supervisor or his/her designated representative. Some examples of situations which might result in good cause are hospitalization, client is out of town, client's new address had not been keyed by County which resulted in the client not receiving the report form, etc.

Determining Initial Eligibility When There Was an Untimely Report of Earnings

In the event the County Office is not informed by a TEA Medicaid recipient of increased earnings in a "timely" manner, eligibility for Transitional Medicaid will be determined from the month the family actually became ineligible for TEA Medicaid.

If the County Office is informed of a TEA Medicaid family's increase in earnings as late as the 5th day of the 4th month of TEA Medicaid ineligibility, eligibility will be determined for TM in each of the months succeeding the last month of TEA Medicaid eligibility. If the eligibility requirements in the Initial 4 Months TM Extension period (MS Appendix M) are not met, no additional benefits will be authorized. If the eligibility requirements in the Initial 4 Months Extension period (MS Appendix M) are met, continuing TM benefits will be authorized. The County will manually issue Form DCO-124 to the family, if it is later than the 3rd month of TEA Medicaid ineligibility. This report must be returned to the County by the last day of the 4th month of the Initial TM Extension Period in order for the family to qualify for the Additional 6 Months TM Extension period.

If the earned income is reported or discovered after the 5th day of the 4th month of TEA Medicaid ineligibility, eligibility for the Initial TM period will be determined (for purposes of an overpayment only) but the family will not be entitled to receive any Additional TM benefits.

Determining Initial Eligibility When There Was an Untimely Report of Earnings

In the event the County Office is not informed by a TEA Medicaid recipient of increased earnings in a "timely" manner, eligibility for Transitional Medicaid will be determined from the month the family actually became ineligible for TEA Medicaid.

If the county Office is informed of a TEA Medicaid family's increase in earnings as late as the 5th day of the 4th month of TEA Medicaid ineligibility, eligibility will be determined for TM in each of the months succeeding the last month of TEA Medicaid eligibility. If the eligibility requirements in the Initial 4 Months TM Extension period (MS Appendix M) are not met, no additional benefits will be authorized. If the eligibility requirements in the Initial 4 Months Extension period (MS Appendix M) are met, continuing TM benefits will be authorized. The County will manually issue Form DCO-124 to the family, if it is later than the 3rd month of TEA Medicaid ineligibility. This report must be returned to the County by the last day of the 4th month of Initial TM Extension Period in order for the family to qualify for the Additional 6 Months TM Extension period.

If the earned income is report or discovered after the 5th day of the 4th month of TEA Medicaid ineligibility, eligibility for the Initial TM period will be determined (for purposes of an overpayment only) but the family will not be entitled to receive any Additional TM benefits.

Six Months TM Extension Period (Second Six Months)

In addition to continuing to meet each eligibility factor listed in MS Appendix M, the eligibility criteria specified in MS Appendix M must also be met for the Additional 6 Months of TM.

The family must have received TM in each of the 6 months of the Initial Transitional Medicaid Extension Period. If the TM case is closed at any point during the Initial 6 months Transitional Medicaid Extension period (e.g., no eligible child in the home or moved out of Arkansas

Reporting Requirements in the Additional 6 months Extension Period (Second Six Months)

Second Report

On the 6th workday from the end of the 6th month of the Initial 6 Months Extension Period, the system will generate a notice and report form, DCO-124; to those families who met the eligibility factors in the Initial 6 months Extension Period. This report should be returned to the County Office by the 5th day of the 1st month of the Additional 6 Months TM Extension Period (the 7th month). The parent (or non-parent specified relative) must again report the household composition, the amount of gross earnings received, the amount of child care paid, and other circumstances which existed in the last 3 months of the Initial TM Extension Period.

Upon receipt of a complete DCO-124, the caseworker will determine the client's continued eligibility for TM and, if eligible, the County will document the case.

If a complete report form, DCO-124 is not returned by the 5th day of the 1st month of the Additional 6 Months Extension Period (the 7th month), or the following workday if the 5th falls on a non-workday or, an incomplete DCO-124 is received, the following procedures will be used:

1. Notice DCO-126 and Form DCO-124 will be manually issued to the parent (or non-parent specified relative) no later than the 1st working day following the 5th day of the month. The DCO-126 will advise the client that the DCO-124 must be returned in 10 days or the case will be closed.
2. If the client returned an incomplete DCO-124, the caseworker will mail the incomplete form back with the DCO-126 and advise the client, in the space provided on the DCO-126, which questions must be completed and what verification is required. The client will be advised that failure to return the DCO-124 in 10 days will result in case closure.

If a complete DCO-124 is not received by the 7th workday from the end of the 1st month of the Additional 6 Months Extension Period (the 7th month), the caseworker will close the case on WATM and in ANSWER with a Medicaid End Date effective the last day of that month. If the client returns the report form after the 7th workday from the end of the month, the case has been closed, and good cause is established, the caseworker will reopen in ANSWER, and WATM ("Convert to TM" and use the appropriate Action Reason, no new application necessary). The original Med. Begin Date will be entered, and the End Date will be zeroed out.

Third Report

On the 6th workday from the end of the 3rd month of the Additional 6 Months Extension Period (9th month), if the case remains open, the system will generate a notice and report form, DCO-124, to the family to be returned by the 5th day of the 4th month of the Additional Extension Period (10th month).

Upon receipt of a complete DCO-124, the caseworker will determine the client's continued eligibility for TM and, if eligible, the County will document the case.

If a complete report form, DCO-124 is not returned by the 5th day of the 4th month of the Additional 6 Months Extension Period (the 10th month) (or the following workday if the 5th falls on a non-workday) or an incomplete DCO-124 is received, the following procedures will be used:

1. Notice DCO-126 and Form DCO-124 will be manually issued to the parent (or non-parent specified relative) no later than the 1st working day following the 5th day of the month. The DCO-126 will advise the client that the DCO-124 must be returned in 10 days or the case will be closed.
2. If the client returns an incomplete DCO-124, the caseworker will mail the incomplete form back with the DCO-126 and advise the client, in the space provided on the DCO-126, which questions must be completed and what verification is required. The client will be advised that failure to return the DCO-124 in 10 days will result in the case closure.

If a complete DCO-124 is not received by the 7th workday from the end of the 4th month of the Additional 6 Months Extension Period (the 10th month), the County will close the case on WATM and in ANSWER, with a Medicaid End Date effective the last day of that month. If the client returns the report form after the 7th workday from the end of the month, the case has been closed, and good cause is established, the County will reinstate the case ("Convert to TM" and use the appropriate action reason, no new application necessary). The original Med. Begin Date will be reentered, and the Med. End Date will be zeroed out.

NOTE: There are no automatic system closures in the Additional 6 Months Extension Period, except at the end of the 12th month.

Employment Requirement

In order for extended benefits to continue in the second 6-month period, the parent (or non-parent specified relative) must continue to be employed and receive earnings in each month preceding the 2nd and 3rd reports unless good cause exists.

Examples of good cause for loss of employment are illness, involuntary layoff, etc.

The 185% Earned Income Test and Computation of Average Monthly Gross Earnings

The family's average monthly gross earnings (less paid child care costs necessary for the parent, or non-parent specified relative, to maintain employment) cannot exceed 185% of the Federal Poverty Level (Re. FPL Chart at Appendix F).

To compute average monthly gross earnings:

1. Total for each month the earning received by all eligible family members in each of the 3 reporting months. Unearned income will be disregarded;
2. Subtract, from each month's total, the amount of child care paid in that month that was necessary for the parent (or non-parent specified relative) to maintain employment (use the actual child care paid);
3. Add the net results from each of these months; and
4. Divide the result by 3.

This figure is the family's average monthly gross earnings.

EXAMPLE: A family of 4 has earnings and paid child care for the reporting period as follows:

•	• Earnings	•	• Child Care Paid	•	• Net Income
Month #1	$1,200.00	–	$180.00	=	$1,020.00
Month #2	$ 925.00	–	$150.00	=	$ 775.00
Month #3	$1,450.00	–	$200.00	=	$1,250.00

$1,020.00 + $775.00 + $1,250.00 = $3,045.00 divided by 3 = $1,015 average gross monthly earnings. Compare the average gross monthly earnings to 185% of the Federal Poverty Level (Re. FPL Chart at Appendix F).

NOTE: The FPL is adjusted annually due to changes in the Consumer Price Index. For continuing eligibility, the average monthly gross income, as computed above, will be compared to the FPL in effect during the report month, if different from the preceding months.

If the family's average gross monthly earnings (less paid child care) do not exceed 185% of Federal Poverty Level, the family will remain eligible. The case will be documented

If the family's average gross monthly earnings (less paid child care) exceed 185% of the FPL, the County will send a notice of closure to the family, and will key a closure to the Transitional Medicaid case in ANSWER with a Medicaid End Date effective the last day of the report month. Earnings that resulted in

Transitional Medicaid closure will be entered in the budget section. Night Edit will convert all open members in category 25 to closed status.

Changes in the Transitional Medicaid Period

Minor children entering the household, who were not in the budget group at the time the group became TEA Medicaid ineligible, will not be eligible for Transitional Medicaid and will not be added to the case. If an excluded child has earnings, they will not be considered in computing the family's average gross monthly earnings. The caseworker will determine eligibility for this child in another category, counting only the child and the child's parent(s) in the unit, and considering only their income.

Minor children, who were in the home and included in the TEA Medicaid case during the last month of TEA Medicaid eligibility, who later leave the home, will be dropped (a 10 day notice will be given). If he/she subsequently reenters the home while the family is receiving TM, he/she will be added to the Transitional Medicaid case. Any earnings that this child may have will be considered in computing the family's average gross monthly earnings.

The return of an absent parent to the home during Transitional Medicaid is not, in itself, a reason for closure (i.e., deprivation is not an eligibility factor for Transitional Medicaid). The absent parent, who returns, if he/she was not in the budget group at the time of the TEA Medicaid case closure, will not be eligible for Transitional Medicaid and will not be added to the case. Any earnings of the returning parent, however, will be used in computing the family's average gross monthly earnings.

If the only child in the home becomes eligible for SSI, the parent(s) (or non-parent specified relative) will remain eligible for Transitional Medicaid as long as the SSI child is under age 18. However, the County will receive a Systems Action Report notifying them that the case has been closed. The caseworker will reopen the Transitional Medicaid case for the adults(s) by using "Converting to TM" and the appropriate action reason. The Transitional Medicaid Status on WATM will be changed to open status. The adult(s) must continue to meet all other eligibility requirements in order to remain eligible for Transitional Medicaid.

System Closures, System Reports, and County Responsibilities

On the first workday of each month the system will search all Transitional Medicaid records for children who will reach the age of 18 that month. If the only child in the home is reaching age 18, the system will close the case and send a notice of case closure to the family. If there are other children under 18 in the home, the system will close only the 18-year-old and leave the remaining individuals open.

The Counties will receive a Systems Action Report that will inform them of Transitional Medicaid 18 year olds and cases closed by the system.

When the system has closed an 18 year old, or at any time a member or a case is found ineligible for Transitional Medicaid, the County Office will make a determination and document the case record as to whether or not the ineligible member(s) meets the eligibility criteria in any other Medicaid Category (e.g., PW, MN-SD, etc.). If it appears that a member or the case would be eligible in another category, an application and notice of potential benefits will be sent to the individual(s).

During the Additional 6 Months TM Extension Period (Second Six Months), a monthly report titled "Transitional Medicaid Cases" will be generated to the Counties to assist them in tracking the Transitional Medicaid cases. This report will list the Case Number, Case head Name, Worker Number, Transitional Medicaid Begin Date, Current Month of Transitional Medicaid and the next month in which a Transitional Medicaid Report (DCO-124) is due.

At the end of the 12th month, the system will send a notice and close all Transitional Medicaid cases which remained open throughout both 6-month periods.

Summary of Sequence of Notices/Reports in Transitional Medicaid

Found TEA Medicaid ineligible prospectively. Determined Transitional Medicaid eligible:

- Form DCO-123 manually issued to family.

<u>Initial 6 months Extension Period</u>

<u>1st Month</u>

- 1st month of TEA Medicaid ineligibility.

<u>2nd Month</u>

<u>3rd Month</u>

- Notice/Report Form DCO-124 system generated to case head on the 6th workday from the end of the month.

<u>4th Month</u>

- Case head must return DCO-124 with income and child care verification by the 5th day of the month. County completes DCO-125 and keys "Y" to WATM by the 7th workday from the end of the month. If the "Y" is not keyed, the system will generate a notice and close the case with a Medicaid End Date effective the last day of the 6th month.

<u>5th Month</u>

<u>6th Month</u>

- Notice/Report Form DCO-124 system generated to the case head on the 6th workday from the end of the month.

<u>Additional 6 months Extension Period</u>

<u>7th Month</u>

- Case head must return DCO-124 with income and child care verification by the 5th day of the month. If family eligible, County documents case. If family ineligible, County must key closure to ANSWER and WATM with a Medicaid End Date equal to the last day of the 7th month.

<u>8th Month</u>

<u>9th Month</u>

- Notice/Report Form DCO-124 system generated to the case head on the 6th workday from the end of the month.

<u>10th Month</u>

- Case head must return DCO-124 with income and child care verification by the 5th day of the month. If family eligible, County documents case. If family ineligible, County must key closure in ANSWER and WATM with a Medicaid End Date equal to the last day of the 10th month.

<u>11th Month</u>

<u>12th Month</u>

- System closes.

Extended Medicaid Eligibility When TEA Medicaid Case Closed Due to Child Support Income

Three months of extended Medicaid will be authorized when a TEA Medicaid case is closed due to child support income provided the case was open for at least three of the six months immediately preceding the first month of ineligibility. The three months will begin with the month following the first month in which the case became ineligible due to child support income. The TEA Medicaid ineligibility may have been caused in whole or in part by the child support income. Only those persons who were included in the budget in the last month of TEA Medicaid eligibility will be entitled to the three months of extended Medicaid.

Medically Needy (MN) Resource Limitations for U-18 and Pregnant Woman (PW)

Resource eligibility for U-18 and PW is determined by computing countable resources as specified below in Part II and comparing them with the Medically Needy resource limitations. There is not applicable transfer of resource provision which applies to the U-18 and Pregnant Woman MN.

The following countable resource limitations are in effect for the Medically Needy Program U-18 and Pregnant Woman.

Resource Limits

Household Size	1/1/86-12/31/86	1/1/87-12/31/87	1/1/88-12/31/88	From 1/1/89
1	$1,700	$1,800	$1,900	$2,000
2	$2,550	$2,700	$2,850	$3,000
3	$2,650	$2,800	$2,950	$3,100
4	$2,750	$2,900	$3,050	$3,200
5	$2,850	$3,000	$3,150	$3,300
6	$2,950	$3,100	$3,250	$3,400
7	$3,050	$3,200	$3,350	$3,500
8	$3,150	$3,300	$3,450	$3,600
9	$3,250	$3,400	$3,550	$3,700
10	$3,350	$3,500	$3,650	$3,800

NOTE: For household sizes above 10, add $100 for each additional member.

1. Determination of Household Size for Medically Needy Resource Consideration
   Household size for MN Resource determination is made according to categorical consideration.
   a. SSI cash assistance recipients and their resources are excluded from MN cases. They cannot be considered in a second eligibility determination.
   b. Determination of household size for MN cases is made as follows. The resources of non-SSI individuals may be considered in more than one MNRL.
      1) U-18. The eligible children and the natural/adoptive parent(s) in the home will be included in the MNRL unit. However, a parent may choose to exclude a child and that child's resources if inclusion of that child and that child's resources would cause

ineligibility. A parent's needs will always be included when determining eligibility for his/her children.

PW. The pregnant woman is the only eligible, the father of the unborn child, if in the home, and the unborn child will be included in the budget unit. If there are other children in the home who meet the relationship requirement, they may be included in the budget, if necessary, to raise the need standard to a level that will allow eligibility for the PW. If inclusion of a child and the child's resources will result in ineligibility for the PW, that child and the child's resources may be excluded. However, the unborn child will always be counted in the need standard for the PW.

2) The resources available only to a stepparent will be disregarded in the MNRL of his/her stepchild and his/her spouse (the stepchild's natural/adoptive parent) if that spouse requests assistance as caretaker relative of her deprived child. The stepparent will not be counted in their MNRL.

3) The resources available only to a grandparent, or any relative other than a parent, who is not included in the assistance unit, will be disregarded.

   If the grandparent, or other relative other than a parent, chooses to be included in the assistance unit, his/her resources will be included in full in determining resource eligibility for all those included in the MNRL.

   When the grandparent or other relative chooses to be included and when the grandparent/other relative has a spouse in the home, the resources available only to that spouse will be disregarded in determining resource eligibility.

4) In dependent child/minor parent/grandparent households, the rules in (3) above will apply, i.e., if the grandparent is to be included as an eligible, the grandparent's resources will be counted; and if the grandparent is not to be included, the grandparent's resources will be excluded.

NOTE: In MN cases, the resources of a parent(s) will always be counted in full in his/her child's MNRL and that parent(s) will be included in the MNRL, even though the parent(s) may be over age 18 and will not be a Medicaid eligible member(s) of the unit. However, in dependent child/minor parent/grandparent households, even though the grandparent's resources must be counted toward the minor parent, they will be disregarded in the resource eligibility determination of the grandchild.

2. Medically Needy Resource Determinations
   Countable resources for Medically Needy are determined as follows according to categorical consideration.

   a. Countable resources are determined and verified in accordance to Part II below. However, there is no applicable transfer of resource provision which applies to Medically Needy cases.

   b. All resources are to be verified on the first day for each month of eligibility.

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Medically Needy Income Limitations

The following countable income limitations are in effect for the Medically Needy Program U-18 and Pregnant Women. Refer to MS E 300-340.

Income Limits

Size of Family Unit	Monthly Income	Quarterly Income	Annual Income
1	$108.33	$ 325.00	$ 1300
2	$ 216.66	$ 650.00	$ 2600
3	$ 275.00	$ 825.00	$ 3300
4	$ 333.33	$1000.00	$ 4000
5	$ 383.33	$1150.00	$ 4600
6	$ 441.66	$1325.00	$ 5300
7	$ 500.00	$1500.00	$ 6000
8	$ 558.33	$1675.00	$ 6700
9	$ 616.66	$1850.00	$ 7400
10	$ 675.00	$2025.00	$ 8100

Add $58.33 per month to the monthly income level or $175.00 per quarter to the quarterly income level for each additional member above family size 10.

Income is the third consideration for Medically Needy applications. Categorical relatedness and resource eligibility should be reasonably established before income eligibility is considered.

Determination of Household Size Used for MN Income Consideration

Determination of Household Size Used for MN Income Consideration:

1. Household size for MN income determination is made as follows according to categorical consideration.
   a. SSI cash assistance recipients and their income are excluded. They cannot be considered in a second eligibility determination.
   b. Determination of household size for MN is made as follows. The income of non-SSI individuals may be considered in more than one MNIL.
      1) The eligible child(ren) and the natural/adoptive parent(s) in the home will be included in the MNIL unit. A parent may choose to exclude a child and that child's income from a case budget if inclusion of that child and the child's income would cause ineligibility for

the other children. Children may also be excluded for other reasons, and the parent who applies need not state the reason.

2) Step-parents may be included in the MNIL with their stepchildren as long as the step-parent's income does not cause ineligibility for the step-children.

3) If the step-parent is not included in the MNIL, the step-parent's income will be disregarded in the MNIL of his/her step-child. If the step-parent's spouse who is the natural/adoptive parent of the step-child requests assistance, the step-parent's income will be deemed to the spouse

EXAMPLE: A husband and wife have living in their home a child by his former marriage. Both the man and his child request assistance.
MNIL #1: To determine the child's eligibility use the 2 person MNIL to include the father and child and their income only. Disregard the wife's income.
MNIL #2: To determine the man's eligibility, use again the 2 person MNIL (father and child) with their income included. The income of the wife would be deemed to the unit.

4) A step-child can be in the same MNIL with children of his/her step-parent.

5) In step-parent households when a natural/adoptive parent of the stepchild requests assistance and when the natural/adoptive parent and the step-parent have a child of their own, they all can be budgeted in the same case as long as the step-parent's income does not cause Medicaid ineligibility for the step-child(ren).

EXAMPLE: A husband and wife have a child, and the wife has a child by a former marriage. Assistance is requested for both children and the wife.
MNIL #1: Eligibility for their child in common will be determined in a 3 person MNIL, with all the income of the husband, wife, and their child considered. Only the child can be found eligible in U-18-MN, assuming that both parents are over age 18.
MNIL #2: Eligibility for the stepchild will be determined in a 2 person MNIL that includes only the stepchild and the natural/adoptive parent. Their income will be considered in full. The stepparent's and half-sibling's income will be disregarded.
MNIL #3: Eligibility for the natural parent of the stepchild will be determined in an MNIL that includes only the natural parent and the stepchild, with their income considered along with the deemed income of the step- parent. Disregard the half-sibling's income.

If there is a step-child who resides in an UP-MN household, the step-child would be set up in the case with his/her natural parent, step-parent and step-siblings. The UP-MN case will include the step-child, the step-child's natural parent, that parent's spouse, and their child(ren) in common. If the stepparent's income cause ineligibility for the step-child, the step-child can then be set up in a separate Medicaid case, other than UP-MN, with his/her natural parent included in the budget in closed status. The UP-MN case would be set up to include the step-child's natural parent, that parent's spouse, and their child(ren) in common but not the stepchild. There is no deeming of income in UP-MN determinations.

6) In minor parent households, deeming of the income of a grandparent not included in the assistance unit to a grandchild in the unit is prohibited. However, the grandparent's income will be deemed to the minor parent. Therefore, in minor parent situations where the grandmother is not included, there will be 2 MNIL's, and 2 Medicaid cases.

EXAMPLE: A grandmother applies for U-18 MN for her minor daughter and the daughter's infant.
MNIL #1: For infant eligibility, the MNIL unit of 2 will include the minor parent and the infant, with only their income considered. Disregard the grandparent's income.
MNIL #2: For the minor parent's eligibility, include the minor parent and infant in a 2 person MNIL, with their income, plus the deemed income of the grandparent.

When the grandparent chooses to be included in the unit, the grandparent and the grandparent's full income will be included in the MNIL with the minor parent and infant and their income - one MNIL for 3 persons and one case.

If there are 2 grandparents in the home and one grandparent chooses to be included in the medical assistance unit, income of the excluded grandparent will be deemed to the MNIL that determines eligibility of the included grandparent/minor parent but will not be deemed to the MNIL that determines eligibility of the grandchild. In this situation, there will be 2 MNIL's and 2 Medicaid cases.

MNIL #1: For infant eligibility, the MNIL unit will include the grandparent, minor parent, and infant. Totally disregard the excluded grandparent's income, but include all other income.

MNIL #2: For grandparent and minor parent eligibility include the same 3 members as above, and their income. Also include the deemed income of the excluded grandparent.

The above rules will also apply to other relatives who care for a dependent child/ren, e.g., an aunt and uncle.

NOTE: In MN cases, a parent's income is always counted in full in his/her own child's case, i.e., there is no deeming of income from a parent to a minor parent in MN eligibility determinations. However the parent's income will be disregarded in the eligibility determination of the minor parent's child.
For certification instructions when there are multiple cases in one household, refer to .

Treatment of Third Party Resources

Refer to MS E-330 for incurred medical expenses which are not coverable under the Medically Needy Program

A third party resource is insurance or some other form of entitlement which helps defray the cost of medical services. Third party resources recognized by the Medicaid program include Medicare, private health insurance, public and private liability insurance, workman's compensation, veteran's insurance, CHAMPUS, etc. Third party resources make specific payment for medical services and/or are assignable to a medical provider. Insurance which makes nonspecific payments (i.e., pay whether or not medical services are rendered) and is nonassignable to a medical provider (i.e., pays to the individual only) is not considered a third party resource. Payments from this type of insurance are considered as unearned income. However, insurance which makes nonspecific payments and is assignable will be considered a third party resource.

Payments which are received from third party resources within a reasonable period of time will be applied to the cost of incurred medical expenses to determine the liability of the individual. Any portion of incurred medical expenses paid by third party resources is not the liability of the individual and cannot be deducted from excess income. Any portion of incurred medical expenses not paid by third party resources is the liability of the individual and can be deducted from excess income.

Statements which are received from third party resources within a reasonable period of time can be used to determine the liability of the individual if they indicate either the amount of payment to be made or that no payment is to be made. When statements indicate the amount of payment to be made, the indicated amount of payment will be applied to the cost of incurred medical expenses to determine the liability of the individual (i.e., it will be treated as if it were an actual payment). When statements indicate that no payment is to be made, the total amount of incurred medical expenses is the liability of the individual and can be deducted from excess income.

When a third party resource has not made payment, does not indicate the amount of payment to be made, or indicates that no payment is to be made within a reasonable period of time, the actual liability of the individual cannot be determined and the incurred medical expenses cannot be deducted from excess income.

NOTE: For administrative ease, the time limit imposed for the disposition of the applicable Medically Needy application (45 or 90 days) will be considered to be "a reasonable period of time" to obtain verification of medical expenses paid by a third party.

The most common third party resources are Medicare and private health insurance. To facilitate an accurate determination of an individual's liability, these resources should be treated as follows:

Medicare Coverage Types

Medicare consists of two types of coverage:

1. Part A - Hospital Insurance - coverage is provided for inpatient hospital care, post hospital extended care and post hospital home health care and skilled nursing care. Part A pays Medicare per diem rate, less any unmet deductible(s) and/or coinsurance.

Under Part A - Medicare pays direct to the hospital/supplier. The hospital/supplier agrees to accept the Medicare per diem rate. The actual liability of the individual is limited to the following, where applicable:

- Inpatient Deductible, and/or
- Blood Deductible, and/or
- Coinsurance.

NOTE: Medicare provides an unlimited number of hospital days after the annual Part A deductible.

2. Part B, Medical Insurance - coverage is provided for physician services, supplies, home health care, outpatient hospital services, therapy and other services. Part B pays 80 per cent of the Medicare amount approved, less any unmet deductible.

   Nonassignment - Under the nonassignment method, Medicare pays 80 per cent of their amount approved, less any unmet deductible, direct to the individual. The actual liability of the individual, (i.e., the difference between the amount billed by the physician/supplier and the amount paid by Medicare), is limited to the following, where applicable:

   - Difference between amount billed and amount approved, plus
   - Deductible, and/or
   - 20 per cent coinsurance.

   Assignment - Under the assignment method, Medicare pays 80 percent of their amount approved, less any unmet deductible, direct to the physician/supplier. The physician/supplier agrees to accept the amount approved by Medicare, (i.e., he discounts the difference between the amount billed and the amount approved by Medicare). The actual liability of the individual is limited to the following, where applicable:

   - Deductible, and/or
   - 20 per cent coinsurance.

NOTE: Some services are not covered under Part B. Where Medicare disallows a charge in its entirety (e.g. $10.00 billed, $0.00 allowed), the individual is liable for the full charge regardless of assignment.

Private Health Insurance

Private Health Insurance, like Medicare, consists of two types of coverage, Hospital and Medical.

For hospital care, private insurance makes reimbursement by means of per diem payments, percent of charge payments or a combination of the two.

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Under the per diem method, the insurance will apply a fixed amount for each day of hospitalization, regardless of the total charges for the hospitalization.

EXAMPLE: A child is hospitalized for 4 days; daily charges are $1200, $1100, $900 and $650 for days 1-4, respectively. The child's parents have insurance which pays a $600 per diem less any unmet deductible. The insurance payment and client's liability are determined, as follows:

Days	Charges	-	Per Diem Payment	=	Liability
7/1	$1200	-	$600	=	$600
7/2	$1100	-	$600	=	$500
7/3	$900	-	$600	=	$300
7/4	$650	-	$600	=	$50
Total 4	$3850		$2400		$1450 (Plus any unmet deductible)

Under the percent of charge method, the insurance will specify a fixed percent to be applied to the total charges for the hospitalization.

EXAMPLE: Mr. Doe is hospitalized for 4 days, daily charges are $1200, $1100, $900 and $650 for days 1-4, respectively. Mr. Doe has insurance which pays 80 percent of total charges, less any unmet deductible. The insurance payment and Mr. Doe's liability are determined as follows:

Days	Charges	-	Per Diem Payment	=	Liability
7/1	$1200	-	$960	=	$240
7/2	$1100	-	$880	=	$220
7/3	$900	-	$720	=	$180
7/4	$650	-	$520	=	$130
Total 4	$3850		$3080		$770 (Plus any unmet deductible)

The following is an example of a combination of the per diem and percent of charge methods:

EXAMPLE: Mr. Doe is hospitalized for 4 days; daily charges, less room charge, are $1325, $1000, $900 and $700 for days 1-4, respectively; the room charge is $250 a day. Mr. Doe has insurance which pays 80 per cent of total charge, less room charge, less any unmet deductible. The insurance also pays a $200 per diem on room charge. The insurance payment and Mr. Doe's liability are determined as follows:

	Unit Charges		-	Unit Payments		=	Unit Liability	
Days	**Room**	**Other**	**-**	**Room**	**Other**	**=**	**Room**	**Other**
7/1	$250	$1325	-	$200	$1060	=	$50	$265
7/2	$250	$1000	-	$200	$800	=	$50	$200
7/3	$250	$900	-	$200	$720	=	$50	$180
7/4	$250	$700	-	$200	$560	=	$50	$140
Unit Total 4	$1000	$3925		$800	$3140		$200	$785 (Plus any unmet Deductible)
Grand Total 4		$4925			$3940			$985 (Plus any unmet Deductible)

Some private insurance (e.g., Medipak, which only covers the deductible and coinsurance charges that Medicare does not pay) provides limited coverage only.

Although private insurance offers an infinite variety of coverage plans, most companies make payment using one of the methods described or a similar method.

Nonmedical charges (e.g., charge for telephone, television, etc. while hospitalized) cannot be deducted from excess income even though the charges are a liability of the individual.

Nonspecific Assignable Payments

When a third party resource makes or indicates that it will make a nonspecific assignable payment (method of calculating payment is not known), the payment will be applied in the following manner.

Divide the nonspecific payment by total charges to determine the percent of payment. For cases in which the charges are not itemized (i.e. only a total summary of charges is available), it will be necessary to divide the charges by the dates of service to determine an average daily charge. Apply the percent of payment to each daily charge to determine the amount of charge covered by the payment. The balance of each daily charge (if any) is the liability of the individual.

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Part II

Resources for U-18 and Pregnant Woman Medically Needy Spend Down Categories

The resource guidelines in this section provide general guidelines used in determining resource eligibility for U-18 and PW categories.

Definition of a Resource

A resource is any real or personal property available to an individual to meet his needs. Only those resources currently available, or for which the individual has the legal ability to make available, will be considered. Accumulations in trust funds, retirement and profit-sharing plans, or other arrangements which preclude the use of the property for meeting current needs will not be considered until such time as the property is actually available to the individual.

All or any portion of a payment which is considered as income in the month of receipt cannot be considered as a resource in the same month.

The equity value of all resources available to the assistance unit, except those specifically disregarded, must be determined. Equity value is the fair market value of the property less any liens or encumbrances.

The total equity value of all countable resources available to the assistance unit, except for that amount specifically disregarded from the equity of certain resources cannot exceed the resource limit for the category of Medicaid for which the client applied.

Resources to be Disregarded

The following resources are not considered in determining MN eligibility:

1. The homestead (Refer to MS 11315);
2. Household furniture, appliances, and personal effects;
3. Farm or other equipment used to produce income;
4. The stock and inventory of a self-employment enterprise;
5. Livestock used for subsistence;
6. Loan obtained under Title III – EOA;

a. Grants or loans to an undergraduate student for educational purposes made or incurred under any program administered by the Commissioner of Education.

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b. Educational assistance provided for attendance costs under programs in the Carl D. Perkins Vocational and Applied Technology Education Act.

7. That portion of a grant, scholarship, payment under the Veterans' Educational Assistance Program (GI Bill), or unearned income paid to or for an individual conditioned upon school attendance which is used for items necessary for school attendance, such as tuition, books, fees, equipment, special clothing needs, transportation, and child care services.

8. Bona fide loans from any source (e.g., bank, any other establishment engaged in the business of making loans, or an individual). Refer to MS 11405. (Interest received on loans and retained in the months following the month the interest was received is considered a resource.)

9. Relocation allowances and adjustment payments made by Federal agencies under any federally financed relocation assistance program.

10. That portion of payments received as a settlement (insurance, law suit, etc.) which is intended and used for a specific purpose, such as medical bills, attorney's fees, etc. or as compensation for the loss of a resource (example – to repair or replace their vehicle).

11. Funds distributed to members of the Red Lake Bank of Chippewa Indian pursuant to Public Law 98-123, enacted October 13, 1983, and funds distributed to members of the Assiniboine Tribe of the Fort Belknap Indian Community and the Assiniboine Tribe of the Fort Belknap Indian Community and the Assiniboine Tribe of the Fort Peck Indian Reservation pursuant to Public Law 98-124, enacted October 13, 1983.

12. One burial plot per assistance unit member.

13. The total amount of federal tax refunds or advance payments for a period of 12 months after receipt. Earned Income Credit (EIC) payments are totally disregarded as income or resources.

14. Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation retroactive to January 1, 1989.

15. Payments made under the Radiation Exposure Act (Public Law 101-426) retroactive to October 15, 1990. These payments may be made to individuals in which injury or death resulted from the exposure to radiation from nuclear testing and uranium mining.

16. Payments made under the Civil Liberties Act of 1988 (Title I of Public Law 100-383) and under the Aleution and Pribilof Islands Restitution Act (Title II of Public Law 100-383) to Aleuts. These Acts provide for the federal government to make restitution payments to the individuals or if deceased, the individual's spouse, children or parents, who were interned during World War II.

17. Payments made under the Maine Indian Claims Settlement Act of 1980. These payments are made to members of the Passamaquoddy Indian Tribe, the Penobscot Nation and the Houlton Band of Maliseet Indians for the settlement of land claims.

18. Payments made under the Aroostook Bank of Micmacs Settlement Act. These payments are made to members of the Arrostook Bank of Micmacs for the settlement of land claims.

19. Major disaster and emergency payments made to individuals and families under the Disaster Relief Act of 1974 and comparable disaster assistance provided by States, local governments, and disaster assistance organizations.

20. Payments made from any fund established as a result of a class settlement in the case of Susan Walker vs. Bayer Corporation are in accordance with Section 4735 of the Balanced Budget Act of 1997 (Public Law 105-33) . This case involved hemophiliacs who contracted the HIV virus from contaminated blood products. Also excluded from countable resources are payments made pursuant to a release of all claims in a case that is entered into in lieu of the Walker vs. Bayer class settlement and that is signed by all affected parties on or before the later of December 31, 1997, or 270 days after the date on which the release is first sent to the persons to whom the payment is to be made.

NOTE: Interest earned by these lump sum funds and allowed to accrue is not excluded from countable resources.

The Homestead

The value of real property used by the assistance unit as a homestead is totally disregarded in determining Medicaid eligibility.

A homestead is a house and tract of land which a person considers his or her home. A mobile home or trailer used as a home will be considered as a homestead, regardless of whether the person also owns the property on which the mobile home is situated.

Only one such tract will be considered a homestead. However, there is no limit to the acreage or number of lots so long as the property is contiguous. Any other dwelling units or apartments on the property will be considered a part of the homestead.

The family must be presently residing on the property or intend to move on to it within a period of six months from the date of application or date of purchase, whichever is later.

If the family ceases to live on the property, it will continue to be regarded as a homestead for a period of six months from the date they left the home or the date of application, whichever was later, provided they intended to return to it. The recipient will be advised that the homestead becomes excess property after six months.

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If the homestead is sold, the net proceeds received from the sale will be disregarded for a period of six months provided the casehead intends to apply such proceeds towards the purchase of another homestead. When the conditions of the sale of the homestead are such that the proceeds will be received through installment payments, then such proceeds will be disregarded as they are received provided they are applied to the payment of another homestead.

Only that portion of the proceeds, whether received in full or through installment payments, which are actually applied towards the purchase of the new homestead may be disregarded. Any remaining amount will be considered according to MS 11335, Items 2 or 3, as appropriate.

The casehead will be advised that if another homestead is not purchased within the six month period, then at the end of the six months the proceeds will be considered a resource if received in full, or as unearned income if received in installment payment. If a client who is receiving installment payments later purchases another homestead and applies the installment payment to the new home, then that portion applied may be disregarded.

Motor Vehicles

Each assistance unit will be allowed a disregard of $1500 of the equity in one motor vehicle. Equity is the vehicle’s wholesale market value less any liens or encumbrances. The full equity value of any other vehicle owned by the persons whose resources must be considered plus any equity in the first vehicle in excess of the $1500 disregard is considered a resource.

Value determinations for vehicles will be made using one of the following web sites: CarPrices.com, Autopricing.com, Intellichoice.com, Edmunds.com, and Kelley Blue Book (kbb.com). No other web sites will be considered acceptable. A copy of the web page showing the vehicle value must be scanned into the electronic case record.

If more than one vehicle is owned, then the equity in each vehicle will be determined. Since the $1500 disregard can be applied to only one vehicle, it will be applied to the vehicle with the greatest equity value. No amount can be disregarded from the equity value of the remaining vehicles even if the value of the first vehicle was less than the $1500 disregard.

Value determination for other types of personal transportation such as boats, buses, motorcycles, etc., should be obtained by the caseworker through contact with a knowledgeable source such as a local dealer, automobile insurance company or the county personal property tax office. Complete information should be given to the contact regarding the particular make, model, and year of the motor vehicle. The case narrative should be documented as to the source of the valuation and the valuation given. If the casehead disagrees with the value determination, he or she may obtain at least two written appraisals of the value from knowledgeable sources. If the appraisals appear to be questionable, the caseworker should verify their accuracy with the knowledgeable sources. If the caseworker determines the appraisals are accurate, the equity in the vehicle(s) will be redetermined.

Jointly Owned Vehicles

When a vehicle is jointly owned by a Medicaid client and another person whose needs are not included in the same assistance unit, only the Medicaid client's prorata share of the vehicle's equity value will be considered. The $1500 disregard will be applied to the Medicaid client's share of the equity value (if not already applied to another vehicle).

This applies equally to situations in which the co-owner is, or is not, an SSI recipient. In either case, the Medicaid client's prorata share of the equity value will be considered in determining his/her Medicaid eligibility.

☐ NOTE If a Medicaid client is the sole owner of a vehicle which was purchased with an SSI child's funds, then the full equity value is considered as belonging to the Medicaid client.

Determining Net Equity

To determine the amount of equity to be considered, the following procedure will be followed:

1. Determine the amount of net equity in each vehicle owned by:

a. Making a value determination for the vehicle as described above.

b. Subtracting from the determination the amounts of any liens or encumbrances.

2. If the vehicle is jointly owned, determine the Medicaid client's prorata share of the net equity.

3. Subtract up to $1,500 from the client's net equity of the vehicle with the highest equity value. Any amount remaining of the $1500 disregard may not be applied to other vehicles.

4. Add the client's full net equity of any other vehicles to the amount remaining after the $1500 disregard. The total will be considered as a resource.

Funeral Arrangements

Each assistance unit member will be allowed a disregard of $1500 of the current equity value in funeral agreements. Any equity value in excess of $1500 is considered a resource.

The term "funeral agreements" includes burial insurance, pre-paid funeral arrangement contracts, and life insurance policies issued by funeral homes. The term "current equity value" is defined as the value of the agreement which can legally be converted to cash by the client.

If a funeral agreement has no current equity value, then it is not considered as an available resource. For example, a burial insurance policy with no cash surrender value or an irrevocable pre-paid funeral contract have no current equity value to the client.

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Resources Considered in Full

Except for property specifically disregarded in MS 11310 or considered according to MS 11320 - 11322, the equity value of any other real or personal property available to the assistance unit will be considered in full.

When an applicant/recipient has joint ownership of a resource, their ownership interest and the availability of the resource to the assistance unit must be determined. If the resource is available to the unit, the net equity must then be determined.

Resources of an alien's sponsor and the sponsor's spouse must be considered as fully available to the alien and his or her family.

Requesting A Legal Opinion on Resource Ownership or Availability

There are situations in which the client's ownership interest or ability to access the resource are not clearly evident. In such situations, it may be necessary to request a legal opinion from the DHS Office of Policy and Legal Services (OPLS). All such requests for a legal opinion will be submitted through the DCO Office of Program Planning and Development (OPPD) according to the following procedures.

1. The caseworker will scan the documents for the legal opinion request in the proper order into the eDoctus library, "County Request for Medicaid Decision." The proper order to scan documents into eDoctus can be found on the OPPD/OPLS legal document review check list.
2. This will trigger an email message to the Program Eligibility Analysts (PEA) for the area that the county office is located in.
3. The PEAs of the specified area will check the "County Request for Medicaid Decision" library on eDoctus to determine if the request originated in one of the counties he/she is responsible for.
4. The appropriate PEA will review the eDoctus documentation based on the guidelines provided by OPPD/OPLS legal document check list to ensure that the documentation is complete, in the proper order and ready for submission to OPPD.
5. Once the review is complete and any discrepancies have been corrected, the PEA will select the option of submitting the request to OPPD.
6. OPPD will review and submit the request to OPLS if needed. OPPD will provide an opinion on the requests that do not require an opinion from OPLS.
7. All opinions will be forwarded in an email message to the PEA and the county worker who requested the opinion.

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8. The county worker will index the document in the client's electronic record. The Medicaid Eligibility Unit will scan the opinion into the client's electronic record on eDoctus.

Sale of a Resource

The sale of a resource, including disregarded resources, is considered a conversion of one type of resource (property) to another type (cash) except when the terms and conditions of the sale preclude the seller's ability to obtain full payment on demand. When an individual sells either real or personal property, the caseworker will determine the amount the individual received for the property and any terms or conditions of the sale.

The net proceeds from the sale (sale price less any outstanding liens or encumbrances and costs related to the sale) will be considered as follows:

1. If the homestead was sold, refer to The Homestead section above.

2. If the individual received full payment for the property, apply the amount received to the resource limit.

3. If the individual entered into a legal agreement or contract with the buyer by which payment is made through installment payments, then the caseworker will determine whether the individual can require full payment on demand.

If the entire balance is payable on demand, then the individual's equity in such balance will be applied to the resource limit. If such amount, combined with other countable resources, does not exceed the resource limit and the case remains eligible, then only the interest portion of the installment payment will be considered as unearned income. The individual's equity in the balance will continue to be applied to the resource limit.

If the entire balance is not payable on demand, then the entire installment payment, less any amount for which the seller is obligated to pay on the sold property, will be considered as unearned income.

Excess Real Property

The equity value of any real property not used as a homestead (excess property) will be considered a resource in determining Medicaid eligibility.

Determining Ownership

Ownership will be verified by deeds, wills, contract of purchase or other documentary evidence. When two or more persons own an interest in the property, the client's ownership interest and the availability of the property as a resource to the assistance unit must be determined (Refer to MS 3331.2 - 3331.3).

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Questions of title, ownership, and property interest which cannot be resolved by the County Office will be submitted by e-mail or memorandum to the Office of Program Planning and Development, Slot S333 following procedures at (MS 11330).

Determining Market Value and Net Equity

The market value of real property is determined by obtaining an estimate of current market value from a knowledgeable source. Knowledgeable sources include:

1. Real estate brokers.

2. Local office of the USDA, Rural Development (for rural land).

3. Local office of the USDA, Farm Services Agency (for rural land).

4. Banks, savings and loan associations, mortgage companies, and similar lending institutions.

5. County Cooperative Extension Service (for rural land).

The estimate must be written, signed and dated, and have enough information so the source can be identified.

The client will be primarily responsible for obtaining the estimate. However, if requested, the caseworker will assist the client or attempt to obtain a free estimate. If an estimate cannot be obtained from any other knowledgeable source, then the assessed value from the tax assessor of the county in which the property is located, multiplied by the county multiplier, 5, will be used. If this method is used, the narrative will be updated in the electronic record to document that no other knowledgeable source estimate could be obtained.

Only the net equity in the property will be considered. Net equity is determined by subtracting the value of any liens, mortgages, or other encumbrances from the market value. If the market value of the property exceeds the maximum limitation, the amount of any encumbrances will be verified.

Personal Property

Personal property is property other than real property and consists primarily of liquid assets. Ownership of personal property can be in the same form as real property. Refer to MS E-512 concerning forms of ownership. The following sections describe more commonly held types of personal property.

Cash and Money on Deposit

Cash on hand includes amounts that the individual has on his person and amounts that he has at home. This amount, less any received during the month and counted as income, is a countable resource.

Money on deposit in a bank, savings and loan, credit union, or other financial institution must be considered a countable resource. Money on deposit includes checking accounts, savings accounts, certificates of deposit, retirement accounts, etc.

Jointly Held Bank Accounts With Non-SSI Recipients

When a Medicaid client has a bank account with a non-SSI person, ownership of the jointly held bank account must be determined prior to determining whether it is a resource to the client. This applies to all situations in which at least one of the persons named on the account, including the client's spouse, is a non-Medicaid person whose resources would not be considered in determining eligibility. (If one of the persons named on the account is an SSI recipient, see the Section below.) A person is considered as the owner of funds in a bank account if that person earned, received, or was given the funds in the account.

As this relates to married couples, for Medicaid purposes, it is normally presumed that both husband and wife are joint owners of funds in a jointly held bank account. However, when there is written documentation, clearly establishing that joint ownership is not intended, then ownership by just one will be determined to exist.

Ownership will be verified by written statements from the persons whose names are on the account, if at all possible, or if not, through collateral contacts. If it is determined that the Medicaid client does not actually own the funds in the account, then none will be considered a resource to the client. If joint ownership does actually exist, then the amount considered to be owned by each of the joint owners will be a prorata amount rather than the full amount.

Jointly Held Bank Accounts With SSI Recipients

Any funds in a jointly held bank account which are being considered in determining an SSI recipient's eligibility cannot be considered in determining eligibility for the Medically Needy categories. This applies to all situations in which a MN client's name is on a bank account with an SSI recipient, including situations in which the SSI recipient is the MN client's child or spouse.

SSI policy presumes that all funds in a bank account which is jointly owned by an SSI recipient and another person belong to the SSI recipient. The SSI recipient may rebut this presumption if some or all of the funds belong to the other person. However, unless the SSI recipient successfully rebuts the presumption, then SSI will consider all of the funds in the account for SSI purposes. In that case, none of the funds can be considered for MN purposes even if the MN client's name is on the bank account.

When a MN client's name is on any type of bank account with an SSI recipient, it will be presumed that all of the funds in the account are being considered for SSI purposes. It will not be necessary to verify with SSI whether the bank account funds are being considered for SSI purposes unless the MN client advises that SSI is not considering all of the funds, or the amount in the account would appear to cause SSI ineligibility if considered. In either of those situations, the Medicaid caseworker will verify with SSI whether the funds are being considered in determining the SSI recipient's eligibility. Any funds not being considered for SSI purposes will be subject to MN consideration as described in the above section. That is, if the MN client is the only other owner, then the funds not considered for SSI will be considered for MN. If, though, there are other owners besides the MN client and SSI recipient, then ownership and prorata shares will be determined.

Except in the above two situations, it will not be necessary to verify with SSI whether the bank account funds are being considered for SSI purposes. It will be presumed that they are being considered for SSI and therefore, will not be considered for MN eligibility purposes.

Life Insurance Policies

The total cash surrender value (CSV) of all life insurance policies, except those issued by a funeral home and considered as a funeral agreement, will be considered when determining the resources available to the assistance unit. The cash surrender value of any life insurance policy which is accessible to any of the persons whose resources must be considered will be included regardless of whether the insured person is a member of the assistance unit.

Federal tax refunds or advance payments are excluded as income and disregarded as a resource for 12 months following the date of receipt. Earned Income Credit (EIC) payments are totally disregarded as income or resources.

Joint Refunds (Client and Spouse)

The client's portion of a joint tax return will be excluded as income and disregarded as a resource for 12 months following the date of receipt.

U.S. Savings Bonds

A U.S. Savings Bond is an obligation of the Federal government which is nontransferable. These bonds are normally owned by the owner(s) shown on the front of the bond. If bond ownership is shared, each person's share as a resource is equal, even though any of the owner's listed on the bond may dispose of it. Value determination should be secured by contact with a bank.

Stocks and Bonds

Shares of stock represent ownership in a corporation. Stock value is determined by the closing price at the time of application or redetermination. Verification of stock value may be made by consulting the financial section of a newspaper or on line listings. If these bids are not listed in the newspaper, contact will be made with a local securities firm for verification.

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Other Types of Personal Property

Any other available property, including livestock not used for subsistence and farming or other self-employment tools and equipment which are no longer used to produce income, will be counted as a resource.

Medical Services – Appendix O, Renewal Forms Chart

Eligibility Group	MAGI Renewal	DCO-215	DCO-777	DCO-811	DCO-950	DCO-7779	DCO-7781	DCO-81	DCO-237	DCO-662	DCO-702	DCO-704	DCO-710	DCO-712	DCO-713	DCO-727	Pub 405	Pub 407	Pub 408	DCO-106	DCO-107	DCO-108 or 108C	DMS-2602	DCO-2603	DHS-3330	DCO- 4000
Families & Individuals																										
ARKids A	🟢									🟢								🟢	🟢							
ARKids B	🟢									🟢								🟢	🟢							
Newborns	🟢									🟢								🟢	🟢							
Parents & Caretakers	🟢									🟢								🟢	🟢							
Former Foster Care	🟢									🟢								🟢	🟢							
Health Care Independence	🟢																	🟢	🟢							
Aid to Aged, Blind or Disabled																										
Long Term Services and Supports																										
Nursing Facility							🟢			🟢	🟢	🟢	🟢	🟢	🟢			🟢	🟢	🔴	🔴	🔴		🔴		🔴
Assisted Living Facility							🟢			🟢	🟢	🟢	🟢	🟢	🟢			🟢	🟢	🔴	🔴	🔴		🔴	🟢	🔴
ElderChoices							🟢			🟢		🟢						🟢	🟢						🟢	
AAPD Waiver							🟢			🟢		🟢						🟢	🟢	🔴	🔴	🔴		🔴	🟢	🔴
DDS Waiver							🟢			🟢		🟢						🟢	🟢	🔴	🔴	🔴		🔴	🟢	🔴
Medicare Savings Program																										
ARSeniors				🟢						🟢								🟢	🟢							
QMB				🟢						🟢								🟢	🟢							
SMB				🟢						🟢								🟢	🟢							
QI-1				🟢						🟢								🟢	🟢							
QDWI				🟢						🟢								🟢	🟢							
Waivers																										
TEFRA						🟢			🟢	🟢		🟢					🟢	🟢	🟢	🔴	🔴	🔴	🔴	🔴		🔴
Autism						🟢			🟢	🟢		🟢						🟢	🟢	🔴	🔴	🔴				🔴
Workers with Disabilities					🟢				🟢	🟢								🟢	🟢	🔴	🔴	🔴				🔴

A green dot signifies this form will be needed for a renewal.

A red dot signifies this form will be needed for a renewal if a disability determination from MRT is needed.

Medical Services – Appendix O, Renewal Forms Chart

Appendix O - Renewal Forms Table

Eligibility Group	DCO-151 or 152	DCO-215	DCO-777	DCO-811	DCO-950	DCO-7779	DCO-7781	DCO-81	DCO-237	DCO-662	DCO-702	DCO-704	DCO-710	DCO-712	DCO-713	DCO-727	Pub 405	Pub 407	Pub 408	DCO-106	DCO-107	DCO-108 or 108C	DMS-2602	DCO-2603	DHS-3330	DCO-4000
Miscellaneous																										
PACE							🟢	🟢	🟢	🟢	🟢	🟢		🟢				🟢	🟢	🔴	🔴	🔴			🟢	🔴
Foster Care																		🟢	🟢							
SSI Medicaid	**Must be an SSI Recipient**																									
Pickle (COLA)		🟢							🟢	🟢								🟢	🟢							
Disabled Adult Child (DAC)		🟢							🟢	🟢								🟢	🟢							
Widows or Widowers (OBRA)		🟢							🟢	🟢								🟢	🟢							

A green dot signifies this form will be needed for a renewal.

A red dot signifies this form will be needed for a renewal if a disability determination from MRT is needed.

DCO-662 is required at renewal if there is a change in insurance information.

APPENDIX P TEFRA

Premium Schedule

How to determine TEFRA Premium Range

Step 1

Look at the chart below. If the family has income after allowable deductions at or below the amount listed for the household size, a premium will not be assessed.

If the household has income that is greater than the amount listed below for the household size, continue to Step 2.

Family Size	150% FPL
1	$17,235
2	$23,265
3	$29,295
4	$35,325
5	$41,355
6	$47,385
7	$53,415
8	$59,445
For each additional member add:	$6,030

Step 2

Find the income here to determine the TEFRA Premium Range

Annual Income		Monthly Premiums		
From	**To**	**Percent %**	**From**	**To**
$0	$25,000	0.0%	$0	$0
$25,001	$50,000	1.00%	$21	$42
$50,001	$75,000	1.25%	$52	$78
$75,001	$100,000	1.50%	$94	$125
$100,001	$125,000	1.75%	$146	$182
$125,001	$150,000	2.00%	$208	$250
$150,001	$175,000	2.25%	$281	$328
$175,001	$200,000	2.50%	$365	$417
$200,001	Unlimited	2.75%	$458	$458

SCHEDULE C (Form 1040)
Department of the Treasury
Internal Revenue Service (99)

Profit or Loss From Business
(Sole Proprietorship)

► For information on Schedule C and its instructions, go to *www.irs.gov/schedulec.*
► Attach to Form 1040, 1040NR, or 1041; partnerships generally must file Form 1065.

OMB No. 1545-0074
2012
Attachment Sequence No. **09**

Name of proprietor | **Social security number (SSN)**

A Principal business or profession, including product or service (see instructions) | **B Enter code from instructions** ►

C Business name. If no separate business name, leave blank. | **D Employer ID number (EIN),** (see instr.)

E Business address (including suite or room no.) ►
City, town or post office, state, and ZIP code

F Accounting method: (1) ☐ Cash (2) ☐ Accrual (3) ☐ Other (specify) ►

G Did you "materially participate" in the operation of this business during 2012? If "No," see instructions for limit on losses ☐ Yes ☐ No

H If you started or acquired this business during 2012, check here ► ☐

I Did you make any payments in 2012 that would require you to file Form(s) 1099? (see instructions) ☐ Yes ☐ No

J If "Yes," did you or will you file required Forms 1099? ☐ Yes ☐ No

Part I Income

1	Gross receipts or sales. See instructions for line 1 and check the box if this income was reported to you on Form W-2 and the "Statutory employee" box on that form was checked ► ☐	1	
2	Returns and allowances (see instructions)	2	
3	Subtract line 2 from line 1	3	
4	Cost of goods sold (from line 42)	4	
5	**Gross profit.** Subtract line 4 from line 3	5	
6	Other income, including federal and state gasoline or fuel tax credit or refund (see instructions)	6	
7	**Gross income.** Add lines 5 and 6 ►	7	

Part II Expenses

Enter expenses for business use of your home only on line 30.

8	Advertising	8		18	Office expense (see instructions)	18	
9	Car and truck expenses (see instructions)	9		19	Pension and profit-sharing plans	19	
10	Commissions and fees	10		20	Rent or lease (see instructions):		
11	Contract labor (see instructions)	11		a	Vehicles, machinery, and equipment	20a	
12	Depletion	12		b	Other business property	20b	
13	Depreciation and section 179 expense deduction (not included in Part III) (see instructions)	13		21	Repairs and maintenance	21	
				22	Supplies (not included in Part III)	22	
				23	Taxes and licenses	23	
				24	Travel, meals, and entertainment:		
14	Employee benefit programs (other than on line 19)	14		a	Travel	24a	
15	Insurance (other than health)	15		b	Deductible meals and entertainment (see instructions)	24b	
16	Interest:			25	Utilities	25	
a	Mortgage (paid to banks, etc.)	16a		26	Wages (less employment credits)	26	
b	Other	16b		27a	Other expenses (from line 48)	27a	
17	Legal and professional services	17		b	**Reserved for future use**	27b	

28	**Total expenses** before expenses for business use of home. Add lines 8 through 27a ►	28	
29	Tentative profit or (loss). Subtract line 28 from line 7	29	
30	Expenses for business use of your home. Attach **Form 8829. Do not** report such expenses elsewhere	30	
31	**Net profit or (loss).** Subtract line 30 from line 29. • If a profit, enter on both **Form 1040, line 12** (or **Form 1040NR, line 13**) and on **Schedule SE, line 2.** (If you checked the box on line 1, see instructions). Estates and trusts, enter on **Form 1041, line 3.** • If a loss, you **must** go to line 32.	31	

32 If you have a loss, check the box that describes your investment in this activity (see instructions).
- If you checked 32a, enter the loss on both **Form 1040, line 12,** (or **Form 1040NR, line 13**) and on **Schedule SE, line 2.** (If you checked the box on line 1, see the line 31 instructions). Estates and trusts, enter on **Form 1041, line 3.**
- If you checked 32b, you **must** attach **Form 6198.** Your loss may be limited.

32a ☐ All investment is at risk.
32b ☐ Some investment is not at risk.

For Paperwork Reduction Act Notice, see your tax return instructions. Cat. No. 11334P **Schedule C (Form 1040) 2012**

Part III Cost of Goods Sold (see instructions)

33 Method(s) used to value closing inventory: a ☐ Cost b ☐ Lower of cost or market c ☐ Other (attach explanation)

34 Was there any change in determining quantities, costs, or valuations between opening and closing inventory? If "Yes," attach explanation . . . ☐ Yes ☐ No

35	Inventory at beginning of year. If different from last year's closing inventory, attach explanation	35	
36	Purchases less cost of items withdrawn for personal use	36	
37	Cost of labor. Do not include any amounts paid to yourself	37	
38	Materials and supplies	38	
39	Other costs	39	
40	Add lines 35 through 39	40	
41	Inventory at end of year	41	
42	**Cost of goods sold.** Subtract line 41 from line 40. Enter the result here and on line 4	42	

Part IV Information on Your Vehicle. Complete this part **only** if you are claiming car or truck expenses on line 9 and are not required to file Form 4562 for this business. See the instructions for line 13 to find out if you must file Form 4562.

43 When did you place your vehicle in service for business purposes? (month, day, year) ▶ ____ / ____ / ____

44 Of the total number of miles you drove your vehicle during 2012, enter the number of miles you used your vehicle for:

a Business ____________ b Commuting (see instructions) ____________ c Other ____________

45 Was your vehicle available for personal use during off-duty hours? . . . ☐ Yes ☐ No

46 Do you (or your spouse) have another vehicle available for personal use? . . . ☐ Yes ☐ No

47a Do you have evidence to support your deduction? . . . ☐ Yes ☐ No

b If "Yes," is the evidence written? . . . ☐ Yes ☐ No

Part V Other Expenses. List below business expenses not included on lines 8–26 or line 30.

48 **Total other expenses.** Enter here and on line 27a	48	

01/01/14

Transfer of Asses Divisor

Time Period	Divisor Amount
04/01/13 through 03/31/14	$4,995.00
04/01/12 through 03/31/13	$4,849.00
04/01/11 through 03/31/12	$4,657.00
04/01/10 through 03/31/11	$4,514.00
04/01/09 through 03/31/10	$4,348.00

The divisor will be re-determined each year and any changes in the divisor will be effective on April 1st.

Home Equity Limit

Year	Limit
2013	$536,000

The home equity limit is re-determined each year by CMS.

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Long Term Care, TEFRA, Home & Community Based Waivers	Individual	$2,130.00
SSI/SPA	Individual Couple	$710.00 $1,066.00
1/3 Reduction for Living in Household of Another	Individual Couple	$473.34 $710.67
In-Kind Support	Individual Couple	$256.66 $375.33
Living Allowance for Ineligible Spouse or Child	Individual	$356.00
Substantial Gainful Activity (SGA) for Disability	Individual	$1,040.00
Substantial Gainful Activity (SGA) for Blindness	Individual	$1,740.00
Assisted Living Facility Waiver Room and Board	Individual	$645.00
Assisted Living Facility Waiver Personal Allowance	Individual	$64.00
Student Earned Income Exclusion	Monthly Annual	$1,730.00 $6,960.00

Effective 01/01/13

Amount Needed to Earn a Qualifying Quarter

Year	Earnings Needed for One Credit	Year	Earnings Needed for One Credit
1978	$250	1996	$640
1979	$260	1997	$670
1980	$290	1998	$700
1981	$310	1999	$740
1982	$340	2000	$780
1983	$370	2001	$830
1984	$390	2002	$879
1985	$410	2003	$890
1986	$440	2004	$900
1987	$460	2005	$920
1988	$470	2006	$970
1989	$500	2007	$1000
1990	$520	2008	$1050
1991	$540	2009	$1090
1992	$570	2010	$1120
1993	$590	2011	$1120
1994	$620	2012	$1130
1995	$630	2013	$1160

Long Term Care, TEFRA, Home & Community Based Waivers	Individual	$2,094.00
SSI/SPA	Individual Couple	$698.00 $1,048.00
1/3 Reduction for Living in Household of Another	Individual Couple	$465.34 $698.67
In-Kind Support	Individual Couple	$252.66 $369.33
Living Allowance for Ineligible Spouse or Child	Individual	$350.00
Substantial Gainful Activity (SGA) for Disability	Individual	$1,010.00
Substantial Gainful Activity (SGA) for Blindness	Individual	$1,690.00
Assisted Living Facility Waiver Room and Board	Individual	$634.00
Assisted Living Facility Waiver Personal Allowance	Individual	$63.00
Student Earned Income Exclusion	Monthly Annual	$1,700.00 $6,840.00

Effective 01/01/12

Long Term Care, TEFRA, Home & Community Based Waivers	Individual	$2,022.00
SSI/SPA	Individual Couple	$674.00 $1,011.00
1/3 Reduction for Living in Household of Another	Individual Couple	$449.33 $674.00
In-Kind Support	Individual Couple	$244.66 $357.00
Living Allowance for Ineligible Spouse or Child	Individual	$337.00
Substantial Gainful Activity (SGA) for Disability	Individual	$1,000.00
Substantial Gainful Activity (SGA) for Blindness	Individual	$1,640.00
Assisted Living Facility Waiver Room and Board	Individual	$612.00
Assisted Living Facility Waiver Personal Allowance	Individual	$61.00
Student Earned Income Exclusion	Monthly Annual	$1,640.00 $6,600.00

Effective 01/01/11

Long Term Care, TEFRA, Home & Community Based Waivers	Individual	$2,022.00
SSI/SPA	Individual Couple	$674.00 $1,011.00
1/3 Reduction for Living in Household of Another	Individual Couple	$449.33 $674.00
In-Kind Support	Individual Couple	$244.66 $357.00
Living Allowance for Ineligible Spouse or Child	Individual	$337.00
Substantial Gainful Activity (SGA) for Disability	Individual	$1,000.00
Substantial Gainful Activity (SGA) for Blindness	Individual	$1,640.00
Assisted Living Facility Waiver Room and Board	Individual	$612.00
Assisted Living Facility Waiver Personal Allowance	Individual	$61.00
Student Earned Income Exclusion	Monthly Annual	$1,640.00 $6,600.00

Effective 01/01/10

Long Term Care, TEFRA, Home & Community Based Waivers	Individual	$2,022.00
SSI/SPA	Individual Couple	$674.00 $1,011.00
1/3 Reduction for Living in Household of Another	Individual Couple	$449.33 $674.00
In-Kind Support	Individual Couple	$244.66 $357.00
Living Allowance for Ineligible Spouse or Child	Individual	$337.00
Substantial Gainful Activity (SGA) for Disability	Individual	$980.00
Substantial Gainful Activity (SGA) for Blindness	Individual	$1,640.00
Assisted Living Facility Waiver Room and Board	Individual	$612.00
Assisted Living Facility Waiver Personal Allowance	Individual	$61.00
Student Earned Income Exclusion	Monthly Annual	$1,640.00 $6,600.00

Effective 01/01/09

Long Term Care, TEFRA, Home & Community Based Waivers	Individual	$1,911.00
SSI/SPA	Individual Couple	$637.00 $956.00
1/3 Reduction for Living in Household of Another	Individual Couple	$424.67 $637.34
In-Kind Support	Individual Couple	$232.33 $338.66
Living Allowance for Ineligible Spouse or Child	Individual	$319.00
Substantial Gainful Activity (SGA) for Disability	Individual	$940.00
Substantial Gainful Activity (SGA) for Blindness	Individual	$1,570.00
Assisted Living Facility Waiver Room and Board	Individual	$579.00
Assisted Living Facility Waiver Personal Allowance	Individual	$58.00
Student Earned Income Exclusion	Monthly Annual	$1,550.00 $6,240.00

Effective 07/25/08

Long Term Care, TEFRA, Home & Community Based Waivers	Individual	$1,911.00
SSI/SPA	Individual Couple	$637.00 $956.00
1/3 Reduction for Living in Household of Another	Individual Couple	$424.67 $637.34
In-Kind Support	Individual Couple	$232.33 $338.66
Living Allowance for Ineligible Spouse or Child	Individual	$319.00
Substantial Gainful Activity (SGA) for Disability	Individual	$940.00
Substantial Gainful Activity (SGA) for Blindness	Individual	$1,570.00
Assisted Living Facility Waiver Room and Board	Individual	$579.00
Assisted Living Facility Waiver Personal Allowance	Individual	$58.00

Effective 01/01/08

Long Term Care, TEFRA, Home & Community Based Waivers	Individual	$1,869.00
SSI/SPA	Individual Couple	$623.00 $934.00
1/3 Reduction for Living in Household of Another	Individual Couple	$415.33 $622.66
In-Kind Support	Individual Couple	$227.67 $331.34
Living Allowance for Ineligible Spouse or Child	Individual	$312.00
Substantial Gainful Activity (SGA) for Disability	Individual	$900.00
Substantial Gainful Activity (SGA) for Blindness	Individual	$1,500.00
Assisted Living Facility Waiver Room and Board	Individual	$566.00
Assisted Living Facility Waiver Personal Allowance	Individual	$57.00

Effective 01/01/07

Long Term Care, TEFRA, Home & Community Based Waivers	Individual	$1,809.00
SSI/SPA	Individual Couple	$603.00 $904.00
1/3 Reduction for Living in Household of Another	Individual Couple	$402.00 $602.67
In-Kind Support	Individual Couple	$221.00 $321.33
Living Allowance for Ineligible Spouse or Child	Individual	$301.00
Substantial Gainful Activity (SGA) for Disability	Individual	$860.00
Substantial Gainful Activity (SGA) for Blindness	Individual	$1,450.00
Assisted Living Facility Waiver Room and Board	Individual	$548.00
Assisted Living Facility Waiver Personal Allowance	Individual	$55.00

Effective 01/01/06

Long Term Care, TEFRA, Home & Community Based Waivers	Individual	$1,737.00
SSI/SPA	Individual Couple	$579.00 $869.00
1/3 Reduction for Living in Household of Another	Individual Couple	$386.00 $579.34
In-Kind Support	Individual Couple	$213.00 $309.66
Living Allowance for Ineligible Spouse or Child	Individual	$290.00
Substantial Gainful Activity (SGA) for Disability	Individual	$830.00
Substantial Gainful Activity (SGA) for Blindness	Individual	$1,380.00
Assisted Living Facility Waiver Room and Board	Individual	$526.00
Assisted Living Facility Waiver Personal Allowance	Individual	$53.00

Effective 01/01/05

Long Term Care, TEFRA, Home & Community Based Waivers	Individual	$1,692.00
SSI/SPA	Individual Couple	$564.00 $846.00
1/3 Reduction for Living in Household of Another	Individual Couple	$376.00 $564.00
In-Kind Support	Individual Couple	$208.00 $302.00
Living Allowance for Ineligible Spouse or Child	Individual	$282.00
Substantial Gainful Activity (SGA) for Disability	Individual	$810.00
Substantial Gainful Activity (SGA) for Blindness	Individual	$1,350.00
Assisted Living Facility Waiver Room and Board	Individual	$513.00
Assisted Living Facility Waiver Personal Allowance	Individual	$51.00

Effective 01/01/04

Long Term Care, TEFRA, Home & Community Based Waivers	Individual	$1,656.00
SSI/SPA	Individual Couple	$552.00 $829.00
1/3 Reduction for Living in Household of Another	Individual Couple	$368.00 $552.67
In-Kind Support	Individual Couple	$204.00 $296.33
Living Allowance for Ineligible Spouse or Child	Individual	$277.00
Substantial Gainful Activity (SGA) for Disability	Individual	$800.00
Substantial Gainful Activity (SGA) for Blindness	Individual	$1,330.00
Assisted Living Facility Waiver Room and Board	Individual	$502.00
Assisted Living Facility Waiver Personal Allowance	Individual	$50.00

Effective 01/01/03

Long Term Care, TEFRA, Home & Community Based Waivers	Individual	$1,635.00
SSI/SPA	Individual Couple	$545.00 $817.00
1/3 Reduction for Living in Household of Another	Individual Couple	$363.34 $544.67
In-Kind Support	Individual Couple	$201.66 $292.33
Living Allowance for Ineligible Spouse or Child	Individual	$272.00
Substantial Gainful Activity (SGA)	Individual	$780.00

Effective 01/01/02

Long Term Care, TEFRA, Home & Community Based Waivers	Individual	$1,593.00
SSI/SPA	Individual Couple	$531.00 $796.00
1/3 Reduction for Living in Household of Another	Individual Couple	$354.00 $530.67
In-Kind Support	Individual Couple	$197.00 $285.33
Living Allowance for Ineligible Spouse or Child	Individual	$265.00

Effective 01/01/01

Long Term Care, TEFRA, Home & Community Based Waivers	Individual	$1,536.00
SSI/SPA	Individual Couple	$512.00 $769.00
1/3 Reduction for Living in Household of Another	Individual Couple	$341.34 $512.67
In-Kind Support	Individual Couple	$190.66 $276.33
Living Allowance for Ineligible Spouse or Child	Individual	$257.00

Effective 01/01/00

01/01/14

Number of Eligible Individuals	100% Standard	29% Reduced Standard
1	$ 280.00	$ 81.00
2	$ 560.00	$ 162.00
3	$ 705.00	$ 204.00
4	$ 850.00	$ 247.00
5	$ 985.00	$ 286.00
6	$ 1,140.00	$ 331.00
7	$ 1,285.00	$ 373.00
8	$ 1,430.00	$ 415.00
9 or more	$ 1,575.00	$ 457.00

01/01/14

Table - Unisex Life Estate or Remainder Table

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
0	.97188	.02812	37	.93026	.06974	74	.53862	.46138
1	.98988	.01012	38	.92567	.07433	75	.52149	.47851
2	.99017	.00983	39	.92083	.07917	76	.50441	.49559
3	.99008	.00992	40	.91571	.08429	77	.48742	.51258
4	.98981	.01019	41	.91030	.08970	78	.47049	.52951
5	.98938	.01062	42	.90457	.09543	79	.45357	.54643
6	.98884	.01116	43	.89855	.10145	80	.43659	.56341
7	.98822	.01178	44	.89221	.10779	81	.41967	.58033
8	.98748	.01252	45	.88558	.11442	82	.40295	.59705
9	.98663	.01337	46	.87863	.12137	83	.38642	.61358
10	.98565	.01435	47	.87137	.12863	84	.36998	.63002
11	.98453	.01547	48	.86374	.13626	85	.35359	.64641
12	.98329	.01671	49	.85578	.14422	86	.33764	.66236
13	.98198	.01802	50	.84743	.15257	87	.32262	.67738
14	.98066	.01934	51	.83674	.16126	88	.30859	.69141
15	.97937	.02063	52	.82969	.17031	89	.29526	.70474
16	.97815	.02185	53	.82028	.17972	90	.28221	.71779
17	.97700	.02300	54	.81054	.18946	91	.26955	.73045
18	.97590	.02410	55	.80046	.19954	92	.25771	.74229
19	.97480	.02520	56	.79006	.20994	93	.24692	.75308
20	.97365	.02635	57	.77931	.22069	94	.23728	.76272
21	.97245	.02755	58	.76822	.23178	95	.22887	.77113
22	.97120	.02880	59	.75675	.24325	96	.22181	.77819
23	.96986	.03014	60	.74491	.25509	97	.21550	.78450
24	.96841	.03159	61	.73267	.26733	98	.21000	.79000
25	.96678	.03322	62	.72002	.27998	99	.20486	.79514
26	.96495	.03505	63	.70696	.29304	100	.19975	.80025
27	.96290	.03710	64	.69352	.30648	101	.19532	.80468
28	.96062	.03938	65	.67970	.32030	102	.19054	.80946

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
29	.95813	.04187	66	.66551	.33449	103	.18437	.81563
30	.95543	.04457	67	.65098	.343902	104	.17856	.82144
31	.95254	.04746	68	.63610	.363690	105	.16962	.83038
32	.94942	.05058	69	.62086	.37914	106	.15488	.84512
33	.94608	.05392	70	.60522	.39478	107	.13409	.86591
34	.94250	.05750	71	.58914	.41086	108	.10068	.89932
35	.93868	.06132	72	.57261	.42739	109	.04545	.95455
36	.93460	.06540	73	.55571	.44429			

Source: Section 20.2031-7 of Title 26 of the Code of Federal Regulations

01/01/14

Voter Registration

The National Voter Registration Act of 1993 (P. L. 103-31) requires each state's public assistance agency to provide the customer the opportunity to complete an Voter Registration Application at any time a request for assistance is made. This requirement became effective January 1, 1996.

Voter registration is not a part of program eligibility requirements. Therefore, an application for assistance will not be denied nor will a case be closed due to failure to complete any forms in relation to voter registration. No forms or other documents related to voter registration except for the DHS-131 and Voter Registration Change of Status will be filed in the customer's case record.

DCO Employees will not:

1. Seek to influence a customer's political preference or party registration;
2. Display any such political preference or party allegiance;
3. Make any statement to a customer or take any action, the purpose or effect of which is to discourage the customer from registering to vote; or
4. Make any statement to a customer or take any action, the purpose or effect of which is, to lead the customer to believe that a decision to register or not to register has any bearing on the availability of services or benefits.

Explanation & Offer

Each customer must be offered an opportunity to apply to register to vote when visiting the county office for purposes of applying for assistance, recertification/reevaluation, or for reporting changes of name or address. If a customer is applying for more than one service and is interviewed by two or more Program Eligibility Specialists on the same day, the offer has to be made at least once. The County Office will put into place a procedure that will ensure that the offer has been made.

Subsequent visits to the County Office for the purpose of completing the application/ recertification process (e.g., customer returns the next day to furnish check stubs) will be considered part of the same application. Therefore, it is not necessary to make another offer for voter registration.

Who Can Make the Offer

The offer can be made by any employee or volunteer. If the offer is made by someone other than the Program Eligibility Specialist, a procedure must be in place to notify the worker that the offer was made to avoid duplication of effort during the program eligibility interview.

A Voter Registration Application form must be provided to anyone who requests one. If someone is not applying for DHS services but requests a Voter Registration Application form, the worker will give him/her the form with instructions to mail it directly to the Secretary of State's office. A declaration form will not be given in this instance, nor will it count on the daily recap report.

Customer Acceptance

If a customer states she/he wishes to register to vote, she/he will be given a Voter Registration Application to complete. The voter registration application can be completed at the county office and given back to the receptionist or the customer can take it with him or her and mail directly to the designated address. Assistance in completing the form will be provided if requested. It is a local decision as to whether the Agency-Based Declaration Statement will be completed. If it is completed, a copy may be given to the customer if requested. It is a local decision as to whether the "yes" declarations will be kept in the county office. Do not mail the declaration forms to the Secretary of State's Office. The customer will be advised that a decision on his/her Voter Registration Application will be provided by the County Clerk's Office.

If there are other adult household members a Voter Registration Application may be given to the customer for the other adult(s) to complete. However, if the other adult(s) chooses not to register, a declination form is not needed.

The worker will put the agency code on the voter registration application that applies at the time it is being completed. For example, if the customer is applying for Supplemental Nutrition Assistance Program benefits at the time a voter registration application is being completed, the worker would use the SNAP code. If the customer is applying for several programs, just use one code (worker choice).

Telephone Interviews and Authorized Representatives

Applicants who are interviewed by phone and indicate a desire to register to vote should be mailed a Voter Registration Application no later than the date that a determination (approval or denial) is made on the case. This applies to both initial applications and reevaluation/recertifications.

The Voter Registration Application form will be mailed to the applicant/recipient any time an authorized representative is interviewed on the customer's behalf. If a customer makes a telephone request for a Voter registration Application form, one will be mailed to his/her mailing address.

Access Arkansas

Applicants who apply through Access Arkansas may apply directly online by following a link to the Secretary of State's website to register to vote.

SNAP/MSP Annual Review

Mail in applicants should be mailed an Arkansas Voter Registration Application no later than the date that a determination (approval or denial) is made on the case. This applies to both reevaluation/recertifications.

Customer Declination

If the customer declines to register to vote, then she/he will be asked to make the declination by checking "no" on the Agency-Based Declaration Statement. She/he should also sign and date the statement. If the customer refuses to complete the form, the DCO employee will print the customer's name on the statement, date, and make a note of "refused to sign" in the comment section. A copy of the Agency-Based Declaration Statement may be provided to the customer if requested. A daily count of the declinations must be provided to the Secretary of State's office when completing the Agency Daily Recap Reporting Form. The Agency Based Declaration Statement will be kept for 2 years in the County Office in a chronological file by month and year.

Change of Address or Name Change

If a customer reports a change of address or name change, a DCO-131, Voter Registration change of Status form and a Voter Registration Application will be sent to the customer advising that the change can be reported to the County Clerk's office for voter registration purposes or that she/he can register to vote. A declaration statement will not be completed in this instance.

Submitting Applications

Completed Voter Registration Applications must ensure that this timeframe is met. The customer may mail his/her application; the address is on the back of the application. An envelope is not needed. An Agency Daily Recap Reporting Form will be completed and sent with the voter registration application. This form advises the Secretary of State's Office of the number of declination and number of completed voter registration applications being submitted. A single report including all programs will be submitted. The County Office will retain a copy of the Daily Recap Reporting form for 24 months in a chronological file by month and year.

The County office must maintain a record of the number of Voter Registration applications mailed to the Secretary of State's Office each day. No later than the 10th calendar day of each month, the county will report to the DCO Field Operations, via the DHS-132, Voter Registration Application Monthly Report, the number of voter registration applications and declinations submitted to the Secretary of State's office in the prior month.

01/01/14

PURPOSE

Section 2651 of the Deficit Reduction Act of 1984 mandates that the Department of Human Services request and utilize IRS tax return information in determining eligibility for assistance. As a condition of receiving IRS tax return information, the Department of Human Services must establish and maintain safeguards designed to prevent unauthorized uses of the information and to protect the confidentiality of such information. This appendix specifically details the confidentiality and safeguard requirements that must be strictly followed.

Each DCO County Administrator has the responsibility of insuring that each employee is fully aware of the criminal and civil penalties for unauthorized disclosure of IRS tax return information. All information contained in this appendix must be reviewed by all staff semi-annually and each new employee must review this appendix prior to receiving and/or utilizing IRS tax return information.

Return information consists of more than an individual identity, amount and source of income, and other monetary values. Internal Revenue Code Section 6103 (b) (2), which defines return information, lists numerous items and continues with "...or any other data, received by, recorded by, furnished to, or collected by the Secretary with respect to a return or with respect to the determination of the existence, or possible existence, of liability...of any person..." "Even the existence or possible existence" of a tax liability has been interpreted (by IRS) to mean that the fact that IRS has information on an individual is considered return information. Any information showing that an IRS match occurred, reveals that IRS has information on that individual; therefore, such information is "return information".

Additionally, tax information never loses its character. That is, tax information remains tax information even after it has been verified. The major determining factor is the source of the information. If the initial source is IRS, the information is return information. If the initial source is the customer or a third party (from their records), the information is generally not return information. If a document contains return information and is verified by the customer or a third party, the information remains return information as the original source was IRS and it does not lose its character.

EMPLOYEE AWARENESS

Each agency employee entitled to access IRS tax return information must be thoroughly briefed on all security procedures and instructions. Periodic reorientation sessions should be conducted to insure that all appropriate employees remain alert to security requirements regarding IRS information.

In compliance with IRS Safeguard requirements, a poster has been developed advising employees of the penalties for unauthorized disclosure. Each DCO County Administrator has the responsibility of displaying the poster so that employees are reminded of the penalties. Penalties apply even if an unauthorized disclosure is made after employment with the agency is terminated. Unauthorized disclosure by current employees will result in termination.

Employees who are entitled to access IRS tax return information must not disclose this information to any party outside the agency other than the taxpayer to whom the information relates, the taxpayer's duly appointed representative who has the explicit written authority to obtain the information, or employees of the federal agency charged with oversight of the particular program the state agency is administering.

Employees who are entitled to access IRS tax return information must not disclose this information to any other officer or employee within the agency whose official duties do not require this information to determine eligibility for, or the correct amount of, benefits under these programs.

Due to stringent IRS safeguarding and disclosure guidelines it is necessary that employees exercise care in composing notices to customers and correspondence to payers with respect to IRS tax return information. It is recommended that notices to customers do not list the IRS as the source of the information but rather should state that the agency has learned about the information through computer matching.

If the customer questions the source of the information then the source of the information may be disclosed to the customer or his/her duly appointed representative. In the case of adults (including spouses) on whom an IRS report is generated, disclosure of the source of the information will be provided only to the adult for whom the information is reported. In the case of children on whom an IRS report is generated, disclosure of the source of the information will be provided only to the child's parent or guardian. Any correspondence written or verbal between the agency and the payer should not reference IRS as the data source.

OFFICE SECURITY AND RECORD RETENTION

All TEA, Food Stamp, and Medicaid case records will be kept in a locked storage area during non-working hours. Further, at no time will any IRS or BENDEX Wage report be left in open view so that unauthorized persons may gain access. IRS reports are generated under the title "State Resource" reports.

All IRS and BENDEX Wage summary reports will be maintained in the county office for one year from the report rundate and may be destroyed at that time following the procedures which follow.

DESTRUCTION OF IRS TAX RETURN INFORMATION

The Tax Reform Act of 1976 requires that certain actions be taken when destroying federal tax information in order to protect its confidentiality. IRS data will be destroyed by burning or shredding.

Burning: The material is to be either burned in an incinerator that produces enough heat to burn the entire bundle or the bundle should be separated to insure that all pages are consumed.

Shredding: To make reconstruction more difficult, the paper should be inserted so that the lines of print are perpendicular to the cutting line; small amounts of shredded paper should not be allowed to accumulate in the shredder bin.

IRS data in identifiable form must never be released to private contractors for unsupervised destruction. Destruction of the data must be witnessed by an agency employee in a manner sufficient to safeguard the data from unauthorized disclosure.

Each Economic Services Supervisor will have the responsibility of maintaining a Control Log of all IRS data that is destroyed. At a minimum, the log will contain the following:

- Date of destruction
- Method of destruction
- Printout number and rundate for summary reports
- Case name and number for cases containing IRS data
- Agency personnel responsible for overseeing destruction

Since IRS data must be logged when destroyed and since Individual Case Sheets will be filed in case records, it is necessary that case records be screened for IRS data prior to destruction. If tax return information is in the case record, then an entry to the IRS destruction log is required. To expedite the screening of cases for tax return data, enter "IRS" in the upper right corner of the face sheet of the case to alert staff that the case contains tax return information from the IRS. It is important that all offices use a consistent method to notate cases for IRS data since cases are often transferred between offices.

The Control logs will be forwarded to the Assistant Director of the Office of Program Planning and Development no later than August 15th of each year. A copy of the Control log will be retained in the county office for five complete years from the date of its submission to Central Office.

SAFEGUARD CONTROLS

A control list will be maintained in each DHS county office substantiating that each employee authorized to receive and use IRS tax return information has received a copy of the IRS Confidentiality and Safeguard Procedures and has been made fully aware of the penalties for unauthorized disclosure. Each new agency employee entitled to access IRS tax return information must also be added to the control list prior to accessing the data. This list will contain, at a minimum, the name and signature of the person responsible for IRS data, the date that safeguard procedures were reviewed and the supervisor's initials. The list is subject to review by the Management & Evaluation Unit, the Program Support Specialist, the Program Support Manager, and other Central Office staff as deemed necessary. In addition, the control list will be made available for on-site inspections made by the Internal Revenue Service.

ON-SITE INSPECTIONS

Annual inspections will be conducted to ascertain that safeguards are being followed. A complete record will be made of each inspection and kept on file in the DCO Office of Program Planning and Development. A complete record of the inspections will be submitted to OPPD by August 15 of each year. Any deficiencies noted as a result of an on-site inspection will require that corrective action measures be taken. These inspection records will be maintained for a period of three years or until reviewed by the Internal Revenue Service, whichever is later. An on-site inspection will include the following:

1. A review of the storage and handling of federal tax information;
2. A review of the dissemination of federal tax reports to appropriate agency staff;
3. An assessment of county office security features;

4. Verification that all IRS tax return is maintained in a locked storage area during non-working hours or that the county office is making a good faith effort to work toward such an arrangement;
5. A review of after-hours security to insure that unauthorized access cannot be obtained by unauthorized personnel (e.g., janitorial staff);
6. A review of all IRS Control Logs;
7. Interviews with appropriate agency staff to ensure that employees are aware of the confidentiality regarding IRS data and the penalties for unauthorized disclosure;
8. Verification that each county office has displayed the poster advising of the penalties for unauthorized disclosure of IRS information; and
9. A review of county office procedures for destruction of IRS information.

Arkansas Department of Human Services
Application for Health Coverage
Single Adults

Use this application to see what coverage you qualify for through DHS.

- Medicaid, ARKids First or the Health Care Independence Program
- If you are not eligible for any of the above coverage, your information will be transferred to the Federally Facilitated Health Insurance Marketplace to determine your eligibility for tax credits to help pay for a Qualified Health Plan.

Who can use this application?

Single adults who:

- Don't have any dependents and can't be claimed as a dependent on someone else's tax return.

NOTE: If any of the following apply you will need to fill out form DCO-152 to make sure you get the most benefits possible:

- You're married or have dependent children.
- You were in the Foster Care system and you're under 26.
- You have items that can be deducted from your income. If your only deduction is student loan interest, you can use this form.
- You're American Indian or Alaska Native.

Apply faster online.

Apply faster online at Access.Arkansas.gov.

What you may need to apply.

- Your Social Security number (or document number if you're a legal immigrant).
- Employer and income information (for example, from paystubs, W-2 forms, or wage and tax statements .

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get help paying for it. **We'll keep all the information you provide private and secure as required by law.** To view the Privacy Act Statement go to Access.Arkansas.gov.

What happens next?

Send your completed, signed application to the address on Page 4**. If you don't have all the information we ask for, sign and submit your application anyway.**

Get help with this application.

- **Phone:** Call our Help Center at 1-855-372-1084.
- **In person:** Contact your local DHS county office for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al 1-855-372-1084.

Step 1 – Tell Us About Yourself

1. First name, Middle name, Last name & Suffix

2. Home address			3. Apartment or Suite number
4. City	5. State	6. Zip Code	7. County
8. Mailing address (if different from home address)			9. Apartment or Suite number
10. City	11. State	12. Zip Code	13. County
14. Phone number ( ) -		15. Other phone number ( ) -	

16. Do you want to get information about this application by email? ☐ Yes ☐ No
Email address: ____

17. What is your preferred spoken or written language (if not English)?

18. Date of birth (mm/dd/yyyy)	19. Sex ☐ Male ☐ Female

20. Social Security number (SSN) ___________-______-______________
We need this if you want health coverage and have an SSN. We use SSNs to check income and other information to see if you're eligible for help with health coverage costs. If you need help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

21. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

22. **If you aren't a U.S. citizen or U.S. national:** Do you have eligible immigration status?
☐ Yes. Fill in your document type and ID number below.
a. Immigration document type
b. Document ID number ____
c. Have you lived in the in the U.S. since 1996? ☐ Yes ☐ No
d. Are you a veteran or an active duty member of the U.S. Military? ☐ Yes ☐ No

23. Are you pregnant? ☐ Yes ☐ No
If yes, how many babies are expected during this pregnancy? ____________________

24. Do you have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

25. **If Hispanic/Latino, ethnicity (OPTIONAL – Check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other ____________

26. Race **(OPTIONAL – Check all that apply.)**

☐ White	☐ Filipino	☐ Japanese
☐ Guamanian or Chamorro Black or	☐ Vietnamese	☐ Korean
☐ African American American	☐ Other Asian	☐ Native Hawaiian
☐ Indian or Alaska Native	☐ Samoan	☐ Other ________________

NEED HELP WITH YOUR APPLICATION? Call us at 1-855-372-1084. Para obtenar una de este formulario en Español, llame 1-855-372-1084. If you need help in a language other than English, call 1-855-372-1084 and tell the Customer Service representative the language you need. We'll get you help at no cost to you.

Step 2 – Current Job & Income Information

☐ **Employed** If you're currently employed, tell us about your income. Start with question 1.

☐ **Not employed** Skip to question 11. ☐ **Self-employed** Skip to question 10.

CURRENT JOB 1:

1. Employer Name and Address	2. Employer Phone Number

3. Wages/tips (before taxes) $ ________________
☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly

4. Average hours worked each **week**: ________________

CURRENT JOB 2:

5. Employer Name and Address	6. Employer Phone Number

7. Wages/tips (before taxes) $ ________________
☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly

8. Average hours worked each week: ________________

9. **In the past year, did you:** ☐ Change jobs? ☐ Stop working? ☐ Start working fewer hours?
☐ None of these?

10. **If self-employed, answer the following questions:**
a. Type of work ________________
b. How much net income (profits once business expenses are paid) will you receive from this self-employment this month?
$ ________________

11. **OTHER INCOME THIS MONTH:** Check all that apply and give the amount and how often you receive that amount.
NOTE: You don't need to tell us about child support, veteran's payments or Supplemental Security Income (SSI).

☐ None
☐ Unemployment $ How often?
☐ Pensions $ How often?
☐ Social Security $ How often?
☐ Other income $ _____ How often? __________
☐ Retirement Accounts $ _______ How often? _________
☐ Alimony received $ ___________ How often?
☐ Net farming/fishing $ ___________ How often?
☐ Net rental/royalty $ _______ How often? _________
Other type: ________________

12. Do you pay student loan interest (not the amount of the loan) that can be deducted on a federal income tax return? ☐ Yes ☐ No **If yes**, how much? ______________ How often? ______________

13. **YEARLY INCOME:** Complete only if your income changes from month to month. If you don't expect changes in your monthly income, skip to Step 3.

Your total income **this year**:	Your total income **next year** (if you think it will be different):
$	**$**

Step 3 – Your Health Coverage

Are you enrolled in health coverage now from any of the following? ☐ Yes ☐ No
If yes, check which coverage you have:

☐ Medicaid (from another state)
☐ CHIP (from another state)
☐ Medicare
☐ TRICARE (Don't check if you have Direct Care or Line of Duty)
☐ Peace Corps
☐ VA Health Care programs
☐ Other
Name of Health insurance:
____
Policy Number: ________________

Step 4 – Read & Sign This Application

I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under the federal law if I intentionally provide false or untrue information.

- I know that I must tell the Department of Human Services if anything changes (and is different than) what I wrote on this application. I can visit Access.Arkansas.gov or call 1-855-372-1084 to report any changes. I understand that a change in my information could affect my eligibility.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability. I can file a complaint of discrimination by calling 1-501-682-6003.
- I confirm that I'm not incarcerated (detained or jailed).
- I confirm that next year I expect to file a federal income tax return, won't claim dependents on that return and can't be claimed as a dependent on anyone else's federal income tax return.
- I understand that the Health Care Independence Program is not a federal or state entitlement program and that it may be ended at any time upon appropriate notice.

We need this information to check your eligibility for Medicaid, ARKids First or the Health Care Independence Program if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Renewal of Coverage in Future Years

To make it easier to determine my eligibility for Medicaid, ARKids First or Health Care Independence Program coverage in future years, I agree to allow the Department of Human Services to use income data including information from tax returns. DHS will send me a notice, allow me to make any changes and I can opt out at any time.

Yes, renew my eligibility automatically for the next: ☐ 5 years (the maximum number of years allowed)

Or for a shorter number of years: ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use tax return information to renew coverage

If I'm eligible:

If I enroll in Medicaid, ARKids First or the Health Care Independence Program, I'm giving the Department of Human Services my rights to pursue and get money from other health insurance, legal settlements or other third parties.

My right to appeal:

If I think DHS has made a mistake, I can appeal its decision. To appeal means to tell someone at the Department of Human Services that I think the action is wrong and ask for a fair review of the action. I know I can find out how to appeal an action by contacting DHS at 1-501-682-8622. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application: The person who filled out Step 1 should sign this application. If you're an Authorized Representative, you may sign here as long as you have provided a signed copy of the DCO-153, Consent for an Authorized Representative.

Signature	Date (mm/dd/yyyy)

Step 5 – Submit Completed Application

Mail your signed application to: **DHS Jefferson County**
1222 West 6th Street
P.O. Box 5670
Pine Bluff, AR 71611

Or email your signed application to: 351Jefferson@arkansas.gov

Or FAX your signed application to**:** 1-870-534-3421

What happens next?

We will process your application for Medicaid, ARKids First or the Health Care Independence Program and send you a notice to tell you if your application has been approved or denied and provide instructions on the next steps needed to complete your health coverage. If you are not eligible for any of these programs, we will screen your application for potential eligibility for tax credits to help you pay for health insurance premiums and then transfer your information to the Health Insurance Marketplace. We will provide instructions on how to complete the application process on the notice we send you.

If you want to register to vote, complete the Voter Registration packet that was given to you as a part of this application packet.

Arkansas Department of Human Services
Application for Health Coverage

Use this application to see what coverage you qualify for through DHS.	• Medicaid, ARKids First or the Health Care Independence Program • If you are not eligible for any of the above coverage, your information will be transferred to the Federally Facilitated Health Insurance Marketplace to determine your eligibility for tax credits to help pay for a Qualified Health Plan.

Who can use this application?	Use this application to apply for you or anyone in your family. • Apply even if you or your child already has health coverage. You could be eligible for lower cost or free coverage. • Families that include immigrants can apply. You can apply for your children even if you are not eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen. • If someone is helping you fill out this application, you may need to complete a DCO-153, Consent for an Authorized Representative.

Apply faster online.	**Apply faster online at: Access.Arkansas.gov**

What you may need to apply.	• Your Social Security number (or document number if you are a legal immigrant) • Employer and income information (for example: from paystubs, W-2 forms, or wage and tax statements) • Information about any job related health insurance available to your family • Policy numbers for any current health insurance

Why do we ask for this information?	We ask about income and other information to let you know what coverage you qualify for and if you can get help paying for it. **We will keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement go to Access.Arkansas.gov.

What happens next?	Send your complete, signed application to the address on page 8. **If you do not have all the information we ask for, sign and submit your application anyway.**

Get help with this application.	• **Phone:** Call our Help Center at **1-855-372-1084**. • **In person:** Contact your local DHS county office for more information. • **En Español:** Llame a nuestro centro de ayuda gratis al **1-855-372-1084**.

Step 1 Tell Us About Yourself

(We need one adult in the family to be the contact person for your application.)

1. First Name, Middle Name, Last Name & Suffix			
2. Home Address			3. Apartment or Suite Number
4. City	5. State	6. ZIP Code	7. County
8. Mailing Address (If different from home address)			9. Apartment or Suite Number
10. City	11. State	12. ZIP Code	13. County
14. Phone Number		15. Other Phone Number	
16. Do you want to receive information about this application by email? ☐ Yes ☐ No Email Address: ______________________			
17. Preferred spoken or written language (if not English)			

Step 2 Tell Us About Your Family

Who do you need to include on this application?

Tell us about all the family members that live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to be eligible for health coverage.)

Do include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return even if they don't live with you
- Anyone else under 21 who lives with you and you take care of

You don't have to include:

- Your unmarried partner who does not need health coverage
- Your unmarried partner's children
- Your parents who live with you but file their own tax return (if you are over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure that everyone receives the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than two people in your family, you will need to make a copy of the Step 2 pages, fill them out and attach them to this application. You don't need to provide immigration status or a Social Security Number (SSN) for family members who do not need health coverage. We will keep all the information you provide private and secure as required by law. We will only use your personal information to check if you are eligible for health coverage.

<u>Please proceed to Step 2 on the following page.</u>

NEED HELP WITH YOUR APPLICATION? Call us at **1-855-372-1084**. Para obtener una copia de este formulario en Español, llame **1-855-372-1084**. If you need help in a language other than English, call **1-855-372-1084** and tell the customer service representative the language you need. We will get you help at no cost to you.

Step 2: Person 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First Name, Middle Name, Last Name & Suffix	2. Relationship to you? **SELF**
3. Date of Birth (mm/dd/yyyy)	4. Sex ☐ Male ☐ Female

5. Social Security Number (SSN) _ _ _ - _ _ - _ _ _ _

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

6. **Do you plan to file a federal income tax return NEXT YEAR?** (You can still apply for health coverage even if you don't file a federal income tax return.)

☐ **YES If yes**, please answer questions a through c. ☐ **NO If no**, skip to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No
   If yes, name of spouse:________________

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No
   If yes, list name(s) of dependents:________________

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
   If yes, please list the name of the tax filer:________________
   How are you related to the tax filer?________________

7. Are you pregnant? ☐ Yes ☐ No **If yes**, how many babies are you expecting during this pregnancy? ________

8. **Do you need health coverage?** (Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ **YES If yes**, answer all the questions below. ☐ **NO If no**, SKIP to the income questions on page 3. Leave the rest of this page blank.

9. Do you have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

10. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

11. **If you are not a U.S. citizen or U.S national**, do you have eligible immigration status?
☐ Yes Enter your document type and ID number below.
a. Immigration document type:________________ b. Document ID number:________________
c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No d. Are you or your spouse or parent a veteran or an active duty member of the U.S. military? ☐ Yes ☐ No

12. Do you want help paying for medical bills from the last three months? ☐ Yes ☐ No

13. Do you live with at least one child under the age of 19 and are you the main person taking care of this child? ☐ Yes ☐ No

14. Are you a full time student? ☐ Yes ☐ No | 15. Were you in foster care in Arkansas at age 18 or older? ☐ Yes ☐ No

16. **If Hispanic/Latino,** what is your ethnicity? **(OPTIONAL – Check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other:________________

17. **Race (OPTIONAL – Check all that apply.)**
☐ White ☐ American Indian or Alaska Native ☐ Filipino ☐ Vietnamese ☐ Guamanian or Chamorro
☐ Black or African American ☐ Asian Indian ☐ Japanese ☐ Other Asian ☐ Samoan ☐ Chinese
☐ Korean ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other:________________

NEED HELP WITH YOUR APPLICATION? Call us at **1-855-372-1084**. Para obtener una copia de este formulario en Español, llame **1-855-372-1084**. If you need help in a language other than English, call **1-855-372-1084** and tell the customer service representative the language you need. We will get you help at no cost to you.

Step 2: Person 1 (Continue with yourself)

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 18.

☐ **Not employed**
Skip to question 28.

☐ **Self-employed**
Skip to question 27.

CURRENT JOB 1:

18. Employer Name and Address	19. Employer Phone Number
20. Wages/tips (before taxes) $ ____________ ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly	
21. Average hours worked each **week**: ____________	

CURRENT JOB 2: (Attach another sheet of paper to list more jobs.)

22. Employer Name and Address	23. Employer Phone Number
24. Wages/tips (before taxes) $ ____________ ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly	
25. Average hours worked each **week**: ____________	

26. **In the past year, did you:** ☐ Change jobs? ☐ Stop working? ☐ Start working fewer hours? ☐ None of these?

27. **If self-employed, answer the following questions:**

a. Type of work

____

b. How much net income (profits once business expenses are paid) will you receive from this self-employment this month?
$ ____________________

28. **OTHER INCOME THIS MONTH:** Check all that apply and give the amount and how often you receive that amount.
NOTE: You don't need to tell us about child support, veteran's payments or Supplemental Security Income (SSI).

☐ None
☐ Unemployment $ How often?
☐ Pensions $ How often?
☐ Net farming/fishing $ How often?
☐ Net rental/royalty $ How often?
☐ Social Security $ How often?
☐ Alimony $ How often?
☐ Retirement Accounts $ How often?
☐ Other income $ ________ How often? ________ Type: ____________

29. **DEDUCTIONS:** Check all that apply and give the amount and how often you receive that amount.
If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You should not include a cost that you already considered in your answer to net self-employment (Question 27b).

☐ Alimony paid $ How often?
☐ Student Loan interest $ How often?
☐ Other Deductions $ ________ How often? ________ Type: ____________

30. **YEARLY INCOME: Complete only if your income changes from month to month.**
If you don't expect changes to your monthly income, skip to the next person.

Your total income **this year:**	Your total income **next** year (if you think it will be different):
$ ____________	$ ____________

Step 2: Person 2

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First Name, Middle Name, Last Name & Suffix	2. Relationship to you?
3. Date of Birth (mm/dd/yyyy)	4. Sex ☐ Male ☐ Female
5. Social Security Number (SSN) _ _ _ - _ _ - _ _ _ _ **We need this if you want health coverage and have an SSN.**	
6. Does **PERSON 2** live at the same address as you? ☐ Yes ☐ No **If no**, list address: ____	

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?** (You can still apply for health coverage even if you don't file a federal income tax return.)

☐ **YES If yes**, please answer questions a through c. ☐ **NO If no**, skip to question c.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse:____

b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents:____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer:____
How is PERSON 2 related to the tax filer?____

8. Is PERSON 2 pregnant? ☐ Yes ☐ No **If yes**, how many babies are expected during this pregnancy? ____

9. **Does PERSON 2 need health coverage?**

☐ **YES If yes**, answer all the questions below. ☐ **NO If no**, SKIP to the income questions on page 5. Leave the rest of this page blank.

10. Does PERSON 2 have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. **If PERSON 2 is not a U.S. citizen or U.S national**, do they have eligible immigration status?
☐ Yes Enter their document type and ID number below.
a. Immigration document type:____ b. Document ID number:____
c. Has PERSON 2 lived in the U.S. since 1996? ☐Yes ☐No d. Is PERSON 2 or their spouse or parent a veteran or an active duty member of the U.S. military? ☐Yes ☐No

13. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No	14. Does PERSON 2 live with at least one child under the age of 19 and are they the main person taking care of this child? ☐ Yes ☐ No	15. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No

Please answer Questions 16 & 17 if PERSON 2 is 19 or younger:

16. Did PERSON 2 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No
a. **If yes**, insurance end date: ____ b. Reason insurance ended: ____

17. Is PERSON 2 a full time student? ☐ Yes ☐ No

18. **If Hispanic/Latino,** what is your ethnicity? **(OPTIONAL – Check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other:____

19. **Race (OPTIONAL – Check all that apply.)**
☐ White ☐ American Indian or Alaska Native ☐ Filipino ☐ Vietnamese ☐ Guamanian or Chamorro
☐ Black or African American ☐ Asian Indian ☐ Japanese ☐ Other Asian ☐ Samoan ☐ Chinese
☐ Korean ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other:____

Step 2: Person 2 (Continue with Person 2)

Current Job & Income Information

☐ **Employed**
If PERSON 2 is currently employed, tell us about their income. Start with question 20.

☐ **Not employed**
Skip to question 28.

☐ **Self-employed**
Skip to question 27.

CURRENT JOB 1:

20. Employer Name and Address	21. Employer Phone Number
22. Wages/tips (before taxes) $ ______________ ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly	
23. Average hours worked each **week**: ______________	

CURRENT JOB 2: (Attach another sheet of paper to list more jobs.)

24. Employer Name and Address	25. Employer Phone Number
26. Wages/tips (before taxes) $ ______________ ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly	
27. Average hours worked each **week**: ______________	

28. **In the past year, did PERSON 2:** ☐ Change jobs? ☐ Stop working? ☐ Start working fewer hours? ☐ None of these?

29. **If self-employed, answer the following questions:**

a. Type of work

____

b. How much net income (profits once business expenses are paid) will PERSON 2 receive from self-employment this month?
$ ______________

30. **OTHER INCOME THIS MONTH:** Check all that apply and give the amount and how often PERSON 2 receives that amount.
NOTE: You don't need to tell us about child support, veteran's payments or Supplemental Security Income (SSI).

☐ None
☐ Unemployment $ How often?
☐ Pensions $ How often?
☐ Net farming/fishing $ How often?
☐ Net rental/royalty $ How often?
☐ Social Security $ How often?
☐ Alimony $ How often?
☐ Retirement Accounts $ How often?
☐ Other income $ __________ How often? __________ Type: ______________

31. **DEDUCTIONS:** Check all that apply and give the amount and how often PERSON 2 receives that amount.
If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You should not include a cost that you already considered in your answer to net self-employment (Question 29b).

☐ Alimony paid $ How often?
☐ Student Loan interest $ How often?
☐ Other deductions $ __________ How often? __________ Type: ______________

30. **YEARLY INCOME: Complete only if PERSON 2's income changes from month to month.**
If you don't expect changes to PERSON 2's monthly income, skip to the next person.

PERSON 2's total income **this year:**	PERSON 2's total income **next** year (if you think it will be different):
$ ______________	$ ______________

Step 3 American Indian or Alaskan Native (AI/AN) Family Members

Are you or is anyone in your family an American Indian or an Alaskan Native?

☐ **No** If No, skip to Step 4.
☐ **Yes** If Yes, go to Appendix B.

Step 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?** ☐ Yes ☐ No

If Yes, check the type of coverage and write the person(s)' name(s) next to the coverage they have.

☐ Medicaid______________________________
☐ ARKids First/CHIP
☐ Medicare______________________________
☐ TRICARE
(Don't check if you have Direct Care or Line of Duty)
____
☐ VA Health Care Programs______________________________
☐ Peace Corps______________________________

☐ Employer insurance
Name of health insurance
Policy number______________________________
Is this COBRA coverage? ☐ Yes ☐ No
Is this a retiree health plan? ☐ Yes ☐ No
☐ Other
Name of health insurance
Policy number
Is this a limited benefit plan (like a school accident policy)?
☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job?** Check Yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ Yes **If yes**, you will need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No
☐ No **If no, continue to Step 5.**

Step 5 Read & Sign This Application

- I am signing this application under penalty of perjury which means I have provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false or untrue information.
- I know that I must tell the Department of Human Services (DHS) if anything changes (and is different than) what I wrote on this application. I can visit access.arkansas.gov or call **1-855-372-1084** to report any changes. I understand that a change in my information could affect the eligibility for members of my household.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, ______________________________(name of person) is incarcerated.

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We will check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security and/or a consumer reporting agency. If the information does not match, we may ask you to send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow DHS to use income data, including information from tax returns. DHS will send me a notice, let me make any changes and I can opt out at any time.

Yes, renew my eligibility automatically for the next:
☐ 5 years (The maximum number of years allowed)
Or for a shorter number of years:
☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medicaid, ARKids First or the Health Care Independence Program

- I am giving to the Department of Human Services our rights to pursue and receive money from other health insurance, legal settlements or other third parties. I am also giving to the Medicaid agency rights to pursue and receive medical support from a spouse or parent.
- I understand that the Health Care Independence Program is not a federal or state entitlement program and that it may be ended at any time upon appropriate notice.
- Does any child on this application have a parent living outside the home? ☐ Yes ☐ No
  If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell DHS and I may not have to cooperate.

My right to appeal

If I think that DHS has made a mistake, I can appeal its decision. To appeal means to tell someone at DHS that I think the action is wrong and ask for a fair review of the action. I know that I can find out how to appeal by contacting Medicaid at **1-501-682-8622**. I know I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application. The person who filled out Step 1 should sign this application. If you are an Authorized Representative you may sign here, as long as you have provided a signed copy of the DCO-153, Consent for an Authorized Representative.

Signature	Date (mm/dd/yyyy)

Step 6 Mail Completed Application

Mail your signed application to:

DHS Jefferson County
1222 West 6th Street
P.O. Box 5670
Pine Bluff, AR 71611

Or email the application to: 351Jefferson@arkansas.gov

Or you can fax the application to: 1-870-534-3421.

What happens next? We will process your application for Medicaid, ARKids First or the Health Care Independence Program and send you a notice to tell you if your application for coverage has been approved or denied and provide instructions on the next steps needed to complete your health coverage application. If you are not eligible for any of these programs, we will screen your application for potential eligibility for tax credits to help pay for health insurance premiums and then transfer your information to the Health Insurance Marketplace. We will provide instructions on how to complete the application process on the notice we send to you.

NEED HELP WITH YOUR APPLICATION? Call us at **1-855-372-1084**. Para obtener una copia de este formulario en Español, llame **1-855-372-1084**. If you need help in a language other than English, call **1-855-372-1084** and tell the customer service representative the language you need. We will get you help at no cost to you.