ARKANSAS REGISTER

Transmittal Sheet

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Name of Agency Department of Human Services

Department Division of County Operations

Contact Person Boyce Lovett 682-1562

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CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted In Compliance with Act 434 of 1967 As Amended.

Signature

Director, Division of County Operations
Title

05-16-97
Date

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SHARON PRIEST
SECRETARY OF STATE
STATE OF ARKANSAS
BY

MANUAL TRANSMITTAL

Arkansas Department of Human Services

Division of County Operations

☒ Policy ☐ Form ☐ Policy Directive **Issuance Number MS 97-7**

Medical Services Policy Manual **Issuance Date 10-01-97**

From: Roy Hart, Director **Expiration Date Until Superseded**

Subj: Revised Policy

Pages to be Deleted	Dated	Pages to be Added	Dated
MS 2093-2095	8/1/94	MS 2093-2095	10/1/97
MS 2095-2100	8/1/94	MS 2095-2100	10/1/97
MS 3301-3330 (14 pages)	11/1/95	MS 3301-3330 (14 pages)	10/1/97

Summary

MS 2095: References to aliens who are Permanently Residing Under Color of the Law (PRUCOL) are deleted from policy. Clarification of the treatment of income and standard of needs is also provided. Other terminology regarding alien status is updated to reflect current law.

MS 3310 #3: Effective 10/1/97, only citizens, some legal aliens residing in the United States prior to 8/22/96, and some individuals documented and found eligible as qualified aliens (as defined by P. L. 104-193 and P.L. 105-32) may be certified for Medicaid, unless approved for emergency services only.

MS 3321: Primary evidence of age is now limited to birth certificates established before age five. Alternative evidence is simplified to include any other record that shows age or date of birth. This applies to applications made on or after 10-1-97.

MS 3324: County office action in citizenship or alien determinations is changed to reflect requirements imposed by P. L. 104-193. Methods of verifying alien status are detailed, a section on deeming of income to immigrants who are sponsored by individuals is included, and provisions concerning Medicaid eligibility for terminated SSI recipients is added.

As each active Medicaid case that includes an immigrant who entered the U.S. on or after 8/22/96 becomes due for reevaluation, the record will be checked for verification of U.S. citizenship or alien status, and a signed declaration of citizenship or satisfactory immigration status. If there is no verification and/or declaration of status, the individual will be required to provide verification from INS of his or her immigration status and/or to complete a DCO-9. The individual will be notified by DCO-700 that failure to provide this information will result in case closure in 30 days.

If an individual does not provide the information until after the case has been closed and it can be determined that he or she is a citizen or meets the criteria outlined at MS 3310 #3 as a qualified alien, the case may be reopened back to the date of closure (Action Reason 096).

If an individual provides the requested verification within 30 days and it is determined that he or she does not qualify for continuing Medicaid, the case will be closed after appropriate notice.

For cases certified prior to 10/1/97, determinations of citizenship/alienage status will be done at the next case change or reevaluation.

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At reevaluation, all eligibility factors (including appropriateness of care and cost effectiveness) will be redetermined (Re. MS 2090.1). Disability will be redetermined as specified in MS 2090.4. Completion of forms DCO-777, DCO-662, DCO-75, DCO-662, DCO-707, DCO-769, DCO-2602 and DCO-2603 is necessary at reevaluation. The DCO-87 must be coded for the next reevaluation, MRT reexamination, or any expected changes.

2094 Change/Closure

When a change occurs that affects eligibility, the county office worker will notify the TEFRA Committee when closure will be made. A copy of the DCO-700 used to notify the individual or a memorandum (when an DCO-55 is sent) will be used for the OMS notification.

Ten day advance notice of closure via the DCO-700 or DCO-55 will be given, unless advance notice is not required (Re. MS.3633). Form DCO-57 will be completed for the close (C) action effective the date notice expires.

* 2095 Emergency Services for Aliens

Aliens who are not qualified aliens(as defined at MS 3310 #3) are eligible for emergency services only if the following conditions are met.

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

   . Placing the patient's health in serious jeopardy,

   . Serious impairment to bodily functions, or

   . Serious dysfunction of any bodily organ or part.

2. To be eligible for emergency services, an alien meeting the medical criteria in paragraph 1 also must meet all other eligibility requirements for Medicaid (categorical, income, resources, etc.) as set forth in the State's approved plan, with the exception of citizenship/alienage requirements, and Social Security enumeration.

   Verification and documentation of the emergency condition must be obtained through the attending physician's statement that the alien met the criteria in paragraph 1. In addition, the alien will provide other supporting documentation of the emergency that may include hospital and emergency room records, ambulance receipts, collateral statements, media reports, etc.

   If certified in a family type Medicaid category, only the alien(s) with the emergency medical condition(s) may be entered in closed status for fixed eligibilty as an eligible member(s); all other citizen or qualified alien family members included in the budget will be entered in closed status with no medical eligibility.

   NOTE: When determining eligibility for an adult, deem the income of a non-qualified alien spouse to the applicant, but do not include his or her needs in the need 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.

When determining eligibility for a child, deem the income of a non-qualified alien parent(s) to the applicant, but do not include needs of the parent(s) in the need standard. Income of a citizen or qualified alien parent(s) must be counted in full, with the needs included. The income and needs of non-qualified alien siblings will be disregarded. A citizen or qualified alien sibling's income and needs may be included if needed.

A period of eligibility will be granted only to cover the period of time in which the necessity for emergency services existed. The period of eligibility will be a fixed retroactive period, and Medicaid begin and end dates will be entered.

The certified alien(s) will be eligible for all medical services relating to the emergency, including transportation.

2100 Medicaid Eligibility Prior to Month of Application - Retroactive Eligibility

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 services in the retroactive period; and

2. were eligible in the month the 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 AAS/ACS, DDS/ACS, QMB, SMB, QDWI, and PW-PE Retroactive coverage for Newborns will not be given prior to the date of birth.

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 County Office 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 Title XIX Utilization Review standards as all other services financed under the State's Title XIX 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. Medical necessity (Re. 3350).

The case record must document that both these requirements have been met before facility services can be authorized.

3310 Establishing Categorical Eligibility

Current recipients of U-18, SSI, and Foster Children (Cat. 91 and 92) 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 case 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 will be contacted.

Categorical eligibility for individuals other than U-18, 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). Re. MS 3320. 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. For 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, and the George W. Jackson Center in Jonesboro. 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:

   a. Aged - Age 65 or older (Re. 3321);

   b. 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. 3322); or

   c. 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:

      (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 (Re. 3322 or 3322.1, and 3323);

* 3. Citizenship or Alien Status (Re. MS 3324) - Under the provisions of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193), enacted August 22, 1996; and the Balanced Budget Reconciliation Act of 1997 (P.L. 105-32), enacted August 5, 1997; Medicaid eligibility will be granted only to an individual who is documented and found eligible as one of the following:

a. **Citizen of the United States:** For Medicaid determinations, the United States is defined as the 50 states, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, and the Northern Mariana Islands. Nationals from American Samoa or Swain's Island are also regarded as United States citizens;

b. **Legal alien who was receiving Medicaid on 8/22/96:** An individual who was lawfully residing in the United States on 8/22/96 may continue to receive Medicaid benefits in the future. This applies to both aged and disabled current recipients;

c. **Legal alien who was residing in the United States on 8/22/96, and who subsequently becomes blind or disabled:** An individual who was lawfully residing in the United States on 8/22/96, and who subsequently becomes blind or disabled, may receive Medicaid benefits in the future;

d. **Non-qualified alien who is in need of emergency services:** An individual who does not meet alienage requirements, including nonimmigrants and individuals paroled for less than one year, may receive treatment for only emergency medical conditions, provided that they meet all eligibility requirements other than the alienage requirements (Re. MS 2095). Organ transplants and routine prenatal or postpartum care cannot be provided under the emergency services provisions. However, all labor and delivery is considered emergency labor and delivery;

e. **Qualified alien (including Cuban, Haitian, and Amerasian entrants) who entered the United States prior to 8/22/96 who is in one of the following eligible categories:**

(1) LAPR: lawfully admitted for permanent residence under the Immigration and Nationality Act,
(2) parolee: paroled into the United States under Section 212(d)(5) of the Act for at least one year,
(3) conditional entrant: granted conditional entry pursuant to Section 203(a)(7) of such Act as in effect prior to 4/1/80,
(4) asylee: granted asylum under Section 208 of the Act,
(5) refugee: admitted as a refugee to the United States under Section 207 of the Act,
(6) individual whose deportation is being withheld: granted withholding of deportation under Section 243(h) of the Act, or

(7) veteran or active duty serviceperson, his or her spouse and dependent children: a veteran with an honorable discharge from the United States Armed Forces whose discharge was not on account of alienage or individuals on active duty (not training) with the United States Armed Forces, their spouses and unmarried dependent children; or

f. **Qualified alien (including Cuban, Haitian, and Amerasian entrants) who entered the United States on or after 8/22/96 who is in one of the following eligible categories** (NOTE: Qualified aliens who entered the United States on or after 8/22/96 are not eligible for Medicaid for a period of five years, with the exceptions listed below. After the five year ban expires, LAPRs, parolees, and conditional entrants may be found eligible for Medicaid.):

(1) asylee,
(2) refugee,
(3) individual whose deportation is being withheld, or
(4) veteran or active duty serviceperson, his or her spouse and dependent children;

4. Residency - It must be verified that the individual is an Arkansas resident (Re. MS 2200);

5. Resources - Countable resources cannot exceed $2000 for an individual and $3000 for a couple.

NOTE: The resource standards above apply to all AABD Medicaid categories (the resource standards are doubled for QMBs, SMBs, and QDWIs), except when one spouse enters LTC and the other does not (Re. MS 3337-3338) or when both spouses enter LTC in the same month. When both spouses enter LTC in the same month, 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 (Re. MS 3330.1);

6. Income - The individual's gross income cannot exceed the maximum income limit allowed for federal financial participation. The income limit for LTC is three times the SSI payment standard. However, individuals with income over the limit may be eligible if they have established an income trust (Re. MS 3336.9);

7. Assignment of Medical Support (Re. MS 1350);

8. Cooperation with Child Support Enforcement Activities (Re. MS 1310); and

9. Social Security Enumeration (Re. MS 1390).

3320 Verification of Institutional Status

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. 3310).

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 3420).

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.

* 3321 Verification of Age

Use primary evidence when possible; if not, use alternative evidence.

1. Primary evidence of age consists of a birth certificate established before age five.

2. Alternative evidence of age consists of any other record which shows age or date of birth (e.g., Social Security record established at least five years before application date, family Bible recorded before age 36, school record, census record, delayed birth certificate, insurance policy taken out before age 21, arrival record, newspaper birth announcement, driver's license, etc.)

3. Best Evidence

To overcome a material discrepancy in the age of an individual, usually the earliest recorded document is used. (Note: Written documentation is necessary).

4. Proof of Age by Social Security Administration

The County Office will accept SSA date of birth when:

a. It has a State Data Exchange Record on ACES with the date of applicant's birth (i.e. the applicant has received SSI and a record exists on ACES for that eligibility);

b. It has a statement from the local SSA Office stating that SSA has verified date of birth; or

c. It has a WTPY Response verifying date of birth.

3322 Verification of Blindness or Disability

Blindness or 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 check. Verify by SSI Award Letter, SSA-1610, "SSI Recipients" printout, or WTPY Response;

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 check. Verify by SSA Award Letter, SSA-1610, or WTPY Response;

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 mental impairment 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 (Re. 2090); or

5. Blindness or Disability determination by the Medical Review Team. The DCO-109 (Report of Medical Review Team decision) must be filed in the record.

The type of documentation used will be entered into the case narrative and a copy filed in the case records, if available.

3322.1 SSA vs. MRT Disability Decisions

The following disability guidelines will apply to all AD 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 3322.3.

3322.2 Referrals to SSA

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, for reconsideration or reopening of a determination, all applicants who allege new information or evidence which affects previous SSA determinations of "not disabled", except in cases specified in 3322.3. When the conditions in 3322.3 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.

3322.3 Applications Which Will Require An MRT Decision

When individuals apply for Medicaid and meet one or more of the conditions below, the DCO-106, DCO-107's and/or DHS-81's, and DCO-108, along with copies of the Social Security Disability or SSI denial letter (if applicable and available) and WTPY, if appropriate, will be submitted to MRT (Re. MS 3323), provided it appears that the other eligibility factors are met.

The Agency will determine eligibility if any one of the following conditions exists:

a. The individual has NOT applied for Social Security Disability or SSI;

b. The individual has been found NOT eligible for Social Security Disability or SSI for reasons other than disability (e.g., income);

c. The individual has applied for Social Security Disability or SSI, and SSA has NOT made a determination;

d. The individual alleges a NEW disabling condition which is different from (or in addition to) the condition considered by SSA in its previous determinations;

e. 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

f. 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;

   (1) 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

   (2) The individual no longer meets the non-disability Social Security Disability or SSI requirements (e.g., income).

AD 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.

3322.4 Verification of Social Security Disability or SSI Status

To verify the Social Security Disability or SSI status of an individual the county will:

a. Request from the applicant all denial letters or other correspondence received from SSA. The denial letter is a 2-page letter which states on the 2nd page what disability was alleged and what the SSA determination was.

b. Check the WSSN and WASM Screens to determine whether the individual has an open or closed SSI case.

c. Utilize the WQRY screen if the client does not have a denial letter or other SSA correspondence and the individual is not shown on WASM as an eligible SSI recipient. The WTPY response will usually show the date of Social Security Disability or SSI application, if one has been made within the past year, and the disposition of that application (sometimes denials are purged from the SSA system in less than a year from application).

The pay status code series beginning with "N"s are the denial codes on WTPY. A brief description of the denial code is included on the query response.

3322.5 Dual Applications

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 Medicaid application to make this determination. While an MRT decision is pending, the county office worker 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 county may certify the case for Medicaid. To verify that no SSA decision has been made, the WASM screen will be checked, if appropriate, and the individual or authorized representative will be contacted by mail or telephone prior to certification.

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 county certifies 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 the county, except to notify MRT that no future reexamination is required, if appropriate.

3323 Procedure for Verification by Medical Review Team

The following procedures will be followed for verification of blindness or disability through the Medical Review Team. The disability onset date will be indicated on the

3323.1 For Blindness

1. The county office worker 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 self-addressed envelope with the County Office address will be provided for return of the DCO - 701 after completion.

2. Upon receipt of the completed DCO-701, the county office worker will check it to assure that all items of identifying information are completed. If necessary, the worker 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 worker 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 case narrative.

3323.2 For Disability

1. 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 or the George W. Jackson Center, Jonesboro), complete Form DHS-81 (Consent for Release of Information). The Medical Review Team will request medical information from these institutions. A separate DHS-81 must be completed for each institution.

2. 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 DHS-81. If an applicant goes to a physician regularly, in lieu of another physical examination, a DHS-81 may be used to obtain copies of the records from the physician (no DCO-107 needed).

   The county office worker 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 stamped envelope addressed to the county office 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 county office worker should report this on the DCO-108 Social Report.

3. Complete Forms DCO-106 and DCO-108 (Social Report). These must be completed for all cases submitted to the Medical Review Team.

4. Attach the following to the completed DCO-108 and DCO-106: DCO-107 and/or DHS-81, and any other medical information which the applicant wishes to provide or which is available in the county office files. Send these to the Medical Review Team.

3323.3 Medical Review Team (MRT) Decision

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.

3323.4 Reapplication Due to Mental or Physical Incapacity

If a reapplication is filed and the case has been closed within the past five years for reasons other than disability and the last Form DCO-109 stated, "Re- examination 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.

3323.5 Reexamination of Disability by the Medical Review Team (MRT)

When 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, the MRT will require reexamination. Whether or not required by MRT, reexamination may be requested by the county office at any time for the aforementioned reasons.

In either case, it is the responsibility of the county office to initiate the reexam by submitting current medical and social information (DCO-106, DCO-108A, and DCO-107 and/or DHS-81) to MRT.

3323.6 Reexamination Required by the Medical Review Team (MRT)

When indicated on the DCO-109, the county office will key the appropriate date to WALR for future action. The county office 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 month in which the reexamination was required, the case will remain open pending receipt of the MRT decision.

3323.7 Reexamination Resulting from Substantial Gainful Activity

Substantial gainful activity (SGA) is defined as the performance of significant physical and/or mental work activities for pay or profit, or in 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 deducts) 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 handicapped individuals 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 a Month - When average countable monthly earnings are less than $300 a 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 $500 a Month - When average countable monthly earnings from nonsheltered employment fall within the $300 to $500 a 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 $500 a month according to pay scales in the community.

   When "a." or "b." occur in a nonsheltered employment situation (or if gross earnings include a subsidy), reexam will be initiated by submitting current medical and social information to MRT.

   When average countable monthly earnings from sheltered employment fall within the $300 to $500 a month range, the work is not ordinarily SGA. However, if earnings include a subsidy, the sheltered worker will also be reexamined by MRT.

3. Countable Earnings of More Than $500 a Month - When average countable monthly earnings are more than $500 a 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 close the case as the individual no longer meets the criteria for disability (Re. 3310). Advance notice will be given on the DCO-700.

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* 3324 Verification of Citizenship or Alien Determinations

All applicants must provide proof of citizenship or qualified alien status, along with a signed declaration of citizenship or satisfactory immigration status, before a case can be certified. If an individual does not have current documents from the Immigration and Naturalization Service (INS), advise him or her to contact INS for replacement documents if it is believed that the individual is a qualified alien. The following is the INS address:

Immigration and Naturalization Service
ATTN: Status Verifier/SAVE
245 Wagner Place, Suite 250
Memphis, TN 38103

1. Methods of Verifying Citizenship - Citizenship may be verified by any document which shows the place of birth. One document is sufficient. A copy of the document used to verify citizenship will be retained in the case record. The document may be the same as that used to verify the date of birth. Acceptable evidence of citizenship include:

   a. Birth records,
   b. Baptismal or other religious records,
   c. Report of Birth Abroad of a Citizen of the U.S. (Form FS-240),
   d. Consulate Report of Birth or Certification of Birth (Form I-97),
   e. Naturalization papers, or
   f. Certificate of Citizenship (Form N-560 or N-561).

2. Methods of Verifying Alien Status - Verification needed to establish alien status is as follows:

   a. Lawfully Admitted for Permanent Residence: I-551 (Green Card or, for recent arrivals, a temporary I-551 stamp on a foreign passport or on Form I-94).

   b. Refugee: INS Form I-94 annotated "Admitted as a refugee pursuant to Section 207 of the INA;" INS Form I-688B or I-766 annotated "274a.12(a)(3);" or Form I-571.

   c. Asylee: Form I-94 annotated "Asylum status granted pursuant to Section 208 of the INA;" a grant letter from the Asylum Office of the INS; Form I-688B or I-766 annotated "274a.12(a)(5);" or an order of an immigration judge granting asylum. If a court order is presented, verify that the order was not overturned on appeal by sending a G-845 to INS, attaching a copy of the document.

   d. Parolee Status Granted for at Least One Year: Form I-94 showing that the bearer has been paroled pursuant to Section 212(d)(5) of the INA, with an expiration date of at least one year from the date issued or indefinite.

   e. Deportation Withheld: An immigration judge's order showing deportation withheld under Section 243(h) and date of the grant; or FormsI-688B or I-766 annotated "274a.12(a)(10)." If a court order is presented, verify that the order was not overturned on appeal by sending a G-845 to INS, attaching a copy of the document.

   f. Conditional Entry: Form I-94 bearing the stamped legend "REFUGEE--CONDITIONAL ENTRY" and a citation of Section 203(a)(7); or Forms I-688B or I-766 annotated "274a.12(a)(3)."

g. Honorable Discharge: A U.S. military discharge certificate (DD Form 214) that shows character of service as "Honorable" and does not show, in the narrative reason for discharge entry, that the discharge was based on alien status, lack of U.S. Citizenship, or other "alienage" reason.

h. Active Duty Member of the Armed Forces: The green service identity card (U.S. Form DD-2) or (rarely) red service identity card and copy of current orders showing active duty (not active duty for training purposes only).

i. Five Year Expiration: Form I-94 with date of admission on the refugee stamp. If missing, contact INS to verify the date of admission with a G-845, attaching the document.

j. Legal Alien Lawfully Admitted for Permanent Residence Prior to 8/22/96: INS Form I-551 or I-151; Form AR-3 and AR-3A (earlier versions of the I-551) if endorsed to show lawful admission; or Reentry Permit.

k. Legal Alien Permanently Residing Under Color of the Law (PURCOL) Prior to 8/22/96: I-94; I-181; I-210; I-220B; INS letter, passport properly endorsed; court order by an immigration judge; or any proof that an individual entered the United States prior to January 1, 1972, and has continuously resided in the United States since entry.

l. Legal Alien with Lawful Temporary/Permanent Resident Status Prior to 8/22/96 Under the Immigration Reform and Control Act of 1986 (P.L. 99-603): I-688A; I-688; or I-551 or I-151.

3. Deeming of Income - In determining eligibility for LAPRs, parolees, and conditional entrants after the five year ban expires, the income and resources of the alien's sponsor and the sponsor's spouse must be considered as fully available to the alien and his or her family when the sponsor has executed a new legally binding affidavit of support.

Deeming applies only to immigrants who are sponsored by individuals. Deeming will not apply to battered immigrants or to those who would be indigent (unable to obtain food and shelter without assistance) because their sponsors are not providing adequate support.

4. Medicaid Eligibility for Terminated SSI Recipients - The alienage requirements of P.L. 104-193 are somewhat different for SSI than for Medicaid. Medicaid has some options under the law that are not allowed for SSI.

The only aliens qualified to receive SSI are refugees, asylees, and noncitizens whose deportation has been withheld (subject to a five year eligibility limit); honorably discharged veterans, active duty armed forces personnel, their spouses and dependent children; and lawfully admitted aliens who have 40 qualifying work quarters for SSA purposes.

The Social Security Administration (SSA) sent active SSI beneficiaries notice in February and March 1997, to advise them that SSA will be reviewing their citizenship or immigrant status. If the recipients were not in one of the eligibility categories, they received a second notice after a period of 90 days telling them that their benefits were terminated. If recipients appeal this action by SSA, their benefits can continue during their appeal.

If an individual whose SSI benefits and Medicaid have been terminated by SSA comes to a county office to apply, the county must look at all Medicaid categories to determine if the individual would qualify (e.g., QMB, SMB, Medically Needy, ElderChoices, etc.). If the individual can meet the alienage requirements along with the other eligibility requirements for a chosen category, the individual may be certified in that category.

3324.1 Declaration of Citizenship or Satisfactory Immigration Status

The Immigration Reform and Control Act (IRCA) of 1986 (P.L. 99-603) requires that, as a condition of an individual's Medicaid eligibility, the individual must declare in writing under penalty of perjury if he or she is a citizen or national of the United States or, if not, that he or she is an alien in satisfactory immigration status. This requirement does not affect the existing citizenship and alienage requirement nor does it affect the verification requirements for citizenship or alienage. Therefore, an allegation of U.S. citizenship must still be verified, and the immigration status of all aliens must be verified.

Each adult applying for or receiving Medicaid assistance must make his or her own declaration of citizenship or satisfactory immigration status. The parent or guardian will make the declaration for all unemancipated persons under the age of 18 or otherwise incapacitated for whom medical assistance is requested. A legal guardian may also make the declaration for minors or for individuals otherwise incapacitated.

The application form will serve as the written declaration of citizenship for the applicant and/or any unemancipated persons under the age of 18. Caseworkers should be alert to the proper completion of the question on the application regarding citizenship for each person. As the declaration of citizenship is an eligibility requirement for the individual, the citizenship question on the application form must be answered for each person who will be an eligible in a Medicaid case.

In LTC cases where the applicant/recipient or the applicant/recipient's legal guardian has completed a DCO-777, no further action is necessary. In instances where an authorized representative other than a legal guardian has signed the DCO-777, the applicant/recipient should sign the DCO-9, unless he or she is physically or mentally incompetent to do so. If the applicant/recipient is unable to sign the DCO-9, then the authorized representative's declaration on the DCO-777 will be accepted as declaration of citizenship.

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

3330 RESOURCES - AABD

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.

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.

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 3336.6). 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 6 full months after the month of receipt (Re. MS 3332.3 #6). SSA lump sum payments also have the 6 month resource exclusion, but will count as income in the month of receipt-Re. MS 3341. 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.

Requests for Legal Opinions Regarding Resources

A legal opinion from the Office of Chief Counsel (OCC), will be requested when the worker, the ES Supervisor, and the DCO Program Support Specialist 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, OCC will be contacted if:

1. Ownership of the resource is questionable, or