0350 OVERVIEW OF MA

0350.05 MANUAL ORGANIZATION

REV:04/1998

The basic policies and procedures to determine eligibility for Aged, Blind, or Disabled individuals or couples (SSI-Related cases) are set forth in this section. Categorically Needy and Medically Needy SSI-Related cases are subject to the income and resource methodologies and limits set forth within this section.

Each determination of eligibility (new, reopening or redetermination) requires a review of resources and income.

Resources and income are also reviewed at the time of a reported change, or when information is received which indicates a change has occurred, or that unreported resources may exist. Certain information must be verified by a review of documentation, with copies of the documentation kept for the case file.

Sections 0350 through 0372 which follow set forth the policies and procedures which govern Medical Assistance eligibility for SSI-Related individuals and couples living in community settings.

- The remainder of this section, OVERVIEW OF MA, briefly summarizes eligibility requirements and lists coverage groups applicable to individuals and couples;

- Section 0352, CHARACTERISTIC REQUIREMENTS, describes the SSI-related characteristic requirements for an individual or member of a couple and the process of verification;

- Section 0354, RESOURCES GENERALLY, contains general provisions which apply to the evaluation of an applicant/recipient's resources -- resource limits, definitions, how resources are distinguished from income, and policies governing the reduction of excess resources;

- Section 0356, EVALUATION OF RESOURCES, contains the First Moment of the Month (FOM) rule and the policies for evaluating specific types of resources;

- Section 0358, SSI-RELATED DEEMING OF RESOURCES, defines resource deeming, and describes how deeming may impact the eligibility determination of a member of a couple and/or child;

- Section 0360, RESOURCE TRANSFERS, defines resource transfers and the conditions under which a prohibited transfer may result in a period of ineligibility for MA payment of long term care;

- Section 0362, INCOME GENERALLY, contains general provisions which apply to evaluation of an applicant/recipient's income -- income limits,

definitions;

- Section 0364, TREATMENT OF INCOME, contains the policies for evaluating specific types of earned and unearned income;

- Section 0366, SSI-RELATED INCOME DEEMING, defines income deeming and describes how income deeming may impact the eligibility determination of a member of a couple and/or child;

- Section 0368, FLEXIBLE TEST OF INCOME, contains the policies governing the spenddown of excess income to achieve Medically Needy MA eligibility;

- Section 0370, Categorically Needy AND Medically Needy COVERAGE GROUPS, describes the eligibility requirements and other specific provisions for the SSI-related coverage groups;

- Section 0372, SPECIAL TREATMENT COVERAGE GROUPS, describes the coverage provisions for Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualifying Individuals (QI-1 and QI-2), and Qualified Disabled Working Individuals (QDWI).

0350.10 ELIGIBILITY REQUIREMENTS

REV:04/1998

To be eligible for Medical Assistance, an individual or couple must meet the program's technical, characteristic, financial and cooperation requirements. The required characteristics for an individual applying for MA are those of the SSI Program -- age (65 or older), blindness, or disability.

To be financially eligible for MA as Categorically Needy, the individual or couple must have countable income and resources within SSI limits. Individuals eligible for and/or receiving SSI are automatically eligible for MA as Categorically Needy.

Medically Needy financial eligibility may be achieved if the individual or couple has income and resources within Medically Needy limits, or has spent down excess income on allowable medical expenses under an Income Flex-Test.

Most MA eligible individuals and couples belong to an SSI-related coverage group. The term "SSI-related" refers to the methodology used for evaluating income and resources, and the standard to be met for MA eligibility. However, some individuals or couples may be eligible without utilizing a strictly SSI-related methodology.

These special treatment coverage groups include Qualified Medicare Beneficiaries (QMB), Special Low Income Medicare Beneficiaries (SLMB), Qualifying Individuals (QI-1 and QI-2) and Qualified Disabled Working Individuals (QDWI) whose income is within a certain percentage of the Federal Poverty Level, and who meet the eligibility requirements of their respective coverage group.

0350.15 COVERAGE GROUPS

REV:01/2002

The following is a summary listing of the Medical Assistance coverage groups applicable to individuals and couples. Following each listing is a reference to the specific section where the requirements of that particular coverage group may be found.

Categorically Needy SSI-related Coverage Groups are:

- SSI-related Recipients (0370.05)
- Deemed SSI Recipients Under 1619(b) of SSA (0370.10)
- Pickle Amendment Eligibles (0370.15)
- Disabled Children Receiving Care at Home (Katie Beckett) (0370.20)
- Disabled Adult Children (0370.25)
- SSI-eligible Non Cash Recipients (0370.30)
- SSI-eligible but for MA Prohibited Rules (0370.35)
- State Supplement Recipients Based on 12/73 AABD (0370.40)
- Disabled Widowers SSI-ineligible Due to Actuarial Changes (0370.45)
- Protected Widowers Age 60 through 65 (0370.50)
- Disabled Widow(ers) and Surviving Divorced Spouses Who Lose SSI or SSP (0370.55)
- Disabled Children Receiving IV-E Adoption Subsidy (0370.60)
- Refugee Medical Assistance (0370.65)

Poverty Level SSI-related Coverage Group:

- Low-Income Aged and Disabled Individuals (0370.70)

Medically Needy SSI-related Coverage Groups are:

- Aged, Blind or Disabled Individuals (0370.75.05)
- 12/73 Blind or Disabled Individuals (0370.75.10)

Special Treatment Coverage Groups are:

- Qualified and Specified Low Income Medicare

Beneficiaries (0372.05)

- o Qualified Disabled Working Individual (0372.10)
- o Qualifying Individual, QI-1 and QI-2(0372.15)
- o Title XV Coverage Group (0372.30)

0352 CHARACTERISTIC REQUIREMENTS

0352.05 ELIGIBILITY BASED ON AGE

REV:01/2002

To qualify for Medical Assistance, an individual or member of a couple must be age 65 years or older, blind or disabled.

The age, as stated on the application, is to be verified.

Appropriate sources of verification are:

- o Birth certificate;
- o Birth record of a child over 50 as evidence that the parent is over 65;
- o Birth record of a child where age of parent is recorded;
- o Marriage certificate; or
- o Other documents such as insurance policies, passport or naturalization papers, employment, school, military, alien registration records, or electronic information obtained from the Social Security Administration via SVES.

In the absence of any of the above, the eligibility supervisor will evaluate the age requirement.

0352.10 ELIGIBILITY BASED ON BLINDNESS

REV:06/1994

To be eligible on the basis of blindness, the individual's (adult or child) vision must meet the policy definition: in terms of ophthalmic measurement, central vision acuity of 20/200 or less in the better eye with corrective lenses, or a field defect in which the peripheral field is contracted to such an extent that the widest diameter of visual field subtends an angular distance no greater than 20 degrees.

0352.10.05 Sources of Verif of Blindness

REV:01/2002

The Services for the Blind and Visually Impaired Agency in the Department of Human Services has current eye examinations on blind persons known to them. Therefore, when eligibility is being determined on the basis of blindness, the medical

examination report on file in Services for the Blind and Visually Impaired can be used, with the knowledge and consent of the applicant documented on the DHS-25.

A current finding of eligibility for RSDI or SSI based on blindness is acceptable verification of blindness. A copy of the report should be obtained from RSDI or SSI with the knowledge and consent of the applicant (DHS-25).

If verification is not available through Services for the Blind and Visually Impaired, or through RSDI or SSI eligibility, an examination is required with a report by the examiner (Form AP-104 or Form AP-105).

0352.10.10 Process of Verifying Blindness

REV:01/2002

If a blind applicant under age 65 comes into the office, the method of verifying the eligibility factor can be explored with the applicant and the proper form processed.

If the application is received by mail, a letter (AP-705A) explaining what is needed is mailed, with the following enclosed:

- o AP-706A - A statement of how the verification will be obtained; and,
- o DHS-25 - Authorization to Obtain or Release Confidential Information (2 copies);
- o AP-104 - Optometrist's Report of Eye Examination (2 copies);
- o AP-105 - Ophthalmologist's Report of Eye Examination (2 copies).

If upon return of the AP-706A, the applicant indicates that verification is available from Services for the Blind and Visually Impaired, RSDI or SSI, a letter will be sent requesting the verification, with a copy of the completed DHS-25 enclosed.

If an eye examination is performed, when the forms are received in the district office, both copies of the completed AP-104 or AP-105 are sent to the Office of Medical Review at Central Office.

Following a decision by the Office of Medical Review, the forms are returned to the district office where appropriate action is taken with respect to eligibility. One copy of the form is filed in the case folder. The second copy is forwarded to Rhode Island Services for the Blind and Visually Impaired. If the AP-706A Requested a referral, and a DHS-25 is completed, a copy of the form is sent to the agency indicated to enable that agency to offer appropriate services.

0352.15 ELIG BASED ON DISABILITY

REV:06/1994

To be eligible for Medical Assistance because of permanent or total disability, a person must have a permanent physical or mental impairment, disease or loss, other than blindness, that substantially precludes engagement in useful occupations or appropriate activities (for children), within his/her competence.

A physical or mental impairment is an impairment which results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable, clinical and laboratory diagnostic techniques.

For purposes of eligibility, an individual is disabled if s/he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted, or can be expected to last for a continuous period of not less than twelve (12) months or, in the case of a child, if s/he suffers from any medically determinable physical or mental impairment of comparable severity.

Statements of the applicant, including the individual's own description of the impairment (symptoms) are, alone, insufficient to establish the presence of a physical or mental impairment.

0352.15.05 Impair Constituting Disability

REV:06/1994

Whether or not an impairment in a particular case constitutes a disability, as defined in Section 0352.15, is determined from all the facts of that case. Primary consideration is given to the severity of the individual's impairment. Consideration is also given to such other factors as the individual's age, education and work experience. Medical consideration alone can justify a finding that the individual is not under a disability where the only impairment is a slight neurosis, slight impairment of sight or hearing, or other slight abnormalities. On the other hand, medical considerations alone (including physiological and psychological manifestations of aging), can, except where other evidence rebuts a finding of "disability," e.g., the individual is actually engaging in substantial gainful activity, justify a finding that the individual is under a disability where the impairment is one that meets the duration requirement, and is one compatible with impairments recognized by the Social Security Administration. (This is determined by the Office of Medical Review at Central Office.)

0352.15.10 Impair Prevents Gainful Act

REV:06/1994

Conditions which constitute neither a recognized impairment nor the medical equivalent of a recognized impairment may be found disabling if they do, in fact, prevent the individual from engaging in any substantial gainful activity. Such an individual shall be determined to be under a disability only if the physical or mental impairment(s) are the primary reason for an inability to engage in substantial gainful activity. In such a case it must be established that the physical or mental impairment(s) are of such severity, i.e., result in such lack of ability to perform significant functions as moving about, handling objects, hearing, speaking, reasoning and understanding, that the individual is not only unable to do any previous work s/he may have done or work commensurate with any such previous work, but the individual cannot, considering age, education, and work experience, if any, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which the individual

lives, or whether a specific job vacancy exists, or whether the individual would be hired if s/he applied for work. For the purposes of the preceding sentence, work "exists in the national economy" with respect to any individual, when such work exists in significant numbers either in the region where the individual lives or in several regions of the country. Thus, isolated jobs of a type that exist only in very limited number or in relatively few geographic locations shall not be considered to be "work which exists in the national economy" for purposes of determining whether an individual is under a disability; an individual is not denied benefits on the basis of the existence of such jobs.

Accordingly, where an individual remains unemployed for reason(s) not due to physical or mental impairment but because of failure to obtain work s/he could do; or because work within his/her competence does not exist in the local area; or because of the hiring practices of employers, technological changes in the industry in which the individual has worked, or cyclical economic conditions; or because there are no job openings or the individual would not actually be hired to do the work s/he could otherwise perform, the individual may not be considered under a disability as defined above.

0352.15.15 Impair Prevents Gainful Work

REV:06/1994

Where an individual with a marginal education and long work history (e.g., 35 to 40 years or more) limited to the performance of arduous unskilled physical labor is not working, and is no longer able to perform such labor because of a significant impairment(s), and considering age, education, and vocational background is unable to engage in lighter work, such individual may be found to be under a disability. On the other hand, a different conclusion may be reached where it is found that such individual is working or has worked despite an impairment(s) (except where such work is sporadic or is medically contraindicated), depending upon all the facts in the case. In addition, an individual who was doing heavy physical work at the time such impairment was suffered might not be considered unable to engage in any substantial gainful activity if the evidence shows that training or past work experience qualifies the individual for substantial gainful work in another occupation consistent with the impairment(s), either on a full-time or a reasonably regular part-time basis.

0352.15.20 Disability Determination

REV:08/1999

When a DHS-2 indicates that an individual is disabled, a determination is made as to whether the applicant meets the criteria for disability as defined in Title XVI of the Social Security Act.

Individuals who receive RSDI or SSI based on disability meet the criteria for disability. A copy of the award letter or similar documentation from the Social Security Administration is acceptable verification of the disability characteristic. A current finding of eligibility for RSDI or SSI based on blindness is acceptable verification of blindness.

For individuals who were receiving SSI based on disability and were closed upon entrance into a group care facility because their income exceeds the SSI standard for

individuals in group care, a copy of the SSI award letter serves as verification of the disability characteristic.

For all others, a disability review must be completed and a positive finding of disability must be made before eligibility for MA based on disability can be established. In such cases, it is the responsibility of the agency representative to provide the applicant with the following:

- Form letter AP-125, explaining the disability review process;
- Form MA-63, the Physician Examination Report with instructions;
- Form AP-70, the applicant's report of Information for Determination of Disability;
- Three copies of form DHS-25M, Release of Medical Information; and,
- A pre-addressed return envelope.

When returned to DHS, the completed forms and/or other medical or social data are date stamped and promptly transmitted under cover of form AP-65 to the Medical Review Team (MART) at Central Office. If the completed forms are not received within thirty (30) days of application, a reminder notice is sent to the applicant to remind them that medical evidence of their disability has not been provided and needs to be submitted as soon as possible. If all completed forms are not received within forty-five (45) days from the date of application, the referral to MART is made with the documentation received as of that date.

It is the responsibility of the applicant to provide medical and other information and evidence required for a determination of disability. The applicant's physician may submit copies of diagnostic tests which support the finding of disability. The physician may also choose to submit a copy of the applicant's medical records or a letter which includes all relevant information (in lieu of or in addition to the MA-63).

The Medical Review Team is responsible to:

- Make every reasonable effort to assist the applicant in obtaining any additional medical reports needed to make a disability decision. Every reasonable effort is defined as one initial and, if necessary, one follow-up request for information. (The applicant must sign a release of information giving the MART permission to request the information from each potential source in order to receive this assistance.)
- Analyze the complete medical data, social findings, and other evidence of disability submitted by or on behalf of the applicant;
- Provide written notification to the applicant when a decision on MA eligibility cannot be issued within the

ninety (90) day time frame because a medical provider delays or fails to provide information needed to determine disability;

- Issue a decision on whether the applicant meets the criteria for disability based on the evidence submitted.

The decision regarding disability is recorded on the AP-65 and transmitted along with the MART case log to the appropriate DHS field office where the agency representative issues a decision on MA eligibility. All medical and social data is retained by the Medical Review Team.

0354 RESOURCES GENERALLY

0354.05 RESOURCE LIMITS

REV:01/2002

Each determination of eligibility (new, reopening or redetermination) requires a review of resources, which includes sending at least one bank statement (AP-91). Resources are also reviewed at the time of a reported change, or when information is received which indicates a change has occurred, or that unreported resources may exist (Income Eligibility Verification System match, etc.). Resources must be verified by a review of documents related to the resource, with copies of the documentation kept for the case file.

The Resource limits for individuals and couples are:

CATEGORICALLY NEEDY RESOURCE LIMITS*

Resource	Individuals	Couples
Real Property and Personal Property	$2,000	$3,000
Property Essential for Self-Support	Excluded	
Burial Spaces	Excluded	
Life Insurance	$1,500	$1,500(each)
Burial Set-Aside	Up to $1,500 Individual & Spouse (See Limits in Section 0356.45).	
Home and Adjoining Land	Excluded as a resource if living in it.	
Automobile	One is potentially excludable based on use. Otherwise, the FAIR MARKET VALUE up to a threshold of $4,500 is excluded. (Section 0356.30)	

RSDI Retroactive Payments	Excluded for up to six (6) months under provisions in Section 0356.60.

* Note: The Low Income Aged and Disabled Coverage Group (Section 0370.70), entitled to the Categorically Needy scope of services, is subject to the Medically Needy Resource Limit.

MEDICALLY NEEDY RESOURCE LIMITS - ALL GROUPS

RESOURCE	INDIVIDUAL	COUPLE
Basic Limit	$4,000	$6,000
Life Insurance	$4,000 Face Value for each individual. If Face Value(s) exceeds this threshold, evaluate as per Section 0356.20.	
Burial Set-Aside**	Up to $1,500 each individual (See limits in Section 0356.45).	
Automobile	One is potentially excludable based on use. Otherwise, the FAIR MARKET VALUE up to a threshold of $4,500 is excluded. (Section 0356.30)	
RSDI Retroactive Payments	Excluded for up to six (6) months under provisions in Section 0356.60.	
Tangible Personal Property (personal valuables, antiques, jewelry, pleasure boats, etc.)	$5,000 threshold limit per household.	

0354.10 RESOURCE DEFINITIONS

REV:06/1994

A RESOURCES is either real or personal property which the applicant/recipient can use (either directly or by sale or conversion) to provide for his/her basic needs for food, clothing, shelter or medical care. Third Party Resources for medical care, such as health insurance, are not countable resources in eligibility determinations.

- o REAL PROPERTY is land and generally whatever is erected or growing upon or attached to land. Real property also includes any interest in land. Examples of real property and interests in land include a lot with or without a house, a life estate, a remainder estate, mineral rights, easements, and leaseholds.

- PERSONAL PROPERTY in a broad sense is everything that is subject to ownership that is not real property. It includes tangible and intangible personal property.

  - TANGIBLE PERSONAL PROPERTY includes movable and tangible things such as animals, furniture, automobiles, jewlery, boats, and merchandise.

  - INTANGIBLE PERSONAL PROPERTY includes such rights as stock, bonds, savings accounts, checking accounts, certificates of deposit, cash, and promissory notes.

0354.10.05 Countable/Excluded Resources

REV:06/1994

Resources are further defined based upon whether they are countable or excluded in the process of determining eligibility for Medical Assistance.

- COUNTABLE RESOURCE: A resource, whether real or personal property, that is counted toward a resource limit. Countable resources are available to the applicant, and are not excluded;

- EXCLUDED RESOURCE: A resource that is not counted toward the resource limit because of a specific exclusion in policy. Some resources are totally excluded regardless of value (e.g. the home of an applicant, or an automobile used for transportation for medical care); some resources are excluded to the extent they do not exceed a specific threshold amount (e.g. life insurance face value limit). See Section 0356, EVALUATION OF RESOURCES.

0354.10.10 Resource Transfer

REV:06/1994

A RESOURCE TRANSFER is the conveyance of right, title, or interest in either real or personal property from one person to another.

The conveyance may be by sale, gift, or other process.

0354.10.15 Compensation/Consideration

REV:06/1994

COMPENSATION/CONSIDERATION is all real and/or personal property, or any other right or item of value that is received by an applicant/recipient pursuant to a binding contract in exchange for a resource. The recipient may receive the consideration or compensation prior to, at the time of, or after the transfer.

Items of value that serve as consideration or compensation include money, food, shelter, services, stocks, bonds, etc.

0354.10.20 Fair Market Value (FMV)

REV:06/1994

The Fair Market Value (FMV) of property (real and personal) is the amount for which the property can be expected to sell on the open market in the geographic area involved and under existing economic conditions at the time of the determination.

0354.10.25 Equity Value

REV:06/1994

Equity value is the FMV less the amount of any legal encumbrances.

0354.10.30 Uncompensated Value (UV)

REV:06/1994

The Uncompensated Value (UV) is the Equity Value of a transferred resource minus the amount of compensation/consideration received by the applicant/recipient in exchange for the resource.

0354.15 DIFFER/RESOURCES FROM INCOME

REV:06/1994

Resources are items such as property, cash, bank accounts, other financial instruments, real estate, buildings, etc. that are owned by or available to individuals. Resources must be distinguished from income. The general rule is: A RESOURCE is that which is owned at the beginning of the month. INCOME is that which is received during the month. Income that is not spent within the month in which it is received becomes a resource at the beginning of the next month.

0354.20 RESOURCE CONVERSION OR SALE

REV:06/1994

A resource that is converted from one form to another does not result in income to the applicant. A previously excluded resource may become a countable resource if converted into another form (e.g. an excluded auto is sold for $400 in cash. The cash received becomes a countable resource - not income). Conversely, a countable resource may become excluded (e.g. an excludable auto is purchased with $400 in cash), but in no event does income result from the transaction.

EXAMPLE: Mr. Bush is receiving MA benefits. He owned a home in which he lived valued at $25,000. The home was an excluded resource. He sold his home to a niece for $15,000 on 10/5/89 because he could no longer maintain the home. His only other resource is a savings account for $1,000. His countable resources are now $15,000 (the actual value received) plus $1,000 (other nonexcludable resource) for a total of $16,000. His resources exceed the Medically Needy limit, and he is no longer

eligible for MA. The fact that the sale was for less than the FMV is irrelevant as long as he lives in a community setting, however, the agency representative records the date of the transfer, and other pertinent information about the transfer on the DHS-2 and InRHODES Statement of Need Transfer Panel. The uncompensated value of the transfer may render him ineligible for payment for nursing facility services should he become institutionalized at a later date (See Section 0360, RESOURCE TRANSFERS).

0354.25 REPLACEMENT OF A RESOURCE

REV:06/1994

When a recipient sells a home and the proceeds are used to purchase a new home within three months, the money obtained from the sale of the home cannot be considered a resource.

Cash (e.g. an insurance settlement) received for the purpose of repairing or replacing an excluded resource that is lost, damaged, or stolen is excluded as a resource for a period of nine months with an additional nine-month extension for good cause.

Similarly, in-kind replacement of a lost, damaged, or stolen excluded resource is also an excluded resource.

0354.30 AVAILABILITY OF A RESOURCE

REV:01/2002

In order to be countable in the determination of Medical Assistance eligibility, a resource must be available to the applicant. The applicant must be able to use the resource to provide food, shelter, clothing, or convert it into a form in which it can be used to meet needs.

- o A resource is considered to be available both when actually available, and when the applicant has the legal ability to make such sum available for support and maintenance.

- o Resources are not available when a legal impediment exists which precludes the applicant from making the resource available for support, maintenance or medical care.

Applicants/Recipients are required, as a condition of eligibility, to cooperate with the Department in making resources available. See Section 0308, COOPERATION REQUIREMENTS.

0354.35 EXCLUDED RESOURCES

REV:06/1994

In determining eligibility for Medical Assistance, for both Categorically Needy and Medically Needy SSI-related individuals/couples, the following resources are EXCLUDED:

- o THE HOME AND ASSOCIATED LAND;

- o HOUSEHOLD GOODS AND PERSONAL EFFECTS up to a maximum of

$2,000 for Categorically Needy, up to a maximum of $5,000 for Medically Needy. If the valuation exceeds these thresholds, the excess amount is countable toward the basic resource limit;

- ONE AUTOMOBILE is excluded if needed for employment, transportation to medical care, or if modified for use by a handicapped household member. Otherwise the first $4,500 of Fair Market Value is excluded, with any balance over the $4,500 threshold counting toward the basic resource limit;
- LIFE INSURANCE with a face value less than $1,500 for Categorically Needy, less than $4,000 for Medically Needy;
- BURIAL SPACES;
- IRREVOCABLE BURIAL CONTRACTS OR TRUSTS;
- FUNDS SET ASIDE FOR BURIAL, up to a maximum of $1,500;
- RETROACTIVE RSDI AND SSI BENEFITS, for a limited period;
- RESOURCES NECESSARY FOR SELF-EMPLOYMENT;
- RESOURCES DESIGNATED BY SSA FOR A PLAN OF SELF-SUPPORT for a blind or disabled individual;
- RESOURCES EXCLUDED BY SPECIFIC STATUTES.

0354.40 RESOURCE REDUCTION

REV:01/2002

If an applicant or recipient is found to be ineligible due to excess countable resources as of the first moment of the month, s/he is notified that eligibility does not exist via the InRHODES Eligibility Notice. Included within the Notice is a description of the possibility of resource reduction.

An applicant whose countable resources exceed the basic resource limitation may establish eligibility on the basis of resources if:

- S/he incurs (or has incurred) outstanding allowable medical bills or other allowable expenses that equal or exceed his/her excess resources; AND,
- S/he reduces the excess resources to the appropriate resource limit by actually paying the allowable expenses or fees, and submitting verification thereof within thirty days of the date of the rejection or closing notice. Both the expenditure of the resource and submission of verification of the expenditure and the reduced resource must occur within the thirty day time period.

The bills used to establish eligibility cannot be incurred earlier than the first day of the third month prior to the date of an application that is eventually approved. Allowable bills, which the applicant has paid and used to reduce resources, may not be the same bills that have been used to meet an income spenddown.

The agency representative must see the receipts for bills that have been actually paid in order to verify that resources have been properly reduced.

0354.40.05 Date of Eligibility

REV:06/1994

An individual who reduces resources and is otherwise eligible will be eligible as of the date the incurred allowable expenses were equal to or exceeded the amount of his or her excess assets, subject to verification that the excess resource was actually expended on the allowable expense. In no event shall the first day of eligibility be earlier than the first day of the month of application. An applicant cannot establish eligibility by resource reduction in the retroactive period.

The applicant will be required to verify that:

- o S/he incurred the necessary amount of expenses; and,
- o His or her excess resources were reduced to the allowable resource limit by expenditure of the excess resource on the allowed expense.

0354.40.10 Allowable Expenses

REV:04/2001

Only certain expenses may be used to establish eligibility by reduction of excess resources. These expenses are as follows:

- o Medical Expenses that would be allowed under the policy on the Flexible-test of income. See Section 0368, FLEXIBLE TEST OF INCOME.
- o Certain fees required for: a) an individual to make income or resources available; or b) an incompetent individual, who needs a court-appointed guardian, to access or consent to necessary medical treatment, including applying for Medical Assistance. Only the fees indicated in Sections 0354.40.10.05 through 0354.40.10.15 are allowable under this provision.

0354.40.10.05 Guardian/Conservatorship Costs

REV:04/2001

Applicants who have court-appointed guardians or conservators are generally required to pay court-approved guardian/conservator's fees. Such fees include but are not limited to court filing fees, the cost of a Probate Bond, court-approved guardianship/conservatorship fees, and court-approved legal fees.

Allowable court-approved expenses not covered by other sources for items listed in Section 0354.40.10, subject to the Rhode Island Supreme Court approved fee schedule (currently $30 per hour for guardians under "Executive Order" Number 95-01) may be considered. When such guardianship fees have been approved by probate courts, related guardian ad litem fees not exceeding $250 may also be recognized. The applicant must submit a copy of the Probate Court Order and any supporting documentation, including an itemized bill for any allowable guardianship/conservatorship expenses.

The case is referred to the Office of Legal Counsel by the Regional Manager for a decision on the amount of the allowable deduction. The referral must contain a brief description of the case, a copy of the Probate Court Order, an itemized bill from the guardian, and any other supporting documentation. The total amount allowed must be reasonable and shall be based on the hours approved by the particular Probate Court for items listed in 0354.40.10 at the rate of compensation paid for guardians ad litem in Family court as specified in the then-current Rhode Island Supreme Court Executive Order on fee schedules.

0354.40.10.10 Legal Fees

REV:06/1994

Individuals who incur legal fees resulting from legal action to obtain income or resources for their support may expend excess resources to pay such fees.

0354.40.10.15 Tax Assessments

REV:06/1994

Individuals ordered by the Internal Revenue Service, the Rhode Island Division of Taxation, or other State or municipal taxing authority to pay income taxes may expend excess resources to pay the taxes.

0354.40.15 Examples of Resource Reduction

REV:06/1994

The following are hypothetical cases involving resource reductions:

- MR. M files an application on 7/21. As of 7/1, he has a savings account of $3075 and an automobile with a countable value of $975, for a total of $4,050. On 7/10, he withdrew $125 from the bank for automobile repairs, reducing his resources to $3,925. He is ineligible as of 7/1 and the change in resources during July does not affect his INELIGIBILITY. He has no allowable expenses on which to expend the excess resource. He remains ineligible in July. He may be eligible in August if his countable resources are $4,000 or less on 8/1.

- MR. E is a Categorically Needy individual who does not receive SSI. As of 3/1, he had a $2,000 life insurance policy with a cash surrender value of $800, a savings account valued at $900 and an excluded automobile, for a

total of $1,700. On 3/5, he sold his automobile for $1,000 and deposited the money in his savings account. His countable resources then amounted to $2,700 (the sale of the car is considered a "converted" resource) and that is the amount he had as of 4/1. The increase in his resources does not affect his ELIGIBILITY for March. He is ineligible as Categorically Needy for April, and is notified that he is Medically Needy. He has no allowable expenses on which he can expend excess resources. He will remain Medically Needy until the month following the month his resources are reduced to $2,000 or less; i.e., he is not Categorically Needy for as long as the excess resources are retained and THROUGH the month that his resources are reduced to within the resource limit.

- MS. D applies for recertification on 5/1. She had $3,700 in her savings account. On 5/3, she received a $460 RSDI check which was directly deposited in her savings account. She is eligible for the month of May since the $460 is income in the month of receipt. However, she retains the $460, and consequently exceeds the resource limit for June 1, with total resources of $4,160. She is notified on 6/2 that she is ineligible due to excess resources, and her case is closed effective June 13th. On June 20th, she enters the hospital. Her Medicare deductible is $676 (the Part A deductible as of January 1, 1993). She opts to reduce her resources by expending $160 on the outstanding deductible for the hospital bill. She re-establishes eligibility effective June 20th.

- MS. I applies for recertification on 7/20. She had $3,975 in her savings account as of 7/1. On 7/31, $43 in interest was added to her account, for a total of $4,017. She is ELIGIBLE in July. As of 8/1, the interest is a cash resource and she is INELIGIBLE for August. She has no allowable expenses incurred or outstanding in August on which she can expend excess resources. On August 10th, she reduces her resources to below $4,000 by purchase of a pair of shoes. She will NOT REGAIN eligibility for the month of August even though her resources are again within the resource limit. The earliest she CAN REGAIN ELIGIBILITY is September 1, if her resources are within allowable limits as of the first moment of that month.

- MR. C applied on July 15th for help with a hospital bill of $12,000 incurred between June 2nd and June 15th. He had total countable resources of $6,485 on June 1st. He paid $2,000 on June 29th toward the bill from his cash resources, leaving countable resources of $4,485 on July 1st. He was notified on July 30th that he was ineligible due to excess resources, and that he could reduce resources to establish eligibility. He expended an additional $500 toward the hospital bill on August 20th. He presented verification of the expenditure and the reduced resources on August 25th, and was determined to be eligible effective July 1st in the ongoing period. He was ineligible for copayment of the balance of the

hospital bill from June, because June is a retroactive month.

- MR. D has resources of $6,500 on the first of July. He incurs allowable medical expenses of $8,000 during a hospitalization from July 5th through July 20th. He applies for Medical Assistance on July 29th. He is rejected on August 10th due to excess resources and is apprised of the ability to reduce resources to establish eligibility. On August 20th, he purchases an excludable automobile for $3,000, reducing his countable resources to $3,500. He does NOT establish eligibility for July or August. He reapplies in September, has countable resources within the limit, and is otherwise eligible. He is accepted effective September 1st.

- MRS. P has resources of $10,000 on August 1. She is hospitalized August 10th, incurring a bill of $22,000 between August 10th and August 17th. She files an application for Medical Assistance on August 30th. On September 12th, she is determined ineligible due to excess resources and notified of the possibility that she could reduce resources to become eligible. On September 15th, she paid $6,000 toward the hospital bill. She was subsequently certified eligible effective August 10th.

0356 EVALUATION OF RESOURCES

0356.05 FIRST MOMENT OF THE MONTH RULE

REV:06/1994

Countable resources are determined as of the FIRST MOMENT OF THE MONTH (FOM). The determination is based on the resources the individuals own, their value, and whether or not they are excluded as of the first moment of the month. The FOM rule establishes a point in time at which to value resources; what a person owns in countable resources can change during a month but the change is always effective with the following month's resource determination.

The kinds of changes that can occur are:

- CHANGES IN VALUE OF EXISTING RESOURCES

  The value of an existing resource may increase or decrease. For example, the value of a share of stock may decrease by $30 or increase by $20.

- DISPOSITION OR ACQUISITION OF RESOURCES

  An individual may dispose of an existing resource (e.g., close a savings account and purchase an item) or may acquire a new resource (e.g., an inheritance which is subject to the income-counting rules in the month of receipt).

- CHANGE IN EXCLUSION STATUS OF EXISTING RESOURCES

An individual may replace an excluded resource with one that is not excluded (e.g., sell an excluded automobile for nonexcluded cash) or vice versa (use nonexcluded cash to purchase an excluded automobile). Similarly, a time-limited exclusion (such as the period for exclusion of retroactive Title II benefits) may expire.

Changes such as these do not effect the countable value of resources in the month in which they occur. Any change does not effect countable resources until the first moment of the following month.

If countable resources exceed the limit as of the first moment of a month, the applicant is not eligible for that month, unless the resources are reduced by expenditure on certain allowable expenses, see Section 0354.40, RESOURCE REDUCTION.

Resources are evaluated using the methodologies set forth below for the various types of resources. Each type of resource has its own unique deductions, exclusions, and methods for evaluation to determine its countable value. If not otherwise indicated, the countable value of a resource is the equity value (Fair Market Value less legal encumbrances).

Once the countable value of each type of resource (after the appropriate exclusions/deductions) is determined, the countable values of all resources (including deemed resources) are added together to determine the total countable resources for an individual or couple.

0356.10 REAL ESTATE

REV:03/2004

The policy and procedures set forth in the following sections will be used to determine eligibility for Aged, Blind, or Disabled individuals or couples (SSI-related cases).

The equity value of real property owned by an applicant that is neither excluded as the home nor determined unavailable is a countable resource.

Real property may consist of land, buildings, and objects permanently attached to the land, (including "mobile" homes permanently sited). Real property includes the value of certain interests in real estate such as life estates, mineral rights, easements, life leaseholds.

0356.10.05 Home and Associated Land Excl

REV:03/2004

Effective March 1, 2004, DHS policy is revised to clarify application of the home exclusion for residential real estate property.

Definitions

For the purposes of this section, the following definitions apply:

--APPLICANT: Both new applicants for Medical Assistance as well as current recipients at any point in which eligibility is redetermined.

--DEPENDENT CHILD: An unmarried child of the applicant and/or the applicant's spouse who is dependent upon the applicant and/or the spouse for financial support, and is either under eighteen (18) years of age; or over eighteen (18) years of age and living with a disability which began before age twenty-two (22).

--HOME: Any residential property in which the applicant and/or applicant's spouse possess an ownership interest that also serves as the principal place of residence of the applicant and/or, in the instances specified in this section, the applicant's spouse or dependent child. A home may be a fixed or mobile residential property. A cooperative or condominium apartment, townhouse, mobile house, and houseboat are all examples of residential properties that may serve as homes. An applicant and spouse may have an ownership interest in several residential properties, but only one (1) shall be considered a home for the purposes of this section.

--HOME EXCLUSION: The treatment of a residential property as a non-countable resource when the property serves as the home of an applicant/spouse as specified in this section. Regardless of whether one or both spouses in the household are applicants, only one residential property is considered to be a home, and as such, is treated as an excluded resource for the purposes of determining MA eligibility.

--OWNERSHIP INTEREST: The individual holds sole or joint legal title to the residential property or is a party to a legal covenant establishing property ownership, such as a life estate.

--PRINCIPAL PLACE OF RESIDENCE: The residential property where the applicant, and/or in the instances specified in this section, a spouse or a dependent child lives the majority of the time during the year. For example, one hundred and eighty-three (183) days in the previous twelve (12) months.

--RESIDENTIAL PROPERTY: A physical structure or shelter in which an applicant and/or the applicant's spouse maintain an ownership interest and, therefore, have the legal right to use as a place of residence. Examples of a residential property include, but are not limited to, single- or multi-family dwellings, condominium apartments/townhouses, and mobile houses used as living residences on land or sea. Residential property includes any contiguous land

or buildings.

--RESIDENT OF RHODE ISLAND: The applicant has an intent to stay in the state permanently or for an indefinite period, in accordance with the provisions set forth in Sections 0106.05 through 0106.25 of the DHS Code of Administrative Rules.

Application of the Home Exclusion:

A home, is an excluded resource if it is:

- O Located in Rhode Island and is the principal place of residence of the applicant; or

- O The principal place of residence of the applicant's spouse or a dependent child.

The value of any property contiguous to the home is also excluded.

0356.10.05.05 Home and Associated Land Defin

REV:06/1994

Home and Associated Land Definition - The home exclusion applies to any land which appertains to the home and other buildings located on such land. To appertain to the home, the real property must adjoin the plot on which the home is located and not be separated from it by intervening real property owned by others.

Where real property adjoins the plot on which the home is located and has contact with that plot, it does not matter if there is more than one document of ownership (e.g., separate deeds). It also does not matter that the home was obtained at a different time from the rest of the real property, or that the holdings may be assessed and taxed separately. In considering whether real property appertains to the home plot, easements or public rights of way (e.g., streets, roads, utility lines) which run through or by the land and separate the land from the home plot or from the rest of the land are not considered. Watercourses, such as streams and rivers, do not separate land, but are included in the term "land." Land parcels which are adjoined side-to-side, corner-to-corner, or in any other fashion are considered to appertain to each other.

If some indication arises that a portion of the property is separated from the home property and does not appertain to the home, the extent of the home property as provided is determined.

Where there is no indication that the plot on which the home is located is separated from other real property, nothing further is needed.

If any of the individual's property is not contiguous with the home plot, the extent of the home property is documented. A copy of the tax assessment bill, title, deed, or other pertinent documents that the individual has in his/her possession is placed in the case record. A description of the property situation and whether all the land appertains to the home is obtained. If the individual cannot provide this evidence or the evidence is insufficient, the agency representative contacts the local tax jurisdiction regarding the property boundaries and records the information.

If the property on which the home is located is recorded as a single holding and treated as a single holding for tax assessment purposes, the agency representative treats the property as a single piece of property to which the home plot is adjoined by the rest of the land. If there has been subdividing of the original holding but the residue is treated as a single holding for tax assessment purposes, the same assumption applies.

If two or more holdings, including one or more homes, are reported to be a combined property and are treated as two or more holdings for recording and tax assessment purposes, the agency representative obtains a description of the holdings and their relationship to one another. A sufficient description is a sketch which shows the locations of the boundaries and the shelter used as a home in relation to the boundaries. The agency representative obtains the description by direct observation of the property or from the public records. If the description is by an individual, the description is recorded on the property sheet.

Where it is determined that land owned by the individual does not appertain to the home plot, such land and any buildings on it cannot be part of the home exclusion.

0356.10.05.10 Multiple Residences

REV:03/2004

When an applicant with an ownership interest in multiple residential properties has not lived in any one for the majority of the time during the preceding twelve (12) months, the home exclusion is applied to the state residential property identified as the applicant's address on one of the following, in order of preference:

1. A valid Rhode Island driver's license;
2. The most recent voter registration form;
3. A government check or electronic deposit receipt (e.g., Social Security, SSI, State Treasury) issued within the last sixty (60) days; or
4. The most recent U.S. federal income tax return submitted by, or on behalf, of the applicant.

All other residential properties in which the applicant or the applicant's spouse maintain an ownership interest shall be treated as countable resources, in accordance with Section 0308.10.

0356.10.05.15 Out-of-State Residences

REV:03/2004

To be eligible for Medical Assistance, an applicant must be a Rhode Island resident and, as such, have an intent to stay in the state permanently or for an indefinite period. Accordingly, an applicant who declares an out-of-state residential property as a home to return to shall not be considered a Rhode Island resident for the purposes of determining eligibility for Medical Assistance.

When an applicant owns residential properties both in and out-of-state, the home exclusion shall be applied to the residential property located in Rhode Island. The value of any out-of-state residential property is a countable resource, even if it is

the principal place of residence of the applicant's spouse/dependent child, as long as the applicant maintains an ownership interest in any Rhode Island residential property.

If the applicant does not own residential property in Rhode Island, but lives and intends to remain in the state, the home exclusion may be applied to an out-of-state residential property if, and only if, it is the principal place of residence of the applicant's spouse or dependent child.

An out-of-state residential property may otherwise only be deemed temporarily excluded when it is determined that:

- There is a legal impediment to the sale of the property due to joint ownership (as specified in Sections 0356.10.10, 0356.10.10.05, 0382.10.10, and 0382.10.10.05); or
- The property is an unavailable resource as defined in Sections 0356.10.10.10 and 0382.10.10.10.

0356.10.05.20 Limitations

REV:03/2004

Although an applicant may own residential properties either alone or in conjunction with others, only one shall be considered a home and, as such, may be treated as an excluded resource at any given point in time. Even in situations in which both spouses in the household are applicants, the value of only one home may be excluded.

When the applicant and the applicant's spouse/dependent child make conflicting claims over which residential property is subject to the home exclusion the following decision rules shall apply:

- If the applicant and applicant's spouse live in separate residential properties in Rhode Island, in which they share ownership, the home exclusion applies to the residential property where the applicant lived at the time the department received the application.
- If each spouse lives in a separate residential property in Rhode Island, in which they share ownership, and both spouses apply for Medical Assistance, the home exclusion applies to the property where the spouse who applied first resides. If both applicants apply on the same day, the applicants must agree in writing which home is to be excluded. If no agreement can be reached, the home exclusion shall be applied to the residential property with the greatest value.

0356.10.10 Legal Imped to Real Est Sale

REV:06/1994

Other persons, in addition to an applicant and spouse (if any), may share in ownership of property in which the individual, spouse, or child is not living. If so, the property is considered to be unavailable if the individual or couple is not legally free to dispose of the property because the other owner(s) will not consent to sell. An unavailable resource is not countable in the eligibility determination.

0356.10.10.05 Joint Ownership of Real Est

REV:06/1994

Whether the applicant is free to dispose of his/her share depends on the type of ownership. The agency representative should examine the deed to determine the type of ownership. The following types of ownership are the most common.

- JOINT TENANTS

  JOINT TENANCY is when two or more persons own the property. (The property may be either real property or personal property). Upon the death of any Joint Tenant, title automatically vests in the surviving Joint Tenants without the necessity of a Probate proceeding. While alive, any Joint Tenant can convey his/her interest to a third person. After such a conveyance, the new parties own the property as Tenants in Common (see below).

- TENANTS IN COMMON

  TENANCY IN COMMON is when two or more persons own the property with no right of survivorship between them. Upon the death of any owner, that owner's interest in the property will pass under the deceased's will or, in the absence of a will, under the applicable laws of intestacy. While alive, any Tenant-in-Common can convey his/her interest to a third person.

- TENANTS BY THE ENTIRETY

  Only a husband and wife can hold property as Tenants by the Entirety. It is the most common tenancy for married couples who own property together. Like a Joint Tenant, the survivor will automatically own the property upon the death of one spouse. Unlike a Joint Tenant, however, both Tenants by the Entirety must join in any deed of an interest in the property. Property owned by a husband and wife under a Tenancy by the Entirety cannot be sold without the consent of both spouses. In the event a spouse refuses to dispose of the property, it is excluded as a resource of the applicant/recipient.

The agency representative obtains documents (usually a copy of the deed) to establish the nature of the shared ownership.

It is presumed that an individual who owns an interest in property as a Joint Tenant or Tenant in Common is free to sell his/her ownership interest without the consent or signature of the other owner(s). If the property is not otherwise excludable, the applicant's proportional share of the equity value of the property is counted toward the resource limit. (Unless stated otherwise in the deed, the applicant's proportional share of ownership is the ratio of 1 to the total number of owners.)

It is presumed that a Tenant by the Entirety is NOT able to liquidate his/her interest without the consent of the other owner.

The applicant's share of the resource is NOT countable, pending the applicant's action to make the resource available for his/her support.

0356.10.10.10 Docu Non-Avail of Real Estate

REV:06/1994

When the individual claims that s/he is unable to liquidate a real property resource, s/he must provide documentation from a competent authority (e.g. real estate broker, attorney) that s/he cannot sell the property. The agency representative refers the case to the Office of Legal Counsel for a decision as to whether the property can be liquidated.

All cases in which real estate is determined to be not countable under these provisions must be referred to the Office of Legal Counsel for review. As a CONDITION OF ELIGIBILITY, an applicant/recipient must take all reasonable actions to liquidate the resource. The Office of Legal Counsel determines what actions are reasonable based on review of each particular situation.

0356.15 INTANGIBLE PERSONAL PROPERTY

REV:06/1994

Intangible personal property includes those resources which are in cash or payable in cash on demand, and financial instruments convertible into cash. The most common types of intangible personal property are savings accounts, checking accounts, NOW accounts, certificates of deposit, money market accounts, stocks, bonds, and mutual funds.

Other intangible resources include promissory notes, loans which may not be secured by promissory notes, and mortgages. Such personal property is always a countable resource, except as excludable under this section.

0356.15.05 Cash

REV:06/1994

Cash is money on hand or available in the form of currency or coins. Foreign currency or coins are cash to the extent that they can be exchanged for U.S. issued currency. Cash on hand is always counted as a resource except when it is a business resource necessary to the operation of a trade or business that is excluded as necessary for self-support.

The applicant's statement of the amount of cash on hand is acceptable without verification.

0356.15.10 Checking and Savings Accounts

REV:06/1994

The terms checking/savings accounts include any and all accounts, certificates, money market or broker's funds and instruments or devices having the general

characteristics commonly associated in the community with checking and savings accounts. The countable resource from such accounts is the amount that the applicant/deemor can withdraw, subject to the policy below.

A penalty for early withdrawal of the funds in a time deposit does not prevent the resource from being countable. If there is a penalty for early withdrawal of funds, the penalty amount is deducted from the balance of the account in determining the countable resource.

In determining the amount of money in, or the existence of, a bank account at least three bank statements (AP-91) are sent. One is sent to the bank where the individual has or had an account. The others are sent to the banking institutions most likely to have been used by the individual considering the location of home and/or employment. If the statement(s) shows deposit and withdrawal activity or cash flow inconsistent with the applicant's/ recipient's alleged financial situation during 30 months prior to application or while receiving assistance, the agency representative determines if funds were transferred to another individual and/or whether such funds are still available to the applicant/recipient.

0356.15.10.05 Availability of Funds

REV:06/1994

Funds maintained in checking or savings accounts are usually payable on demand. An individual should be able to withdraw money from a checking account on the same day (s)he presents a check.

Funds can usually be withdrawn from a savings account the same day the request is made.

However, some unusual circumstances may occur which prevent the immediate withdrawal of money, and may result in the resource being unavailable.

For example, if there is a joint account with only one individual having authority to withdraw money and that individual dies, a prolonged period may elapse before the surviving owner can withdraw the money.

Certain time deposits (e.g. savings certificates or certificates of deposit) may not be legally available to the applicant/deemor until a specific point in time. If so, the policy in Section 0354.30 regarding availability of resources is applied to determine if the resource is not countable until the maturity of the certificate.

0356.15.10.10 Joint Checking and Savings

REV:06/1994

Whenever the applicant or deemor is a joint account holder who has unrestricted access to the funds in the account, ALL of the funds in the account are PRESUMED to be the resources of the applicant or deemor. The applicant or deemor will be offered the opportunity to submit evidence in rebuttal of this presumption.

A successful rebuttal will result in finding that the funds (or a portion of the funds) in the joint account are not owned by the applicant or the deemor and , therefore, are not the resources of the applicant.

0356.15.10.12 Presump of Owner, One Account

REV:06/1994

When only the holder of a joint account is an applicant who has unrestricted access to the funds in the account, explain to the applicant that ALL of the funds in the account are presumed to be the applicant's. This presumtion is made regardless of the source of the funds.

0356.15.10.14 Presump of Owner, Two or More

REV:06/1994

When two or more eligible individuals or applicants (with or without ineligible individuals) are holders of the same joint account and each has unrestricted access to the funds in the account, the agency representative explains the presumption that each eligible individual or applicant owns an EQUAL SHARE of the total funds in the account. This presumption is made regardless of the source of the funds.

0356.15.10.16 Presump of Owner, Joint Accoun

REV:06/1994

The presumption of ownership which apply to applicants who are joint account holders also apply to deemors who are joint account holders. When a deemor is a joint account holder with an applicant and each has unrestricted access to the funds in the account, ALL of the funds in the account are presumed to be the applicamt's resources. If two or more applicants are joint account holders with a deemor, then eahc eligible applicant owns an equal share of the total funds in the account. If two deemors, who are not considered parents, hold a joint account, "divide" the funds EQUALLY between them for deeming purposes.

0356.15.10.18 Determining Access to Funds

REV:06/1994

The determination of accessibility does not fall upon the individual but depends upon the LEGAL STRUCTURE of the account.

Where an applicant is a joint holder of a bank account and is legally able to withdraw funds from that account, (s)he is considered to have UNRESTRICTED ACCESS to the funds.

It is possible to have ownership interest in a bank account but have RESTRICTED ACCESS to the funds. An example of language which restricts access is: "In trust for John Jones and Mary Smith, subject to the sole order of John Jones, balance at death of either to belong to the survivor." In this example, only John Jones has unrestricted access. When it is clearly established that all funds in an account are legally accessible to the applicant only in the event of the death of the co-owner, the applicant's access to the funds is restricted and the funds are not a countable resource. Regardless of whether the applicant has unrestricted access to the resources of an individual whose resources must be DEEMED, the funds in the account are deemable resources to the applicant.

If unrestricted access is an issue which cannot be resolved with the evidence on hand, the agency representative requests the financial institution to provide additional information. This ma include the exact language used inthe document which established the account, a description of any legal restrictions on the individual's access to the funds, etc.

If there is a legal impediment to the access to funds which may be owned by the applicant, see policy on availability of resources, Section 0354.30.

0356.15.10.20 Rebuttal of Presump of Owner

REV:06/1994

There may be a situation where an individual has unrestricted access to the funds in a joint account but does NOT consider himself/herself an owner of the funds (either fully or partially).

For example, the individual may allege that all of the funds in the account are deposited by the other account holder(s). The individual may declare that (s)he has never withdrawn funds from the account or, if withdrawals were made, the funds were used for or given to the other accunt holder(s); i.e., the applicant acts as agent for the other account holder(s).

0356.15.10.22 Rebuttal Procedures

REV:01/2002

When a joint account is alleged or discovered during the application process, the agency representative explains the applicable ownership presumption to the applicants or deemors.

If the applicant disagrees with the presumption of ownership, the agency representative provides an explanation of the rebuttal procedure. If the individual chooses not to rebut the presumption of ownership, the resource determination proceeds in the usual manner.

If the individual wishes to rebut the presumption, the agency representative explains to the individual that all of the necessary rebuttal evidence must be submitted within thirty days.

An additional thirty day period is granted if the applicant establishes good cause for his or her inability to provide the necessary documentation within the initial thirty day period.

If the required information is not provided, the presumption of ownership is used to determine the value of resources.

Once the rebuttal evidence is submitted, the agency representative determines who owns the funds in the joint account and documents the findings for the record.

If the applicant is ineligible due to any other factor of eligibility (such as excess income) or if a successful rebuttal would not change a determination of ineligibility due to other excess resources, it would then be unnecessary to initiate the rebuttal procedure.

0356.15.10.24 Evidence for a Success Rebut

REV:06/1994

In order for an applicant or deemor to rebut successfully the presumption of full or partial ownership, ALL of the following evidence is required:

- A statement by the applicant or deemor on an AP-92 containing the penalty clause, giving his/her allegation regarding ownership of the funds, the reason for establishing the joint account, the date the account was made joint, the source of the funds, who made deposits and the source of the deposits, who made withdrawals from the account, how the withdrawals were spent, whose Social Security number was on the account; and,

- Corroborating statements (on form AP-92A) form other account holder(s); and,

- A new account must be established in the name of the applicant which contains only the applicant's funds, or a change must be made in the account designation which removes the applicant/deemor's name from the account, or restricts the applicant/deemor's access to the funds in the account; and,

- Submittal of the original and revised (if any) account records showing that the change above was made. Photocopies are necessary for the record; and,

- The AP-92 from the applicant and the AP-92A(s) from the joint account holder(s) must provide the information needed to establish that none of the funds, or only a portion of the funds are owned by the applicant. The applicant must submit all available documentary evidence to support the statements in the AP-92 and AP-92A(s). The evidence should, if available, include a financial institution record, or other source document. A source document is a passbook or other document which shows deposits, withdrawals, and interest for the period for which ownership is being rebutted. The documentary evidence should support the allegations of ownership, and should not contradict the statements on the AP-92 and AP-92A.

It is the applicant's or deemor's responsibility to provide the required evidence. The district office provides assistance in obtaining the evidence only when thr individual is unalbe to do so.

If the applicant alleges that there is no documentary evidence available, s/he must submit evidence to substantiate the allegation.

0356.15.10.26 Minor/Incompetent Co-Holder

REV:06/1994

If either the applicant of the co-holder of the joint account is incompetent or a minor, it is unnecessary to obtain a corroborating statement fron that individual. That person's incompetency or age may be the reason why the applicant is listed as a joint account holder. In this event, the agency representative obtains a

corroborating statement fron a third party who has knowledge of the circumstances surrounding the establishment of the joint account. If there is no third party, the agency representative makes a rebuttal determination without a corroborating statement. The decision is documented with an explanation why no corroborating statement was obtained. The agency representative determines if the rebuttal is successful.

The rebuttal process may result in determination showing the applicant owned varying dollar amounts for prior periods.

0356.15.15 Stocks, Bonds, Like Securities

REV:06/1994

Securities may include stocks, bonds, and other securities held individually, or as shares in a mutual fund.

0356.15.15.05 Stocks

REV:01/2002

A STOCK is a negotiable instrument which represents ownership in a corporation. Most stocks are assigned a certain value, known as "par value". Par value, which in many cases is only one dollar, has no significance or correlation to the actual market value of stock.

The value of stock is normally determined by the demand for it when it is bought or sold on one of the stock exchanges or on the "over-the- significantly. The daily fluctuating prices of most stocks are listed on the New York Stock Exchange, the American Stock Exchange, the NASDAQ, or on the "over-the-counter" market. There are also several regional exchanges located in large cities which list stocks not shown on the major exchanges. Many newspapers publish the closing prices for stocks listed on the NASDAQ, New York and American Exchanges. The value of the stock should be determined through one of the listings after verifying the identity of the stock and number of shares held.

0356.15.15.10 Municipal and Corporate Bonds

REV:06/1994

A BOND is not cash but a promise to pay cash to the holder (bearer) of the bond. The term "bond" signifies an obligation in writing to pay a sum of money at a future specified date, usually to the bearer. It is a negotiable instrument and is transferable. The term "bond" is commonly understood in financial circles to be the obligation of a state, its sub-divisions (counties, districts or municipalities) or private corporations. These entities issue municipal or corporate bonds to raise money for improvement projects.

To redeem a municipal or corporate bond for its stated value, it must be held until the specified date of maturity. However, if a person wants to cash in a bond before maturity date, the current cash value is determined by the market for such bonds, which is similar to stocks. If there is a great demand for certain bonds, the market value may be more than its face value; or less, if there is little or no demand. The bond's current market value may be substantially less than the face value. The current market value of a bond can be determined in the same manner as stocks. When an individual requests that his/her municipal or corporate bond(s) be sold, it takes

about 7 to 10 work-days from the day the brokerage firm completes the transaction to the time the seller receives the proceeds from the sale.

0356.15.15.15 U.S. Savings Bonds

REV:06/1994

U. S. Savings Bonds are backed by the Federal Government. There are several series of U.S. Savings Bonds: E, I, J, H, which normally can be quickly converted into cash at local banks. However, some bonds must be held at least 60 days from the date of issue before they can be converted into cash, and others must be held for a minimum of 6 months before they can be liquidated. During the period in which the bonds cannot be liquidated, they are not available, and are not countable resources. U.S. Savings Bonds are usually registered in the name of the owner (the name shown on the face of the bond) and are redeemed by the owner completing a form on the back of the bond.

When it is necessary to establish the value of a U.S. Savings Bond, the date of issue on the face of the bond is controlling. The bond's value depends on the time elapsed from the date of issue.

Although many U.S. Savings Bonds have a table of values on the reverse of the bond, this table is often inaccurate since the interest rate may have changed since the bond was issued. Contact a bank for documentation of a U.S. Savings Bond's current value.

0356.15.15.20 Mutual Funds

REV:06/1994

A Mutual Fund is a company that buys and sell securities and other investments as its primary business. Shares in mutual funds represent ownership in the investments held by the fund. The value of the mutual fund shares varies with market conditions. The current value of the shares of many funds is published in the financial section of newspapers. If the current value of the fund is not published, it must be obtained from a broker, or from the fund itself. Most mutual fund shares may be liquidated on demand.

0356.15.15.25 Presump of Owner and Rebuttal

REV:06/1994

Jointly-held financial instruments described in Sections 0356.15.15.05 through 0356.15.15.20 above are subject to the same presumptions of ownership share as for real estate, e.g. the applicant is presumed to own his/her proportional share of the resource. For example, if the applicant is presumed to owns shares of stock jointly with a sibling, the applicant is presumed to own half the stocks. THis presumption is subject to the rebuttal procedure in Sections 0356.15.10.20 through 0356.15.10.26.

0356.15.20 Promissory Notes, Loans, Mortgag

REV:06/1994

In some financial transactions, the applicant may be the lender or the person to whom money is owed. This section sets forth the policy for considering transactions or agreements in which the applicant is the lender, or person to whom money is owed.

Section 0356.15.25 provides policy when the applicant is the borrower, and receives the proceeds of a loan.

Types of instruments in which the applicant may be the LENDER are:

- PROMISSORY NOTES

  A PROMISSORY NOTE is a written agreement signed by a person who promises to pay a specific sum of money at a specified time, or on demand, to the person or organization named on the note as holder. The note may be secured by real estate (a mortgage), or a security agreement on personal property (chattel mortgage). A promissory note held by an individual is a resource of the individual.

- LOANS

  A LOAN is a transaction in which one party advances money (or other property) to another party who promises to repay the amount in full within his/her lifetime, with or without interest. The loan agreement may be oral or written. When an applicant has loaned money to another, the loan is a resource to the applicant, subject to the policy regarding its negotiability, valuation and salability set forth in the following sections.

0356.15.20.05 Negotiability of Instruments

REV:06/1994

Promissory notes, mortgages, and loan agreements generally may be sold or discounted. For example, a bank may be willing to pay $450 for a $500 promissory note due in one year's time. Promissory notes, mortgages, and loans are negotiable if the owner (lender) has the legal right to sell the instrument, or has an interest in the instrument which can be converted into cash. Examination of the instrument establishes negotiability. Negotiable instruments are countable resources. Questions regarding negotiability are referred to the Office of Legal Counsel for review. Instruments determined to be non-negotiable by the Office of Legal Counsel are considered unavailable resources.

0356.15.20.10 Valuation

REV:06/1994

Once negotiability is established, the instrument is considered a resource in the amount of the outstanding principal balance, unless the individual can furnish evidence from a reliable source which shows that the instrument is worth a lesser amount. Reliable sources include banks, other financial institutions, real estate brokers, private investors, etc.

0356.15.20.15 Salability

REV:06/1994

If the individual is unable to sell or liquidate the resource because no market exists, the resource is considered to be unavailable, and is not countable. To establish unavailability, the individual must present:

- o Evidence showing that the instrument was offered for sale for example, newspaper advertisement; and,
- o Statements from two different reliable sources stating that, in their opinion, the instrument cannot be sold, and the reason(s).

The case must be referred by memo to the Office of Legal Counsel for a determination regarding availability.

0356.15.20.20 Treat of Count/Non-Count Instr

REV:06/1994

If the instrument is determined to be non-countable, the entire amount of any payments on the loan are considered to be unearned income. If the instrument is a countable resource, the principal portion of each payment is considered to be a converted resource; the interest portion is unearned income.

0356.15.25 Proceeds of Loan

REV:06/1994

The policy set forth in this section provides instruction when the applicant is the BORROWER, and receives the proceeds of a loan.

When the applicant is the borrower, the proceeds of a bona fide loan which requires repayment by the applicant are not income or resources in the month of receipt, but become a countable resource if retained beyond that month. If the loan is not bona fide, the proceeds are countable as unearned income when received.

For a loan to be considered bona fide, the terms of the loan must be legally binding on the borrower under State law.

0356.15.25.05 Commercial Loans

REV:06/1994

Loans granted by organizations that are in the lending business (such as banks, finance companies, and credit unions) are considered to be bona fide. There will be a formal written contract between the organization and the borrower which specifies the promise to pay a sum on a certain date, or when certain circumstances are met.

0356.15.25.10 Informal Loans

REV:06/1994

Loans which are negotiated between individuals may be less formal, even unwritten. A bona fide loan may exist without a written contract. The loan need not be secured by specific items of collateral.

A loan agreement (oral or written) must include all the following to be considered bona fide:

- The borrower's acknowledgement of obligation to repay (with or without interest); and,
- A timetable and plan of repayment; and,
- The borrower's express intent to repay the loan by pledging real or personal property or anticipated income. It is not necessary that the loan be secured by real or personal property. It is necessary that the borrower express intent to repay the loan when funds become available in the future and indicate that s/he will begin repaying the loan when s/he receives future anticipated income.

If the agreement is oral, statements are obtained from all parties to the loan, and any witnesses to the transaction. The agency representative evaluates the statements to determine if the loan is bona fide.

All documents relating to informal loans are photocopied and retained in the case record. Questionable situations are referred by memo through LTC/AS to the Office of Legal Counsel for review. All available documentation is attached to the memo.

0356.15.30 Retirement Funds

REV:06/1994

Retirement funds are annuities or work related plans for providing income when employment ends (such as a pension, disability or retirement plan administered by an employer or union), or funds held in Individual Retirement Accounts (IRA'S), or plans for self- employed individuals, sometimes referred to as Keogh plans.

An applicant who owns a retirement fund must apply for the benefits of such fund or liquidate the fund. However, the applicant is not required to terminate active employment in order to make a retirement fund available. If the applicant must terminate employment in order to receive benefits from the retirement fund, the fund is not a countable resource.

If the applicant is eligible for periodic retirement benefits (monthly, quarterly payment, etc.), the retirement fund is not a resource, but the payments from the fund are unearned income when received.

If an applicant owns a retirement fund and is not eligible for periodic payments, but has the option of withdrawing the funds, the retirement fund is counted as a resource. The resource is the amount the applicant can actually withdraw from the account. If there is a penalty assessed for early withdrawal, the resource is the amount available after these penalties are deducted. If taxes are owed on the funds, any taxes due are NOT deducted in determining the value of the retirement fund.

0356.15.35 Annuities

REV:12/2000

An annuity is an investment of funds from which an individual is paid or promised regular payments over a lifetime or a fixed period of time. Generally an annuity is established with a lump sum of money which is paid to a bank, insurance company, or other entity.

A deferred annuity is one under which payments begin at some date to be specified in the future. Once an individual selects a periodic payment option (frequency, amount and duration of payments), the annuity has been annuitized.

When determining eligibility for MA, COUNT AS AN AVAILABLE RESOURCE:

> The cash value of an annuity which can be surrendered or "cashed in." The cash value is equal to the amount of money used to establish the annuity, plus any earnings, minus any earlier withdrawals and surrender fees. No consideration in determining cash value is given for income tax withheld or tax penalties for early withdrawal.
>
> Annuity contracts that do not allow for cash surrender but instead allow the owner to sell the annuity on the open market are assignable. Annuity contracts that are silent regarding assignability are presumed to be assignable. Assignable annuities are countable resources. The countable value of the resource is equal to the outstanding principal balance, unless the individual can furnish evidence from a reliable source which shows that the annuity is worth a lesser amount. Reliable sources include banks, other financial institutions, insurance companies, brokers, viatical settlement companies, etc.

COUNT AS AVAILABLE INCOME:

> Payments received from an annuity are counted as unearned income.

TRANSFER OF ASSET PROVISIONS FOR INSTITUTIONALIZED INDIVIDUALS MAY APPLY WHEN:

> A non-cashable, non-assignable annuity was purchased by the individual (or the individual's spouse if purchased prior to establishment of MA/LTC eligibility) within thirty-six (36) months immediately prior to or anytime after the date the individual was both institutionalized and applied for MA. Such purchases must be evaluated when the individual applies for MA payment of Long Term Care Services to see if a transfer of assets for less than fair market value has occurred. See Sections 0382.15.35 and 0384 a for a detailed discussion of this topic.

EXAMPLE 1:

> Mrs. Findlay, age 65, purchases a $10,000 annuity on January 1st. Under the terms of the contract, she has the right to cancel and receive the full amount of $10,000 back within

ninety (90) days of the purchase. She applies for MA on February 15th.

Because the annuity provides for a $10,000 cash surrender at the time of MA application, this amount is added to Mrs. Findlay's countable resources. Her MA application is denied.

EXAMPLE 2:

Mr. Luke, a 68 year old MA applicant, receives monthly payments from a $10,000 annuity that he purchased thirty-seven months ago. The annuity contract does not provide for a cash surrender after he begins receiving payments. The annuity is not assignable.

Since the annuity has no cash surrender or saleable value at the time of MA application, it is not an available resource.

The payments Mr. Luke receives from the annuity are counted as unearned income.

0356.20 LIFE INSURANCE

REV:06/1994

Life insurance that is owned by the applicant (or deemor) is a resource which is evaluated according to the face value threshold limits set forth in Section 0356.20.15. Policies on the applicant's life insurance owned by others are not countable unless deeming policies apply. However, regardless of ownership, all policies on the individual's life are recorded in the case file for use in the event a subsequent request for assistance with burial expenses is made.

0356.20.05 Types of Policies

REV:06/1994

A life insurance policy can be either a GROUP or INDIVIDUAL policy.

Group insurance policies generally have no cash surrender value.

Group policies are usually issued through a company or organization insuring the participating employees or members and perhaps their families. The group policy may be paid partially by the employer.

This is not counted as a resource. The individual policy is paid for entirely by the owner of the policy.

Individual policies include policies having no cash surrender value (term insurance) and those having a cash surrender value (ordinary life, limited payment life, or endowment).

0356.20.10 Life Insurance Terminology

REV:06/1994

FACE VALUE is the amount for which a policy is written, or the benefit amount. For example, a $10,000 insurance policy has a face value of $10,000.

CASH SURRENDER VALUE -- As the premiums of certain life (not term insurance) policies are paid over time, a cash value accumulates in the policy. The cash surrender value is the amount of cash which may be advanced to the policy owner when the policy is surrendered according to the conditions stipulated in the policy.

A TERM INSURANCE POLICY is a contract of temporary protection.

The insured pays relatively small premiums for a limited number of years, and the company agrees to pay the face amount of the policy only if the insured should die within the time specified in the policy. If the insured outlives the period, he receives nothing. It is a temporary protection. IT HAS NO CASH SURRENDER VALUE and is not counted as a resource.

AN ORDINARY LIFE (known as whole or straight) policy is a contract for which the insured pays the premium during his life time or to age one hundred (unless purchased by a single premium or by letting dividends accumulate). The company pays the face value of the policy to the beneficiary upon the death of the insured. THIS POLICY HAS A CASH SURRENDER VALUE, usually after the second year. The policy combines protection and savings with the emphasis on protection for the whole life.

A LIMITED PAYMENT LIFE POLICY is a contract for which the insured makes payments for a definite number of years (20 or 30) after which no more payments are required. The policy remains in force for life and affords the same protection as an ordinary life policy. THE POLICY HAS A CASH SURRENDER VALUE.

AN ENDOWMENT INSURANCE promises payment upon death of the insured within a specified period or upon his survival to the end of a specified period. AN ENDOWMENT HAS A CASH SURRENDER VALUE.

INSURED PERSON - The insured person shown on the policy identifies the person whose life is insured. The $1,500 ($4,000 for Medically Needy) face value exclusion applies to all policies on each insured person which are owned by the applicant (individual or couple). The exclusion applies to policies the applicant holds on his life, the life of a family member, or the life of any other person. Where the face value exclusion is exceeded on one insured person, this does not affect its application to policies on another insured person.

JOINT POLICIES generally cover a man and wife, often with whole life for the husband and term for the wife.

FAMILY POLICIES cover each family member on one policy. They are sometimes a combination of whole life for the father and term for the mother and children.

OWNER OF THE POLICY - The owner of the policy is the only person who can receive the proceeds under the cash surrender provisions of the policy. If the applicant is the insured person, but not the owner, the value of the policy does not count as his/her resource unless deeming policy applies. Conversely, if another individual is the insured person, but the applicant is the owner, the value of the policy counts as his/her resource (subject to the $1,500/$4,000 face value exclusion).

If the consent of another person is needed to cash in a policy, and consent cannot be obtained after a reasonable effort, the insurance policy is excluded.

0356.20.15 Policy and Procedure for Eval

REV:06/1994

STEP 1: Determine the face value of each insurance policy on the individual as listed on the application. Total the face values of all policies owned by the individual or couple, or in a deeming situation, policies owned by a spouse or parent. If the total face value of all the policies is less than the appropriate face value threshold for exclusion ($1,500 for Categorically Needy determinations, $4,000 for Medically Needy), no further determination is needed. There is no countable resource from life insurance. If the total exceeds the appropriate face value threshold limit, all the policies must be reviewed further.

STEP 2: Exclude all policies that do not have a cash surrender value (e.g., group insurance, term insurance). Sum up the face values of all remaining policies to determine the total face value of all policies which do have a cash surrender value. If the total face value is now less than the appropriate limit, there is no countable resource from life insurance.

STEP 3: If the total face value still exceeds the appropriate face value threshold limit, determine the total cash surrender value of all policies. The total cash surrender value of all policies counts toward the basic resource limit.

Staff should note that the tables of values accompanying many policies may be inaccurate due to the existence of a loan on the policy, or due to changes in the rate at which the policy gains value. The cash surrender value of each policy should be obtained directly from the issuing insurance company.

STEP 4: Retain copies of all policies and relevant documents for the case record.

If countable resources exceed the appropriate basic resource limit, due in whole or in part to the countable value of life insurance, the individual/couple is ineligible and may pursue one of the following options:

- o Cash in a policy to bring the resource within the limit;
- o Spend down the cash amount by which the resource exceeds the eligibility limit of combined cash, stocks, bonds and personal property;
- o Adjust the insurance to bring it within the eligibility limit;
- o Determine eligibility for a Burial Funds Set-Aside (section 0356.45); or,
- o Elect to retain the resources and the case will be rejected/closed.

0356.20.20 Policies Owned by Spouses

REV:06/1994

Policies owned separately by a husband and wife on the same person (e.g., a child), must be evaluated together, (e.g., the husband and wife may each hold a policy on a child with a face value of $1,000). Since the COMBINED total face value exceeds the $1,500 Categorically Needy face value limit, the entire cash surrender value of both policies counts as a resource in the Categorically Needy determination. CONVERSELY, BECAUSE THE COMBINED FACE VALUES ARE LESS THAN THE $4,000 Medically Needy FACE VALUE LIMIT, THERE IS NO COUNTABLE RESOURCE IN A Medically Needy DETERMINATION.

0356.25 HOUSEHOLD AND PERSONAL EFFECTS

REV:06/1994

Household goods and personal effects are excluded if their total current market value does not exceed the following threshold values:

- o For Categorically Needy eligibility $2,000;
- o For Medically Needy eligibility $5,000.

An applicant's HOUSEHOLD GOODS AND PERSONAL EFFECTS OF REASONABLE VALUE ARE EXCLUDABLE unless there is strong evidence the value is exceptional or unusual. Household appliances, furniture, carpeting, drapes, utensils, garden equipment, etc. are essential for the care and maintenance of the premises to support an adequate standard of health or the normal life comforts. Clothing, hobbies of reasonable value, jewelry, family heirlooms, and other effects typically restricted to the use of one individual are also essential to maintaining a reasonable living standard.

When the individual has items of exceptional value, all the items discussed in the preceding paragraph are combined and valued at $1,000.

0356.25.05 Items of Exceptional Value

REV:06/1994

When there is evidence that the applicant possesses household or personal items of unusual or exceptional value, there shall be verification that such item is a resource by establishing the fair market value (FMV) for it. Items of unusual value are those not essential to the physical health and safety, or items not normally used to maintain an adequate standard of comfort and convenience for the household.

Recreational boats, expensive jewelry (one wedding ring and one engagement ring are always excluded), art objects, or valuable collections are luxury items of unusual value and represent resources that can, along with other countable resources, exceed the resource limit for eligibility.

In such cases, a FMV is established for each such item and the amount is added to the $1,000. The $2,000 exclusion is subtracted.

(Do not include excluded items in this computation.) If there is a balance which, when added to other countable resources, would exceed the basic resource limit and render the individual/couple ineligible, it is then necessary to establish the equity value of the items and recompute in the same manner, as above. If the total equity value of household goods and personal property computed as above is in excess of the tangible personal property limit ($2,000, for Categorically Needy determinations, or

$5,000 for Medically Needy determinations), the value in excess of the tangible personal property limit is a resource countable toward the appropriate basic resource limit.

0356.30 AUTOMOBILE (S)

REV:01/2002

An automobile is any vehicle which is used to provide necessary transportation, such as passenger automobiles, motorcycles, trucks, boats and special vehicles (e.g., snowmobiles, animals or animal-drawn vehicles).

0356.30.05 Exclusion Based on Use

REV:06/1994

One automobile (motor vehicle) will be TOTALLY EXCLUDED regardless of value if (for the individual or member of the individual's household):

- o It is necessary for employment; or,
- o It is necessary to get to medical treatment for a specific or regular medical problem (used at least four times a year to receive treatment or to pick up prescribed medication for a specific medical problem); or,
- o It is modified for operation by or for transportation of a handicapped person.

0356.30.10 Threshold Exclusion

REV:06/1994

If no automobile (motor vehicle) is excluded based on use, one automobile is excluded from counting as a resource to the extent its NADA book value does not exceed a threshold of $4,500. If the automobile exceeds the $4,500 threshold, the amount in EXCESS of $4,500 is counted toward the basic resource limit. EQUITY VALUE IS NOT USED IN APPLYING THIS PROVISION. HOWEVER, THE LOWEST NADA VALUE ASSIGNED TO THE TYPE OF AUTOMOBILE IS USED, MINUS THE AMOUNT ALLOWED FOR ANY EQUIPMENT THE AUTOMOBILE DOES NOT HAVE.

0356.30.15 Equity Value

REV:06/1994

The EQUITY VALUE of any additional automobiles or motor vehicles is counted toward the basic resource limit.

0356.35 BURIAL SPACES

REV:06/1994

Burial space owned by the individual intended for use by the individual, his/her spouse or another member of the individual's immediate family is excluded from resources.

Burial space owned by an individual from whom resources are deemed to an applicant is excluded if the burial space is intended for use by the individual, the individual's spouse or another member of the individual's immediate family.

0356.35.05 Definitions

REV:06/1994

The following definitions apply to determinations regarding burial spaces:

- BURIAL SPACE

  Burial spaces are conventional gravesites, crypts, mausoleums, urns or other repositories which are customarily and traditionally used for the remains of deceased individuals.

- IMMEDIATE FAMILY

  Immediate family includes an individual's minor and adult children, stepchildren, adopted children, brothers, sisters, parents, adoptive parents, and the spouses of those individuals.

  Dependency and living-in-the-same household are not factors. Immediate family DOES NOT INCLUDE the members of an ineligible spouse's family unless they meet this definition.

0356.35.10 Examples of Burial Space Eval

REV:06/1994

EXAMPLE: Mary Jackson is applying for Medical Assistance. She owns three gravesites which she states are intended for the use of herself, her daughter and her daughter's future husband. Two of the gravesites are excluded. One cannot be excluded because it is intended for the use of an individual (her daughter's future husband) who is not currently a member of Mary Jackson's immediate family.

EXAMPLE: Bob Sullivan is applying for Medical Assistance. His resources are deemed to include those of his wife, Alice Sullivan, who owns four burial spaces. Alice Sullivan states that the burial spaces are intended for use by herself, Bob, John Sullivan (Bob's brother) and Frances Gates (Alice's sister). Three of the burial spaces are excluded. One cannot be because it is intended for the use of Frances Gates who is not a member of Bob's immediate family.

0356.40 IRREVOC BURIAL CONTRACT, TRUST

REV:06/1994

Funds in an IRREVOCABLE agreement which are available only for burial are excluded from countable resources. These are:

- o Funds which are held in an irrevocable burial contract, or irrevocable burial trust; or,
- o An amount in an irrevocable trust specifically identified for burial expenses.

When, prior to application, an individual has an irrevocable contract or trust, the funds are not considered as a countable resource. To determine revocability or irrevocability, the contract or trust must be evaluated. A photocopy must be filed in the record.

0356.40.05 Revocable Burial Contract/Trust

REV:01/2002

A burial arrangement that may be liquidated by the mutual consent of the buyer (the individual) and the seller (the funeral director) is considered revocable unless the seller refuses to consent to liquidation. A statement of the seller's willingness or unwillingness to liquidate the arrangement is obtained and a copy placed in the record. If the seller is willing to liquidate, the arrangement is considered revocable; if the seller is unwilling to liquidate, the arrangement is considered irrevocable.

Any questions regarding revocability will be sent in writing through the Regional Manager, with appropriate documentation, to the Office of Legal Counsel for a decision.

If the contract or trust is revocable, it may be considered as "funds set aside for burial" or cash, depending on the amount of other resources. If the contract or trust is irrevocable, then the amount allowed as "funds set aside for burial" must be reduced by the amount held in the irrevocable burial arrangement.

0356.40.10 Post-Elig Burial Agreement

REV:06/1994

After eligibility has been established, an individual who wishes to do so may place some or all of his/her resources, that are within the resource limit, in an irrevocable burial arrangement without affecting eligibility.

0356.45 FUNDS SET ASIDE FOR BURIAL

REV:06/1994

In addition to cash which may be retained under the appropriate basic resource limit, the applicant is permitted to set aside up to $1,500 in a separately identifiable fund for burial purposes. Funds can include a revocable burial contract, burial trust

or any separately identifiable resource. If the conditions set forth below are met, the set-aside amount is excluded from resources.

The maximum amount which may be excluded from resources as a burial set aside is $1,500 for both Categorically Needy and Medically Needy determinations. The maximum excludable set aside amount is reduced by amounts held in irrevocable burial contracts and certain insurance policies, as specified below. At each application it is necessary to learn whether any funds are set aside for burial of the eligible individual or the eligible individual's spouse. If there are no such funds, no special procedures are required.

0356.45.05 Comput Burial Set-Aside Examples

REV:06/1994

If the applicant has funds set-aside for burial, the amount which is excluded from resources is determined in the following manner:

- o Start with the maximum of $1,500 for an individual and $1,500 for the spouse.

  Funds can include a revocable burial contract, burial trust or any separately identifiable resource.

- o Reduce the maximums by the FACE VALUE of any non-term life insurance policies ON THE INDIVIDUAL'S LIFE, owned by the individual or the spouse, if the cash surrender values of the policies were excluded in determining countable resources according to policy in section 0356.20, LIFE INSURANCE. For Categorically Needy individuals, this means the total face values of such non-term life insurance policies which have cash surrender values and the total face values are $1,500 or less. For Medically Needy individuals, this means the total face values of such non-term life insurance policies which have cash surrender values and the total face values are $4,000 or less. (The face amounts of term life insurance or other life insurance on the individual's life, owned by his/her spouse, which have no cash surrender values, have no affect on the amount that can be set aside for burial.)

- o Reduce the balance further by the amount held by each individual in an irrevocable burial arrangement as defined in 0356.40.

- o When both of these resources have been deducted from the $1,500 limit, any remaining balance may be set aside in a burial fund which meets the following requirements.

  The funds must be:

  - Separately identifiable and not combined with other funds or resources which are not set aside for burial. If they are combined, they must be restructured into separate accounts with separate

account numbers within the month of application, if eligibility is to exist for that month.

- Clearly designated as set aside for burial. If the funds are not so designated, the funds may be excluded if the individual states that he/she intends to use the funds for burial and submits, within 30 days of application, a statement (AP-5.2) and documentary evidence that the funds have been designated as set aside for burial. Where the funds are set aside in a bank account, it is necessary to obtain a copy of the account to verify the existence and amount of the "set-aside" account. The designation that the funds are for burial need not be indicated on the account since banks will not normally allow the designation.

o Obtain a statement (AP-5.2) from each individual and/or deemor regarding the revocable burial agreement, trust and/or fund set aside for burial. The statement must be dated and must include the amount, account number (if applicable) and other pertinent information in each such arrangement. If a contract or trust, the statement should be fastened to the record copy of the contract or trust.

  Once excluded from resources, any increase in the value of excluded burial funds due to interest on such funds which was left to accumulate, or appreciation of such funds which occurred after the date of first eligibility, is excluded.

  Once a burial set-aside is excluded in whole or in part from resources, the excluded funds may not be used for any purpose other than burial expenses. An individual with set-aside must be advised that if the excluded set aside funds are used for any purpose other than burial, the amount used must be counted as income.

  Eligibility will need to be redetermined (including this additional income) for the period during which the income was used. Any question of fraud should be referred in accordance with Section 107.

0356.45.10 Burial Set-Aside Funds

REV:06/1994

The following examples assume that the funds are separately identifiable and clearly designated for burial, and that the individuals possess only the resources indicated.

o An individual has $1,900 in cash, no life insurance and $1,500 in an account set aside for burial. S(he) has countable resources of $1,900 and is resource-eligible as Categorically Needy.

Example: Max. Possible Set-Aside $1,500
Insurance excluded
previously - 0

	$1,500
	$1,500
Irrevocable Contract	- 0
Allowable Set-Aside	$1,500

- An individual has $2,000 in cash, $1,500 set aside for burial and a term insurance policy on his/her life with face value of $7,000. The face amount of this insurance policy does not affect the amount available (or set aside) and thus this individual has countable resources of $2,000, and is eligible as Categorically Needy.

Example:	Max. Possible Set-Aside	$1,500
	Insurance excluded previously	- 0
		$1,500
	Irrevocable Contract	- 0
	Allowable Set-Aside	$1,500

- An individual has cash of $3,900, no insurance, an irrevocable burial contract of $1,500, and $1,500 set-aside. The amount excludable set-aside amount is determined by reducing the maximum possible excludable set aside of $1,500 by the $1,500 in the irrevocable contract. There is no excludable set-aside amount. Therefore, the individual has countable resources of $5,400 and is ineligible both as Categorically Needy and Medically Needy.

Example:	Max. Possible Set-Aside	$1,500
	Insurance excluded previously	- 0
		$1,500
	Irrevocable Contract-	-1,500
	Excludable Set-Aside	0

- An individual has a bank account of $1,900 and life insurance with a face value of $2,000, cash surrender value of $1,500. In a Categorically Needy determination, the total cash resources are $3,400 ($1,900 bank account plus $1,500 cash value of overthreshold insurance), the individual would be ineligible*. However, the individual states that s(he) plans to use $1,500 in the bank account as a set-aside for burial and submits an AP-5.2 and evidence of restructured bank accounts within 30 days. In this

instance, the individual would be eligible since the cash surrender value of the insurance plus the $400 remaining in the original account is within the Categorically Needy resource limit. The bank account containing the burial funds qualifies as an excludable set-aside as long as the funds remain untouched.

Example:	Max. Possible Set-Aside	$1,500
	Insurance excluded previously	- 0
		$1,500
	Irrevocable Contract	- 0
	Allowable Set-Aside	$1,500

The set-aside can be either a portion of the bank account or the insurance.

*Note that in a Medically Needy determination, the life insurance face value is less than the $4,000 threshold. As a result, the cash value of the lie insurance policy is excluded. The $4,000 face value reduces the permissible set-aside to zero.

- o An individual has $1,500 in a bank account, non-term life insurance with a face value of $500 and non-home property valued at $800. The individual states that the property is to augment the insurance for burial.

Example:	Maximum Set-aside	$1,500
	Insurance excluded previously	-500
		$1,000
	Irrevocable Contract	-0
	Allowable Set-Aside	$1,000

The non-home property is an allowable set-aside. The individual is eligible once the statement regarding the set-aside is completed.

0356.50 TRUSTS

REV:12/2000

A trust is an arrangement in which a grantor transfers property to a trustee with the intention that it be held, managed, or administered by the trustee for the benefit of the grantor or certain designated beneficiaries.

When an applicant or recipient is a party to a trust, the trust must be reviewed to determine if it has an impact on the individual's eligibility for MA. Trusts and portions of trusts may be treated as available income, available resources or as a

transfer of assets for less than fair market value. Trusts are referred to the Regional Manager for evaluation.

Trusts established prior to 8/11/93, called Medical Assistance Qualifying Trusts, are treated under provisions contained in 0356.50.05 and 0356.50.05.05.

Trusts established on or after 8/11/93 are evaluated in accordance with provisions contained in 0356.50.10.

Exceptions to trust provisions and hardship exemptions are contained in 0356.50.20 and 0356.50.25.

The following definitions apply in general to trusts created other than by will:

A TRUST is any arrangement in which a grantor transfers property to a trustee with the intention that it be held, managed, or administered by the trustee for the benefit of the grantor or other designated beneficiaries. The term "trust" also includes any legal instrument or device that is similar to a trust. It does not cover trusts established by will. If trust which includes assets of the individual and assets of other person(s), this policy applies only to the portion of the trust attributable to the individual. The trust must be valid under Rhode Island law.

A REVOCABLE TRUST is one which:

- under RI law can be revoked by the grantor;
- provides for modification or termination by a court; or,
- terminates if some action is taken by the grantor.

AN IRREVOCABLE TRUST is one which cannot, in any way, be revoked by the grantor.

THE GRANTOR/SETTLOR is the person who creates a trust. For purposes of this policy the term grantor/settlor includes:

- the individual;
- the individual's spouse;
- A person, including a court or administrative body, with legal authority to act on behalf of the individual or the individual's spouse; and,
- A person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

THE BENEFICIARY/GRANTEE is the person(s) for whose benefit the trust exists. In some cases, the person creating the trust (the grantor) is named as one of the beneficiaries.

THE TRUSTEE is the person or entity (such as a bank or insurance company) that holds and manages a trust, and has fiduciary responsibilities. In most cases, trustees do not have legal right to use the trust fund for their own benefit.

THE TRUSTEE'S DISCRETION is the power the terms of the trust grant expressly to use judgement as to when and/or how to handle trust income and/or principal. Not all trusts grant discretion to a trustee.

THE TRUST PRINCIPAL is the property or funds placed in trust by the grantor/settlor or by another individual.

TRUST INCOME is the amount earned by trust property. Trust income may take various forms, such as interest, dividends, or rent. Trust income may also be called trust earnings.

A TRUST DOCUMENT is the legal document setting forth the terms of the trust.

0356.50.05 Trusts Established Prior to 8/11/93

REV:12/2000

A trust, or similar legal device, is called a MEDICAL ASSISTANCE QUALIFYING TRUST when it:

- was established prior to 8/11/93 by the individual, the individual's spouse or legal guardian, or the individual's legal representative acting on his/her behalf;
- was established through a method other than a will;
- names the individual as a beneficiary;
- gives a trustee any discretion to disburse funds from the trust to or for the benefit of the individual; and
- was created for a purpose other than to qualify for MA.

Medical Assistance Qualifying Trusts may be irrevocable or revocable. There are no "use" limits on the funds in a Medical Assistance Qualifying Trust; trusts established by the individual to pay for special needs (e.g., medical, rehabilitative, or educational) may be considered MA Qualifying Trusts insofar as they meet the criteria above.

However, if a beneficiary of a trust is a mentally retarded individual who resides in an Intermediate Care Facility for the Mentally Retarded, that individual's trust is NOT considered a Medical Assistance Qualifying Trust, provided the trust or initial trust decree was established prior to April 7, 1986, and is solely for the benefit of that mentally retarded individual.

Legal instruments such as trusts are almost always drafted by an attorney. It is the grantor (beneficiary) himself who actually establishes or creates the trust when he signs or executes it.

0356.50.05.05 Eval an MA Qualifying Trust

REV:12/2000

In the determination of financial eligibility and in the post- eligibility treatment of income, count as AVAILABLE to the applicant the maximum amount which the trustee(s) may distribute from a Medical Assistance Qualifying Trust. The maximum amount is the amount that the trustee could disburse if (s)he exercised his/her full discretion under the terms of the trust.

Distributions are considered available to the individual establishing the trust whether or not the distributions are actually made or the trustee(s) exercise their authority under the trust.

The amount from the trust that is deemed to be available as a RESOURCE to the beneficiary is the maximum amount that could have been distributed to the beneficiary from the PRINCIPAL of the trust under the terms of the trust, provided the trustee exercised his full discretion under the terms of the trust to distribute the maximum amount to the beneficiary.

The amount from the trust that is deemed to be available as INCOME to the beneficiary is the maximum amount that could have been distributed to the beneficiary from the INCOME of the trust under terms of the trust, provided the trustee exercised his full discretion under the terms of the trust to distribute the maximum amount to the beneficiary.

The maximum distributable amounts deemed available include only those amounts which CAN be but are not distributed from either the income (interest) or principal of the trust. Amounts which are actually distributed to the beneficiary for any purpose, including amounts to pay for the beneficiary's health, personal and other maintenance needs, are treated as income and/or resources, depending on whether the distribution was made from the income or principal of the trust.

0356.50.10 Trusts Established On Or After 8/11/93

REV:12/2000

The following provisions apply to TRUSTS ESTABLISHED BY THE INDIVIDUAL (as defined below) OTHER THAN BY WILL ON OR AFTER 8/11/93. These rules apply without regard to:

- o the purpose for which the trust was established;
- o whether the trustees have or exercise any discretion under the trust;
- o any restriction on when or whether distribution can be made from the trust; or
- o any restriction on the use of distributions from the trust.

An individual includes: the individual; the individual's spouse; any person, including a court or administrative body, with legal authority to act on behalf of the individual or the individual's spouse; and any person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse. A trust must be valid under RI law.

I. REVOCABLE TRUSTS

A revocable trust is a trust that can be revoked by the grantor under RI law. A trust providing for modification or termination by a court is considered to be revocable since the grantor can petition the court to terminate the trust. Any trust which terminates if some action is taken by the grantor is a revocable trust even if it is called irrevocable. For example, a trust may require the trustee to terminate a trust and disburse funds to the individual if the individual leaves a nursing facility. This would be considered to be a revocable trust.

Revocable trusts are treated as follows:

* The entire corpus (principle and interest) of the trust is treated as a countable RESOURCE;

* Payments made from the trust to or for the benefit of the individual are counted as available INCOME;

* Any other payments made from the trust are considered to be a TRANSFER OF ASSETS FOR LESS THAN FAIR MARKET VALUE and are subject to a TRANSFER PENALTY with regard to payment for Long Term Care services. (Refer to Section 0384 for information about Transfer Penalties.)

II. IRREVOCABLE TRUSTS

An irrevocable trust is one which cannot, in any way, be revoked by the grantor. Irrevocable trusts are treated as follows:

* Payments from trust income or principal which are made to or for the benefit of the individual are treated as INCOME to the individual;

* Portions of the principal that COULD BE PAID to or for the benefit of individual are treated as an available RESOURCE;

* Payments from income or principal which under the trust could have been made to or for the benefit of the individual, but are instead made to someone else and not for the benefit of the individual are treated as a TRANSFER OF ASSETS FOR LESS THAN FAIR MARKET VALUE and may be subject to a penalty with regard to payment for Long Term Care services. (Refer to Section 0384 for information about Transfer Penalties.)

* Portions held in the trust which CANNOT UNDER ANY CIRCUMSTANCES BE PAID to or for the benefit of the individual are treated as a TRANSFER OF ASSETS FOR LESS THAN FAIR MARKET VALUE and may be subject to a penalty with regard to payment for Long Term Care Services. The date of the transfer is equal to the date the trust was first established or, if later, the date payment to the individual was foreclosed. (Refer to Section 0384 for information about Transfer Penalties.)

0356.50.15 Trust Evaluation Process

REV:12/2000

When field staff encounter a trust, the individual must provide a copy of the trust document or other device, and relevant documents to verify the value of any investments and distributions that have been made by the trustee. A memorandum, along with copies of the trust document and all documentation, is forwarded to the Regional Manager for a determination of the amount to be counted in the eligibility determination. Copies are retained in the case record. The Office of Legal Counsel is available for consultation with the Administrator to aid in establishment of the countable resource amount. The countable income/resource amount is added to other countable income/resources to determine eligibility. The imposition of a penalty related to a prohibited transfer is calculated based on the date of the transfer and the uncompensated value of the transfer.

0356.50.20 Exceptions To Trust Provisions

REV:12/2000

The following trusts receive special treatment in the determination of eligibility for MA. No transfer of assets is considered to have taken place as a result of establishing or funding the trust. The income and resources considered available to the individual are ONLY those made available by the trust.

1. SPECIAL NEEDS TRUST, defined as a trust which

   - contains the assets of an individual under age 65 who is disabled (as defined by the SSI program);
   - was established as a trust for the sole benefit of the individual by a parent, grandparent, legal guardian or court; and,
   - provides that upon the death of the individual, the State will receive all amounts remaining in the trust, up to an amount equal to the total MA payments made on behalf of the individual.

   The trust may contain assets of individuals other than the disabled individual.

   This exemption remains once the individual turns age 65 as long as there are no changes in the terms of the trust once the individual attains age 65. Any assets added to the trust as of age 65 are not subject to this transfer of assets exemption.

AND

2. POOLED TRUST, defined as a trust that contains the assets of a disabled individual and meets the following conditions:

   - The trust is established and managed by a non-profit association;

- A separate account is maintained for each beneficiary of the trust, but for purposes of investment and management of funds, the trust pools the funds in these accounts;

- Accounts in the trust are established solely for the benefit of the disabled individual by the individual, parent, grandparent, legal guardian or by a court; and,

- To the extent that any amounts remaining in the beneficiary's account upon his/her death are not retained by the trust, the trust pays to the State the amount remaining in the account, up to the total amount of Medical Assistance paid on behalf of the individual.

0356.50.25 Claims of Undue Hardship

REV:12/2000

Trust provisions shall be waived if application of those provisions would cause the individual undue hardship. Undue hardship exits when:

1) Application of trust provisions would deprive the individual of medical care to the extent that his/her life or health would be endangered or would deprive the individual of food, shelter, clothing or other necessities of life; AND

2) All appropriate attempts to retrieve the property which was the subject of the prohibited transfer have been exhausted.

Undue hardship does not exist when application of the trust provisions merely causes inconvenience or restricts lifestyle but would not put him/her at risk of serious deprivation.

When eligibility for Medical Assistance has been denied due to imposition of trust provisions, the individual may claim undue hardship. The individual must submit a written request and any supporting documentation. The individual's request for consideration of undue hardship does not limit his or her right to appeal denial of eligibility for reasons other than hardship.

Claims of undue hardship are forwarded to the Administrator-Field Operations for evaluation. The Administrator-Field Operations may instruct the agency representative to obtain documentation from the individual which can include but is not limited to the following:

- A statement from the attorney, if one was involved;

- Verification of medical insurance coverage and statements from medical providers relative to usage not covered by said insurance;

- A statement from the trustee and/or transferee.

The Administrator-Field Operations, in consultation with the Office of Legal Counsel, determines whether undue hardship exists. The individual is provided written notification of the Department's decision, along with appeal rights, within sixty (60) days of the Department's receipt of the request.

0356.55 LIFE ESTATE

REV:06/1994

A life estate is a legal procedure giving a person certain rights in a property for his/her lifetime. Usually a life estate conveys the property to one party (the life estate holder) for life and to a second party (remainderman) when the life estate expires. The holder of the life estate agreement is entitled to all of the income produced by the property unless the life estate specifies otherwise. The agreement which creates a life estate is a will, a deed or some other legal instrument.

When considering a life estate it is necessary to distinguish between the physical property and the life estate. The physical property has one value and the life estate has another, separate value. The value of the life estate is based on the equity value of the property and the age of the life estate holder.

The life estate holder may use the property as his home for the rest of his life, or he may rent the property or sell his interest.

A primary obligation of the life estate holder is to preserve the property in the same condition as when s/he received it so that, at his/her death, it will pass to the remainderman in much the same condition.

The remainderman has an ownership interest in the physical property but s/he cannot possess or use the property until termination of the life estate. Unless restricted by the life estate agreement, the remainderman can sell his/her interest in the property before the life estate expires.

0356.55.05 Life Estate Exclusions

REV:06/1994

A life estate in real property is excluded if the property is the applicant's home or it produces income to the applicant.

A life estate in real property is excluded if the real property is the home of a person residing in a long term care facility for the first six month's of the person's stay in the facility, OR is the primary residence of the LTCF resident's spouse, minor child or disabled child of any age.

A life estate may be excluded if the life estate cannot be sold.

If the life estate cannot be sold, then the value is not available to the applicant and it is excluded on that basis.

The salability of the life estate must be reviewed at each redetermination.

0356.55.10 Eval Life Est/Remainder Inter

REV:06/1994

The value of a life estate or reminder interest is based on the equity value of the real property and the mortality table.

To determine the value of a life estate, the Office of LTC would:

- o Determine the EQUITY VALUE of the real property by subtracting any encumbrances from the Fair Market Value;
- o Round the age of the estate holder to the nearest year;
- o Consult the Life Estate and Remainder Interest Tables which provides the value of a life estate and the value of a remainder estate at any given age. Multiply the equity value of the real property by the appropriate figure from the mortality table.

0356.55.15 Resource Transfer

REV:06/1994

When an individual owns real estate and establishes a life estate for himself or herself in the property, the individual has transferred an asset, the remainder interest. These transfers are handled the same way as any other transfer of real property. The value of the transfer is the remainder interest in the life estate.

The remainder interest is the equity value of the property minus the value of the life estate.

0356.60 RSDI AND SSI RETRO PAYMENTS

REV:06/1994

An RSDI or SSI retroactive payment DUE FOR ONE (1) OR MORE PRIOR MONTHS is excluded from resources FOR SIX (6) MONTHS following the month of receipt.

This exclusion applies to retroactive payments received by the individual, the individual's spouse and/or any other individual whose income is deemed to the individual (or spouse).

RSDI benefits are regularly paid for the prior month. Therefore, a retroactive RSDI payment is one made for a month that is TWO (2) OR MORE MONTHS PRIOR TO THE MONTH OF PAYMENT.

This exclusion applies to retroactive payments only if they remain in the form of cash or identifiable funds; this exclusion does not apply once the retroactive payment has been converted to any other form.

If a resource is excluded under this policy, the case record must clearly indicate the resource, its amount and the period of the exclusion. If the excluded resource in conjunction with other resources would render the individual ineligible for MA, the redetermination must be scheduled for the month prior to the month in which the period of exclusion ends.

Although excluded from resources, retroactive RSDI benefits are COUNTABLE unearned income in the month received. As such, they are included in the calculation of income, and the calculation of the excess income under the flexible test policy.

Such benefits are also included in the calculation of monthly income to be applied to the cost of care of a applicant in an LTC facility, or the cost of services received under a Waiver.

0356.65 RESOURCES FOR SELF-EMPLOYMENT

REV:06/1994

Resources essential to the applicant's (or deemor's) means of self support are excluded from countable resources if the property is currently used to produce income, or will be used to produce income within one year, such as the boat of a shell fisherman during the winter. Such resources are the tools and equipment necessary for and normally used in the operation of a trade or business, or for an employee to perform his/her job. For example, the boat of a commercial fisherman, the tools of a plumber or mechanic, the automobile of a cabdriver, etc. are excluded.

0356.70 PLAN FOR ACHIEV SELF-SUPPORT

REV:06/1994

When a blind or disabled individual has a specific plan (PASS) approved by the Social Security Administration (SSA) for achieving self-support, resources (and income) necessary for accomplishing the objective of the plan are excluded from countable resources.

To document the exclusion, the applicant must provide a copy of the approved plan, or, with the applicant's permission, a copy must be obtained from SSA.

0356.75 RESOURCES EXCLUDED BY STATUTE

REV:01/2002

The exclusion of resources made available by statute applies as long as the resource is maintained in a separate and identifiable account, and not commingled with other, countable resources.

Except as noted below or in the policy on specific types of resources (e.g. burial set-asides), interest or dividends paid on the excluded resource are NOT excluded from counting as income, or if retained, as resources.

0356.75.05 Disaster Assistance

REV:06/1994

Disaster Assistance provided under a federal statute pursuant to a Presidential declaration of a disaster (which are excluded from income) are excluded from resources for a period of nine (9) months from the date of receipt. In addition, INTEREST EARNED ON SUCH FUNDS IS ALSO EXCLUDED from income and resources for a period of nine months. The exclusions may be continued for one additional nine month period if circumstances beyond the control of the recipient make it impossible for him/her to use the funds for the purpose intended within the first period.

0356.75.10 German Reparation Payments

REV:06/1994

As a result of the court case Grunfeder v. Heckler (9th Cir. 1984) and section 4715 of OBRA '90, German Reparation Payments are not counted for any Medical Assistance Program purpose. German Reparation Payments are disregarded in Medical Assistance eligibility determinations and in the post-eligibility process, and payments retained beyond the month of receipt are excluded from resources.

0356.75.15 Agent Orange Settlement Pay

REV:06/1994

OBRA '89 provides that Agent Orange Settlement Payments paid from a trust fund set up, pursuant to the Agent Orange product liability settlement, by manufacturers of a chemical defoliant used by the U.S. military in Vietnam are excluded from income and resources for veterans or their survivors.

0356.75.20 Burial Spaces, Accru Income

REV:06/1994

OBRA '89 provides that interest earned on the value of agreements representing the purchase of burial spaces (provided that the burial spaces are excluded from resources and provided that the interest is left to accrue) is excluded from income and resources in eligibility determinations.

The intent of the statute is that interest left to accumulate together with the excluded value of the burial space should not be counted as income or resources because it is not intended to be used for the purchase of food, clothing, or shelter (the criteria used to define countable income).

0356.75.25 Restit Pay to Japanese, Aleuts

REV:01/2002

Under provisions contained in Public Law 100-383, the U. S.

Government made individual restitution payments to certain Japanese-Americans and Aleuts who were relocated or interned during World War II. In certain instances, payments on behalf of deceased individuals were made to survivors. The payments were $20,000 to Japanese-Americans, and $12,000 to Aleuts. Payments made under this law are not to be considered resources (or income) for Medical Assistance purposes.

The recipient should have documentation of the amount of the payment.

0358 SSI-RELATED DEEMING OF RESOURC

0358.05 COUNTABLE RESOURCES

REV:06/1994

COUPLE'S COUNTABLE RESOURCES

In a couple situation, the total countable resources for the applicant/recipient are the combination of the resources of the applicant/recipient (the eligible individual) and the non-applicant or ineligible, i.e., no characteristic, spouse (the ineligible individual) after all applicable resource exclusions are applied.

Total countable resources, the value of which is determined as of the first moment of the month, are compared with the Medical Assistance resource limitation for:

- a couple.

If the amount of the resources does not exceed the Medical Assistance limit (either Categorically Needy or Medically Needy, as appropriate), the applicant/recipient meets the Medical Assistance financial eligibility requirements. If countable resources exceed the Medical Assistance limit, the applicant/recipient is ineligible.

CHILD'S COUNTABLE RESOURCES

Step-parent deeming is prohibited in Medical Assistance eligibility determinations.

In determining Medical Assistance eligibility of a child under 18 who lives with his natural or adoptive parent(s) or with the parent and the "spouse of the parent" (step-parent), the resources of the child include the value of the countable resources of the PARENT(S), (but not the step-parent,) to the extent that the resources of the parent(s) EXCEED THE MEDICAL ASSISTANCE Categorically Needy RESOURCE LIMIT for:

- AN INDIVIDUAL, if the child lives in the household with ONE PARENT OR ONE PARENT AND A STEP-PARENT; or,
- A COUPLE, if the child lives in the household with TWO PARENTS.

A child's countable resources are the combination of the value of the deemed resources and the non-excluded resources of the child.

A child's total countable resources, determined as of the first moment of the month, are compared with the MEDICAL ASSISTANCE RESOURCE LIMIT for:

- AN INDIVIDUAL.

If the amount of the resources does not exceed the Medical Assistance limit (either Categorically Needy or Medically Needy, as appropriate), the applicant/recipient meets the Medical Assistance resource eligibility requirements. If countable resource eligibility requirements. If countable resources exceed the Medical Assistance limit, the applicant/recipient is ineligible.

0358.05.05 Resource Deeming Exclusions

REV:06/1994

UNLIKE REGULAR MEDICAL ASSISTANCE RESOURCE ELIGIBILITY DETERMINATIONS, PENSION FUNDS OWNED BY AN INELIGIBLE PARENT (IN PARENTAL DEEMING) OR BY AN INELIGIBLE SPOUSE (IN SPOUSAL DEEMING) ARE EXCLUDED FROM RESOURCES FOR DEEMING PURPOSES. "Pension funds" are defined as funds held in individual retirement accounts (IRA's) as described by

the Internal Revenue Code, or in work-related pension plans (including such plans for self-employed individuals, sometimes referred to as Keogh plans).

In addition, all Medical Assistance resource exclusions (see Section 0354.35) that apply to an eligible individual's resources apply to the resources of an ineligible parent or an ineligible spouse.

0358.10 RESOURCE DEEMING

REV:06/1994

There are two categories of individuals whose resources may be deemed to a Medical Assistance applicant/recipient: Ineligible Spouse and Ineligible Parent.

The term "deeming" is used to identify the process of considering another person's resources to be the resources of the Medical Assistance applicant/recipient. When the deeming rules apply, it does not matter whether the resources of the other person are actually available; the deeming rules are applied anyway.

When determining eligibility for the Medical Assistance Program, resources are deemed from one individual to another ONLY when the owner of the resource is INELIGIBLE FOR THE SSI PROGRAM BECAUSE the value of the countable resources EXCEEDS THE RESOURCE LIMIT OF THE SSI PROGRAM. In order for deeming rules to apply, the deemor (individual with the resource) must not be eligible for the SSI Program. Therefore, during the deeming computation, the value of the resource is compared to the SSI resource standard. Only when the total countable resources of the Medical Assistance applicant have been computed, i.e., the value of the Medical Assistance applicant's own resources added to the resource value deemed to be available to the MA applicant, is the total resource value compared to the Medical Assistance resource standard (Categorically Needy or Medically Needy).

RESOURCES ARE DEEMED FROM THE "INELIGIBLE" TO THE "ELIGIBLE." The terms "eligible" and "ineligible" in this context refer to the individual's position in the deeming process. "Ineligible" refers to the spouse or parent WHOSE RESOURCES will be considered as belonging to the "eligible" spouse or child. The deemed resource is then considered to be the resource of the Medical Assistance applicant/recipient and is used in determining the individual's financial eligibility for Medical Assistance. FINAL ELIGIBILITY FOR MEDICAL ASSISTANCE IS CONTINGENT UPON ALL FINANCIAL AND NON-FINANCIAL CRITERIA OF THE PROGRAM BEING MET.

For all types of resource deeming, there is no resource allocation for ineligible children in the household.

0358.15 DEEM FROM INELIG SPOUS

REV:06/1994

When both members of a couple (spousal relationship and living together in the community) apply for Medical Assistance and both members of the couple have an SSI-related coverage group, the resources of the couple are combined and tested against the appropriate Medical Assistance resource standard (categorically or Medically Needy) for two. Each member's eligibility is determined under his/her own particular coverage provision.

Spouse-to-spouse deeming of resources applies in Medical Assistance eligibility determinations when only one member of a couple applies or when only one member of the couple is potentially eligible for Medical Assistance under an SSI-related coverage group. EVEN THOUGH ONLY ONE MEMBER OF THE COUPLE IS APPLYING OR IS POTENTIALLY ELIGIBLE FOR MEDICAL ASSISTANCE, THE RESOURCES OF THE COUPLE ARE STILL COMBINED AND TESTED AGAINST THE APPROPRIATE MEDICAL ASSISTANCE STANDARD FOR TWO.

The applicant/recipient member of the couple is termed the "ELIGIBLE INDIVIDUAL." The "INELIGIBLE SPOUSE" means someone who lives with the eligible individual as that person's husband or wife, either through a ceremonial marriage or through a common-law marriage, and who is not eligible or who is not applying for Medical Assistance.

When an ineligible or non-applicant spouse lives in the same household as the Medical Assistance applicant/recipient, the amount of the ineligible spouse's resources are first determined, applying the appropriate resource exclusions (see C., above).

The eligible individual's resources are deemed to include any resources, not otherwise excluded, of the ineligible spouse whether or not the resources are actually available to the Medical Assistance applicant/recipient. The applicant/recipient's countable resources are then tested against the appropriate Medical Assistance resource standard (categorically or Medically Needy) for the couple.

- o All non-excluded resources of the ineligible spouse, whether owned solely or jointly, are deemed available to the applicant/recipient.

- o The COUNTABLE RESOURCES of the Medical Assistance applicant/recipient, i.e., the TOTAL VALUE OF THE COUPLE'S NON-EXCLUDED RESOURCES, are compared to the Medical Assistance couple's resource standard (Categorically Needy or Medically Needy).

0358.15.05 Examples of Resource Deeming

REV:06/1994

1. NO RESOURCES EXCLUDED - INDIVIDUAL MEETS THE RESOURCE ELIGIBILITY REQUIREMENT

Mr. and Mrs. Daley are a married couple living in the community. Mr. Daley, who is age 65, applies for Medical Assistance. His wife is under age 65 and neither blind or disabled. Mr. Daley has no resources of his own. Mrs. Daley has $1,900 in a savings account and $800 in a checking account. The couple's countable resources are as follows:

$ -0-	-	Couple's excludable resources
$1,900	-	Mrs. Daley's savings account
+ 800	-	Mrs. Daley's checking account
+ 0	-	Mr. Daley's resources
$2,700	-	couple's countable resources

The resource computation follows:

$2,700 is the amount of the couple's countable resources used in determining Mr. Daley's eligibility.

The countable resources of $2,700 are less than the Medical Assistance Categorically Needy couple's resource standard ($3,000). Assuming all other financial and non-financial eligibility criteria are met, Mr. Daley is eligible for Medical Assistance as Categorically Needy.

2. NO RESOURCES EXCLUDED - INDIVIDUAL IS NOT ELIGIBLE

Mr. and Mrs. Bailey are a married couple living in the community. Mrs. Bailey, who is blind, applies for Medical Assistance. Her husband is under age 65 and neither blind or disabled. Mrs. Bailey has $1,500 in a savings account. Mr. Bailey has $3,600 in a savings account and $2,000 in U.S. savings bonds. The couple has $237 in a joint checking account. The couple's countable resources are as follows:

$ -0-	-	Couple's excludable resources
$1,500	-	Mrs. Bailey's savings account
+3,600	-	Mr. Bailey's savings account
+2,000	-	Mr. Bailey's U.S. savings bonds
+ 237	-	the couple's joint checking acct.
$7,337	-	couple's countable resources

The resource computation follows:

$7,337 is the amount of the couple's countable resources used in determining Mrs. Bailey's eligibility.

Countable resources of $7,337 are greater than both the Medical Assistance categorically and Medically Needy couple's resource standards ($3,000 and $6,000 respectively).

3. SOME RESOURCES EXCLUDED - INDIVIDUAL MEETS THE RESOURCE ELIGIBILITY REQUIREMENT

Mr. and Mrs. Sands are a married couple. Mr. Sands, who is disabled, applies for Medical Assistance. Mrs. Sands works for a company with a pension plan and has accumulated $5,000 in her pension fund which she can withdraw at any time. Mr. and Mrs. Sands jointly own two gravesites worth $800 each and have a joint savings account with a balance of $4,248.

The couple's resources are as follows:

Excluded Resources	$5,000	- Mrs. Sands' pension fund
	+1,600	- Mr. & Mrs. Sands' gravesites
	$6,600	- excluded resources
Countable Resources	$4,248	- the couple's joint savings account

The resource computation follows:

$4,248 is the amount of the couple's countable resources used in determining Mr. Sands' eligibility.

Countable resources of $4,248 are greater than the Medical Assistance Categorically Needy couple's resource standard ($3,000), but less than the Medical Assistance Medically Needy couple's resource standard ($6,000). Assuming Mr. Sands meets all other financial and non-financial eligibility criteria, Mr. Sands is eligible for Medical Assistance for the Medically Needy scope of services.

4. SOME RESOURCES EXCLUDED - INDIVIDUAL IS NOT ELIGIBLE

Mr. Smith, who is 75 years old, lives with his wife, who is 64 years old and neither blind or disabled. At the time he applies for Medical Assistance, they have the following resources: a joint savings account of $1,342; a joint checking account of $249; United States savings bonds (in both names) worth $850; and two automobiles -- one used for essential daily activities and valued at $7,000, and the other with a current market value and equity value of $4,000. In addition, they own two burial spaces with a value of $700 each. Mr.

Smith owns a life insurance policy on his own life with a face value of $2,500 and a cash surrender value of $1,895. Mrs.

Smith owns a life insurance policy on her own life with a face value of $1,000 and a cash surrender value of $900. Their household goods and personal effects are valued at $1,000.

a) The couple's resources for a Categorically Needy eligibility determination are as follows:

Excluded Resources	$1,400	- Mr. & Mrs. Smith's two gravesites
	+7,000	- essential automobile
	+ 900	- Mrs. Smith's life insurance (face value under $1,500)
	+1,000	- household goods
	$10,300	- excluded resources

Countable Resources $1,342 - Mr. & Mrs. Smith's joint sav. acct.
249 - joint checking account
850 - U.S. savings bonds
1,895 - Mr. Smith's life insurance cash value (face value greater than $1,500)
+4,000 - second automobile

$8,336 - countable resources

The resource computation follows:

$8,336 is the amount of the couple's countable resources used in determining Mr. Smith's eligibility.

Countable resources of $8,336 are greater than the Medical Assistance Categorically Needy couple's resource standard ($3,000). Mr. Smith is ineligible for Medical Assistance as Categorically Needy and must be retested for eligibility as Medically Needy.

b) The couple's resources for a Medically Needy eligibility determination are as follows:

Excluded Resources $1,400 - two gravesites
+7,000 - essential automobile
+1,895 - Mr. Smith's life insurance (face value under $4,000)
+ 900 - Mrs. Smith's life insurance (face value under $ 4,000)
+1,000 - household goods

$12,195 - excluded resources

Countable Resources $1,342 - joint savings account
249 - joint checking account
850 - U.S. savings bonds
4,000 - second automobile

$6,441 - countable resources

The resource computation follows:

$6,441 - countable resources
6,000 - couple's resource

limit

______

$ 441 - excess resources

Countable resources of $6,441 are greater than the Medical Assistance Medically Needy couple's resource standard ($6,000). Mr. Smith is ineligible for Medical Assistance at the time of application.

0358.20 DEEMING FROM INELIG PARENT

REV:06/1994

The resources of a natural or adopted eligible child, under age 18, who is living in the household of a natural or adoptive ineligible parent(s) are deemed to include any resources, not otherwise excluded, of the ineligible natural or adoptive parent. Step- parent deeming is prohibited in Medical Assistance. The resources are deemed whether or not the resources are available to the eligible child. The deemed resources are combined with any non- excluded resources of the eligible child's own.

- o If the eligible child is living with only one natural or adoptive parent, resources are deemed to the extent that the resources of the ineligible parent exceed the MEDICAL ASSISTANCE Categorically Needy RESOURCE LIMIT FOR AN INDIVIDUAL.
- o If the eligible child is living with both natural or adoptive parents, resources are deemed to the extent that the resources of the ineligible parents exceed the MEDICAL ASSISTANCE Categorically Needy RESOURCE LIMIT FOR A COUPLE.
- o If the eligible child is living with a natural or adoptive parent and the spouse of that parent (step-parent), resources owned solely and jointly by the parent are deemed to the extent that the resources of the parent exceed the MEDICAL ASSISTANCE Categorically Needy RESOURCE LIMIT FOR AN INDIVIDUAL. RESOURCES OWNED SOLELY BY THE STEP-PARENT ARE NOT CONSIDERED IN THE DEEMING PROCESS.

If more than one Medical Assistance eligible child under age 18 lives in the household, EQUALLY DIVIDE the value of the deemed resources among those children.

If an eligible child is later determined ineligible for any reason or is no longer subject to deeming, divide the total value of that child's deemed resources among the remaining eligible children, effective with the first month the child is ineligible or no longer subject to deeming.

Note: If an eligible child later becomes ineligible, any income or resources deemed to that child must be redistributed among remaining applicant/recipient children in the family. The treatment applied to the deemed resource differs from the treatment applied to the deemed income. The total amount of the resource deemed to the ineligible child is divided equally among the remaining eligible

children, but only that portion of the deemed income which exceeds the standard is redistributed to the remaining eligible children.

0358.20.05 Examples of Resource Deeming

REV:06/1994

1. CHILD LIVING WITH INELIGIBLE PARENT - CHILD MEETS MEDICALLY NEEDY RESOURCE ELIGIBILITY REQUIREMENTS

   Mrs. McAngus lives with her son, Tim, who is age 11 and blind. Tim has no resources of his own. Mrs. McAngus has $4,251 in a savings account. Mrs. McAngus applies for Medical Assistance on behalf of Tim.

   The resource computation follows:

$4,251	-	parent's countable resources
-2,000	-	Individual CN resource limit
$2,251	-	resource value deemed
+ 0	-	child's resources
$2,251	-	child's countable resources

   Since Tim's countable resources exceed the Categorically Needy Medical Assistance resource limit for an individual ($2,000), Tim is not eligible for Medical Assistance as Categorically Needy. However, Tim does meet the Medically Needy Medical Assistance resource limit for an individual ($4,000) and is eligible assuming all other financial and non-financial eligibility criteria are met.

2. CHILD LIVING WITH INELIGIBLE PARENTS - CHILD MEETS THE CATEGORICALLY NEEDY RESOURCE ELIGIBILITY REQUIREMENTS

   Mr. and Mrs. Blake live together with their son, Thomas, who is age 16 and blind. Thomas has no resources of his own. Mr. and Mrs. Blake apply for Medical Assistance on behalf of Thomas. The parents have $4,251 in jointly owned savings.

   The resource computation follows:

$4,251	-	parents' countable resources
-3,000	-	Couple CN resource limit
$1,251	-	resource value deemed
+ 0	-	child's resources
$1,251	-	child's countable resources

   Since Thomas' countable resources do not exceed the Categorically Needy Medical Assistance resource limit for an

individual ($2,000), Thomas is eligible for Medical Assistance as Categorically Needy assuming all other financial and non-financial eligibility criteria are met.

3. TWO CHILDREN LIVING WITH AN INELIGIBLE PARENT AND AN INELIGIBLE STEPPARENT - CHILDREN MEET THE RESOURCE ELIGIBILITY REQUIREMENT

John and Joan Jones, ages 15 and 16, are both disabled and live with their mother, Mary Goode, and stepfather, James Goode. John's only resources are two U.S. savings bonds with a total worth of $150. Joan has a savings account with a balance of $2,000. The mother and stepfather jointly own an automobile valued at $5,000, a savings account with a balance of $4,789, a checking account with a balance of $725, cash on hand of $124, and four family gravesites with a total value of $3,600. Mr. Goode holds U.S. savings bonds in his name only valued at $7,250. Mrs. Goode applies for Medical Assistance on behalf of each of the children.

The resource computation follows:

PARENTS' (MOTHER'S AND STEP-FATHER'S) Excluded Resources

Amount		Description
$ 5,000	-	automobile
+ 3,600	-	gravesites
+ 7,250	-	Mr. Goode's savings bonds
$15,850	-	excluded resources

PARENT'S (MOTHER'S) Countable Resources

Amount		Description
$4,789	-	savings account
+ 725	-	checking account
+ 124	-	cash on hand
$5,638	-	parent's total countable resources
-2,000	-	Individual CN resource limit
$3,638	-	value of deemed resources with $1,819 deemed to each child

John's resources

Amount		Description
$ 150	-	U.S. saving bonds
+1,819	-	resource value deemed
$1,969	-	countable resources

Joan's resources

Amount		Description
$2,000	-	savings account

+1,819	-	resource value deemed
3,819	-	countable resources

It is determined that each child has met all other Medical Assistance financial and non-financial eligibility criteria. Since John's countable resources do not exceed the Medical Assistance Categorically Needy individual resource limit ($2,000), he is eligible for the Medical Assistance Categorically Needy scope of services. Joan's countable resources exceed the Categorically Needy individual resource limit, but are within the Medical Assistance Medically Needy individual resource limit ($4,000). She is certified for the Medically Needy scope of services. (Note: Mrs. Goode chooses not to rebut the MA assumption that all funds in the jointly owned savings and checking account belong to her.)

4. TWO CHILDREN LIVING WITH AN INELIGIBLE PARENT AND AN INELIGIBLE STEPPARENT - ONE CHILD FOUND INELIGIBLE FIRST AND OTHER CHILD'S ELIGIBILITY CHANGES AS A RESULT

The same situation exists as described in 3., above, except that Joan also owns two savings bonds worth $200 each.

Joan's resources

$2,000	-	savings account
+ 400	-	two U.S. savings bonds
+1,819	-	resource value deemed
$4,219	-	countable resources

Joan's brother, John, initially met the Medical Assistance Categorically Needy resource eligibility requirement because his countable resources did not exceed the Categorically Needy resource limit. But Joan does not meet the resource eligibility requirements for either the Medical Assistance Categorically Needy or the Medically Needy scope of services because her countable resources now exceed both limits ($2,000 and $4,000 respectively).

Since Joan is ineligible, the value of the deemed resources must ALL be deemed to John, as follows:

John's resources

$ 150	-	two U.S. saving bonds
+3,638	-	resource value deemed
$3,788	-	countable resources

Johns's countable resources make him ineligible for the Categorically Needy scope of services ($2,000). As his countable resources are within the Medical Assistance Medically Needy individual resource limit ($4,000) he

must now be certified for the lesser scope of services.

0358.25 MULTIPLE DEEMING OF RESOURCES

REV:06/1994

When more than one eligible individual lives in the same household and there is a spousal relationship as well as a parental relationship, a multiple deeming situation may exist. The same adult person may be financially responsible for both a spouse and a child. The following guidelines provide the rules to follow in multiple deeming situations.

- If a child under age 18 lives in the same household with a parent or parents who ARE RECEIVING SSI, do not deem the value of any parental resources to the child. The SSI Program's eligibility determination has already considered the couple's resources.

- If a parent or parents would meet the MEDICAL ASSISTANCE Categorically Needy RESOURCE ELIGIBILITY REQUIREMENTS, do not deem the value of any parental resources to the child.

- If a parent or parents would not meet the Medical Assistance categorical test, but would meet the Medically Needy test, deem the difference between the categorical resource limit and the parent(s) non-excludable resources to the child. Test the child's total countable resources for Categorically Needy eligibility.

- If parental resources deemed to the child are greater than the Categorically Needy resource requirement, the child is ineligible as Categorically Needy and must be tested for Medically Needy eligibility. From the FULL amount of the parent(s) non-excludable resources, subtract the Medically Needy resource standard to determine the amount of parental resources to be deemed to the child. Test the child's total countable resources against the Medically Needy resource standard. NOTE: It is possible for the amount of resources, under this Medically Needy evaluation, to be less than the Categorically Needy standard. Since the child has already been tested and failed the categorical eligibility requirement, Medically Needy eligibility is now being determined.

0358.25.05 Example of Multiple Deeming

REV:06/1994

1. ELIGIBLE CHILD LIVES WITH PARENTS WHO RECEIVE SSI

   Mr. and Mrs. Sullivan lice together with their daughter, Paula, who is age 15. Mr. & Mrs. Sullivan are disabled and receiving SSI. Paula has a heart problem. Mr. & Mrs.

Sullivan apply for Medical Assistance for Paula. Mr. & Mrs. Sullivan have a bank account with a balance of $1,000 and $200 cash on hand. Paula has a savings acount with a balance of $3,752.

The parent's resources:

$1,000 - Mr. & Mrs. Sullivan's bank account
\+ 200 - cash on hand
$1,200 - parent's resources

Since Mr. & Mrs. Sullivan are SSI recipients, there are no parental resources to be deemed to Paula.

The resource computation for Paula follows:

$3,752 - Paula's non-excludable resources
\+ -0- - deemed resources
$3,752 - Paula's countable resources

Determine Paula's Medical Assistance resource eligibility on the basis of only her own resources. Since she has $3,752 in resources, she is ineligible for Categorically Needy Medical Assistance ($2,000), but is eligible for Medically Needy Medical Assistance ($4,000) assuming all other MA eligibility requirements are met.

2. ELIGIBLE CHILD LIVES WITH PARENTS WHO WOULD MEET THE MEDICAL ASSISTANCE CATEGORICALLY NEEDY RESOURCE ELIGIBILITY REQUIREMENTS

Mr. and Mrs. White live together with their son, Peter, who is age 16 and is blind. Mr.& Mrs. White applied for Medical Assistance for Peter only. Mr.& Mrs. White have $1,000 in savings and $200 cash on hand. Peter has no resources.

The parents have the following resource:

$1,000 - Mr. & Mrs. White's savings
\+ 200 - cash on hand
$1,200 - parent's non-excludable resources

If Mr. & Mrs. White were to apply for Medical Assistance, they would met the Categorically Needy resource requirements. Therefore, no parental resources are deemed to Peter.

Peter has no resources of his own and is eligible for Medical Assistance as Categorically Needy assuming he meets all other MA eligibility requirements.

3. ELIGIBLE CHILD LIVES WITH PARENTS: ONE PARENT ALSO APPLIES FOR MEDICAL ASSISTANCE AND IS ELIGIBLE AS CATEGORICALLY NEEDY

Mr. and Mrs. Armstrong lice together with their daughter,

Bethany, who is age 14 and is disabled. Mrs. Armstrong applied for Medical Assistance for herself and for Bethany. Mr. & Mrs. Armstrong have $1,200 in savings and $100 cash on hand. Bethany has no resources.

The parents hace the following resources:

$1,200	-	Mr. & Mrs. Armstrong's savings
+ 100	-	cash on hand
$1,300	-	parents' countable resources

Assuming all other MA eligibility criteria is met Mrs. Armstrong is eligible for Medical Assistance as Categorically Needy since the couple's countable resources ($1,300) are within the categorical resource requirement ($3,000). Therefore, no parental resources are deemed to Bethany.

Bethany has no resources of her own and is eligible for Medical Assistance as Categorically Needy assuming she meets all other MA eligibility requirements.

4. ELIGIBLE CHILD LIVES WITH BOTH PARENTS: ONE PARENT NOT APPLYING FOR MA; ONE PARENT APPLIES FOR MA, BUT DOES NOT MEET THE MEDICAL ASSISTANCE RESOURCE ELIGIBILITY REQUIREMENT

Mr. and Mrs. Ryder live with their daughter, Mary, who is age 17 and disabled. Mrs. Ryder, who is also disabled, applied for Medical Assistance for herself and Mary. Mr. and Mrs. Ryder have $7,200 in savings and $200 cash on hand. Mary owns U.S. Savings bonds worth $200. The parents have the following resources:

The couple's non-exlcudable resurces are:

$7,200	-	Mr. & Mrs. Ryder's savings
+ 200	-	cash on hand
$7,400	-	spouse/parents' countable resources

The resource computation follows:

$7,400	-	spouse/parents' countable resources
-3,000	-	Medical Assistance CN Couple's resource limit
$4,400	-	excess resources

Mrs. Ryder does not meet the CN resource eligibility requirement.

Since Mrs. Ryder would be ineligible for Medical Assistance as Categorically Needy, the resource computation for Mary is as follows:

$4,400	-	parents' countable resources
-3,000	-	couple's resource limit
$1,400	-	resource value deemed to Mary
+ 200	-	Mary's own resources
$1,600	-	Mary's countable resources

Since Mary's countable resources ($1,600) do not exceed the Medical Assistance Categorically Needy resource limit for an individual ($2,000), Mary meets the resource eligibility requirements and is eligible for Medical Assistance (assuming she meets all other financial and non-financial eligibility criteria).

5. ELIGIBLE CHILD LIVES WITH BOTH PARENTS: ONE PARENT IS NOT APPLYING FOR MA WHILE ONE PARENT APPLIES FOR MA, BUT DOES NOT MEET THE RESOURCE ELIGIBILITY REQUIREMENT

Mr. & Mrs. Snyder live with their daughter, Marlene, who is age 14 and disabled. Mrs. Snyder, who is also disabled, applies for Medical Assistance for herself and Marlene. Mr. and Mrs. Snyder have $7,200 in savings and $300 cash on hand.

Parents non-excludable resources:

$7,200	-	Mr. & Mrs. Snyder's savings
+ 300	-	cash on hand
$7,500	-	spouse's countable resources

The resource computation for Mrs. Snyder's Medical Assistance eligibility follows:

Spouses' countable resources

$7,500	-	spouses' countable resources
-6,000	-	MA Medically Needy Couple's resurce limits
$1,500	-	excess resources

Mrs. Snyder does not meet either the Medical Assistance Categorically Needy ($3,000) or Medically Needy ($6,000) resource eligibility requirement. Therefore, she is ineligible for Medical Assistance and her MA application is rejected.

Since Mrs. Snyder is ineligible for Medical Assistance, parental resources must be determined for Marlene. The resource computation for Marlene follows:

$7,500	-	parents' countable resources
-6,000	-	MA Medically Needy resource limit
$1,500	-	resource value deemed to Marlene
+ 200	-	Marlene's own resources
$1,700	-	Marlene's countable resurces

Silnce Marlene's countable resources ($1,700) do not exceed the Medical Assistance Categorically Needy resource limit for an individual ($2,000), Marlene meets the resource eligibility requirements and is eligible for Medical Assistance (assuming she meets all other financial and non-financial eligibility criteria).

0358.30 TEMPORARY ABSENCES AND DEEMING

REV:06/1994

TEMPORARY ABSENCE

FOR THE PURPOSE OF DEEMING, a temporary absence such as for visiting or for another reson, occurs when the Medical Assistance applicant/recipient, the ineligble spouse or ineligible parent or and ineligible child leaves the household but intends to, and does, return in the same month or the month immediately following. If the absence is temporary, the person is considered to be a member of the household.

CHILD AWAY AT SCHOOL

An eligible child who is away at school, but who comes home on some weekends or lengthy holidays and who is subject to the control of his/her parent(s), is considered to be temporarily absent from the household and income deeming rules apply.

However, if the child is not subject to parental control, the absence is not considered to be temporary and the deeming rules do not apply. Being subject to parental control affects deeming only if the child is away at school.

0360 RESOURCE TRANSFER

0360.05 LEGAL BASIS

REV:12/2000

The Omnibus Budget Reconciliation Act (OBRA) of 1993 provides a penalty for institutionalized individuals who transfer or have transferred assets for less than fair market value on or after 8/11/93 when the transfer was made:

- o within 36 months immediately prior to or anytime after the date the individual was both institutionalized and applied for MA; or,

- o if the transfer involves a trust, within 60 months immediately prior to or anytime after the individual was both institutionalized and applied for MA.

The penalty is a period of RESTRICTED MA ELIGIBILITY during which payment is denied for Long Term Care Services, including nursing facility services, Intermediate Care Facility Services for the Mentally Retarded, administratively necessary days in a hospital, and home and community based waiver services.

See Section 0384 for a detailed discussion of this topic.

0362 INCOME GENERALLY

0362.05 INCOME STANDARDS - INDIVIDUAL/COUPLE

REV:03/2006

The following standards are used in the determination of an individual's or couple's income eligibility:

- 2006 Monthly Federal Benefit Rate (FBR);
- Categorically Needy Income Limits;
- Medically Needy Monthly Income Limits;
- 2006 Federal Poverty Level Income Guidelines (for Low Income Aged and Disabled Individuals, Qualified Medicare Beneficiaries, Specified Low Income Medicare Beneficiaries and Qualified Disabled and Working Individuals).

2006 MONTHLY FEDERAL BENEFIT RATE (FBR)

INDIVIDUAL - OWN HOME	$603.00
COUPLE - OWN HOME	$904.00
INDIVIDUAL - HOME OF ANOTHER	$402.00
COUPLE - HOME OF ANOTHER	$602.68

"DIFFERENCE BETWEEN"

COUPLE AND INDIVIDUAL - OWN HOME	$301.32
COUPLE AND INDIVIDUAL - HOME OF ANOTHER	$200.68

"DOUBLE THE FBR"

INDIVIDUAL - OWN HOME	$1,206.00
INDIVIDUAL - HOME OF ANOTHER	$ 804.00
COUPLE - OWN HOME	$1,808.00
COUPLE - HOME OF ANOTHER	$1,205.36

CATEGORICALLY NEEDY NET MONTHLY INCOME LIMITS FOR AGED, BLIND, OR DISABLED INDIVIDUALS/COUPLES

INCOME LIMITS	INDIVIDUAL	COUPLE
Living in a Nursing Facility or ICF-MR Facility	$ 1,809.00**	N/A
Living in Own Household	636.35	$ 977.50
Living in Household of Another	455.94	707.84
Living in a Residential Care and Assisted Living Facility	1,809.00**	Treat as Individual
Institutionalized Individual eligible for the Federal and State Supplement	50.00	100.00

** By Federal Law, to be eligible as Categorically Needy while living in a Nursing Facility, ICF-MR Facility or a licensed Residential Care and Assisted Living Facility, an individual's gross income cannot exceed 300% of the Federal SSI level of payment for an individual. This is the FEDERAL CAP which is $1,809 effective 01/01/2006.

TABLE OF MEDICALLY NEEDY MONTHLY INCOME LIMITS

1 Person	$ 717	5 Persons	$1,200
2 Persons	758	6 Persons	1,358
3 Persons	942	7 Persons	1,492
4 Persons	1,075	8 Persons	1,642

2006 FEDERAL POVERTY LEVEL MONTHLY INCOME GUIDELINES

100% of FEDERAL POVERTY LEVEL INCOME GUIDELINES FOR QUALIFIED MEDICARE BENEFICIARIES (QMB's) AND LOW-INCOME AGED AND DISABLED.

INDIVIDUAL	$ 816.67
COUPLE	$1,100.00

120% of FEDERAL POVERTY LEVEL INCOME GUIDELINES FOR SPECIFIED LOW- INCOME MEDICARE BENEFICIARIES (SLMB's).

INDIVIDUAL	$ 980.00
COUPLE	$1,320.00

135% of FEDERAL POVERTY LEVEL INCOME GUIDELINES FOR QUALIFIED INDIVIDUALS (QI-1)

INDIVIDUAL	$1,102.50
COUPLE	$1,485.00

200% of FEDERAL POVERTY LEVEL INCOME GUIDELINES FOR QUALIFIED DISABLED AND WORKING INDIVIDUALS (QDWI's).

INDIVIDUAL	$1,633.33
COUPLE	$2,200.00

0362.10 INCOME DEFINITIONS

REV:06/1994

Income is anything received in cash or in-kind that can be used to meet the needs for food, clothing or shelter. In-kind income is not cash, but is actually food, clothing, or shelter, or something the individual can use to get one of these. Earned and unearned income is considered when determining an individual's and couple's financial eligibility.

0362.10.05 Earned Income

REV:06/1994

Earned income may be in cash or in-kind and consists of the following types of payments:

- o Wages;
- o Net earnings from self employment;
- o Payments or refunds of earned income tax credits;
- o Payments for services performed in a sheltered workshop or work activity.

Earned income is counted as earned income when received (or would have been received except that the applicant/recipient decided to postpone receipt) rather than when earned. This recognizes that the time between earning and receiving income sometimes is long.

In a program based on the current need, the relevant time is when income is received.

0362.10.10 Unearned Income

REV:06/1994

Unearned income is defined as all income that is not earned income whether cash or in-kind. Some types of unearned income are:

- o Deemed income;
- o Income from legally liable relatives;
- o Workers' Compensation;
- o Annuities, pensions, and other periodic payments;
- o Alimony and support payments;
- o Dividends, interests and royalties;
- o Rents;
- o Benefits received as the result of another's death to the extent that the total amount exceeds the expenses of the deceased person's last illness and burial paid by the recipient;
- o Prizes and awards;
- o In-kind support and maintenance (ISM);
- o Life insurance proceeds; and,
- o Gifts and inheritances.

0362.10.15 Forms of Income

REV:06/1994

Income, whether earned or unearned, may be received in either of two forms, cash and in-kind.

- o Cash includes currency, checks, money orders, or electronic funds transfers (EFT), such as:
  - social security checks;
  - unemployment compensation checks; and,
  - payroll checks or currency.
- o In-kind includes noncash items such as:
  - real property;
  - food;
  - clothing; and,
  - noncash wages (e.g., room and board as compensation for employment).

0362.10.20 Living in Own Househol, Defin

REV:06/1994

The following is a list of individuals living in their own households:

- o An individual (or living-with spouse or any person whose income is deemed to the individual) who has an ownership interest or a life estate interest in the home;
- o An individual (or living-with spouse or any person whose income is deemed to the individual) who is liable to the landlord/landlady for payment of any part of the rental charges;
- o An individual who is in a noninstitutional care situation;
- o An individual who lives in an all-public assistance household; or,
- o An individual who pays at least a pro rata share of household operating expenses, AND
  - is living with someone other than a spouse and/or child(ren) and/or someone whose income is deemable to such individual, AND
  - is eating meals which s/he did not purchase separately.

0362.10.20.05 Proof of Pro Rata Share

REV:06/1994

If the applicant claims that s/he is contributing to the household, his/her pro rata share is established by averaging the monthly household operating expenses over the past 12 months and dividing by the number of persons in the household, regardless of age. If exact figures are unavailable, a reasonable estimate is used, considering current expenses and seasons of the year.

The household expenses to be considered, provided someone outside the household does NOT pay for them, are:

- Real Property Taxes
- Water
- Sewer
- Heating Fuel
- Garbage Removal
- Gas
- Food
- Electricity
- Rental Payments
- Mortgage (including property insurance)

0362.10.20.10 Documentation of Sharing

REV:06/1994

The applicant must submit evidence of sharing. This includes bills and receipts which establish the household expenses, and canceled checks or money order receipts which establish the applicant's contributions. When such evidence is not available, statements from the applicant and the person who owns or rents the household are accepted. Copies of all supporting documents are retained in the case record.

the applicant must be advised to retain future bills/receipts in the event a redetermination is required because changes occur, or because s/he wants to rebut one or more of the amounts used in determining the household expenses.

When a change does occur, it is only necessary to determine what is affected by the change. For example, if the only change is in household composition, only the food expense will increase or decrease. If the individual's contribution has decreased, a determination must be made that the lower contribution still constitutes a pro rata share.

0362.15 WHEN INCOME IS COUNTED

REV:06/1994

Generally, income is counted at the EARLIEST of the following points:

- When it is received; or,
- When it is credited to an individual's account; or,
- When it is set aside for his/her use.

Income is determined monthly and counted in the month it is received.

Occasionally, a regular periodic payment (e.g., wages, title II, or VA benefits) is received in a month other than the month of normal receipt. As long as there is no intent to interrupt the regular payment schedule, the funds are considered to be income in the normal month of receipt.

0364 TREATMENT OF INCOME

0364.05 EARNED/UNEARNED INCOME EXCLUS

REV:06/1994

Certain exclusions apply only to EARNED income, some apply only to UNEARNED income and a few apply to BOTH earned and unearned income.

The following exclusions apply to both earned and unearned income:

- o Infrequent and irregular income exclusions;
- o $20 per month General Income Exclusion;
- o PASS Exclusion.

0364.05.05 Infrequent/Irregular Inc Excl

REV:06/1994

Income which is received infrequently and irregularly is excluded provided the total income of such exclusion does not exceed:

- o $10/month of earned income; and/or,
- o $20/month of unearned income.

An individual receives income on an INFREQUENT basis if s/he receives it no more than once in a calendar quarter from a single source. An individual receives income on an IRREGULAR basis if s/he could not reasonably expect to receive it.

This exclusion can apply to both earned and unearned income in the same month provided the total of each does not exceed the allowed limits. Thus it is possible to exclude as much as $30 in a month under this provision.

0364.05.10 $20/Month General Income Excl

REV:06/1994

The first $20 per month of unearned income is deducted from income.

The $20 is applied to earned income only if the $20 cannot be applied to unearned income. The dollar amount of this exclusion is not increased when an eligible individual and eligible spouse both have income. An eligible couple receives one $20 exclusion per month.

0364.05.15 PASS Exclusion

REV:06/1994

Income, whether earned or unearned, of a blind or disabled recipient may be excluded if such income is needed to fulfill a Plan for Achieving Self-Support (PASS).

This exclusion does not apply to a blind or disabled individual age 65 or older, unless s/he was receiving SSI or State disability or blind payments for the month before s/he reached age 65.

0364.10 EARNED INCOME EXCLUSIONS

REV:06/1994

Earned income is never reduced below zero. Any unused earned income exclusion is never applied to unearned income. Any unused portion of a monthly exclusion cannot be carried over for use in subsequent months.

0364.10.05 $65 and 1/2 Earned Inc Excl

REV:06/1994

If the applicant or spouse is employed, earned income of $65/month plus one half (1/2) of the balance is excluded. When both eligible spouses are employed, this exclusion is applied to only one earned income.

0364.10.10 Impairment-Rel Work Expenses

REV:06/1994

Impairment related work expenses are deducted provided:

- o The individual is under age 65 and disabled (but not blind), or received SSI as a disabled individual (or received disability payments under a former State plan) for the month before attaining age 65; and,
- o The severity of the impairment requires the individual to purchase or rent items and services in order to work; and,
- o The expense is reasonable; and,
- o The cost is paid in cash (including checks, money orders, credit cards and/or charge cards) by the individual and is not reimbursable from another source (e.g. Medicare, private insurance); and,
- o The payment is made in a month the individual receives earned income for a month in which s/he both worked and received the services or used the item, or the individual is working but makes a payment before the earned income is received.

The determination of the amount of the allowable work expense is an off-line evaluation and determination is deducted from gross income.

0364.10.15 Blind Work Expenses

REV:06/1994

The following expenses related to a blind individual's employment are excluded:

- o TRANSPORTATION EXPENSES: Bus, cab fare, instructions for use of cane; cost/upkeep of guide dog; private automobile.
- o JOB PERFORMANCE: Braille instruction; child care costs; equipment needed on job (e.g. for homebound work); instructions in grammar (if work related); licenses; lunch; prosthesis needed for work even though not related to blindness; optical aids; reader; safety shoes; income (federal, state, local) taxes; FICA taxes; self-employment taxes; translation of material into braille; uniforms and care of them; union dues; wheelchair if necessary due to other disability.
- o JOB IMPROVEMENT: Computer program training, key punch training, stenotype instructions for blind typist. Further expenses are disregarded if the individual has an approved plan for self support. The amounts must be reasonable and not exceed the earned income of the blind individual or a blind spouse.

The determination of the amount of the allowable work expense is an off-line evaluation and determination is deducted from gross income.

0364.10.20 Earned Income Tax Credit Excl

REV:06/1994

The earned income tax credit (EITC) is a special tax credit which reduces the Federal tax liability of certain low income working taxpayers. This tax credit may or may not result in a payment to the taxpayer. EITC payments can be received as an advance from the employer or as a refund from the IRS.

Income from any EITC received January 1, 1991 or later is excluded, regardless of the tax year involved.

0364.10.25 Student Child Earned Inc Excl

REV:06/1994

For a blind or disabled child who is a student regularly attending school, up to $400/month of earned income (but not more than $1620 in a calendar year) is excluded.

The exclusion is applied only to the child's income. The child must be under age 22 and regularly attending school. Regularly attending school means the child was a

student in at least one month of the current calendar quarter, or expects to attend school for at least one month in the next calendar quarter.

0364.15 UNEARNED INCOME EXCLUSIONS

REV:06/1994

Exclusions never reduce unearned income below zero. Except for the $20 general unearned income exclusion, no other unused unearned income exclusion may be applied to earned income.

0364.15.05 Distinguishing IBON and ABON

REV:06/1994

Income Based On Need (IBON) is assistance provided under a program which uses income as a factor of eligibility and is funded wholly or partially by the Federal government or a non-government agency (e.g. Catholic Charities or the Salvation Army) for the purpose of meeting basic needs.

Income Based on Need is COUNTED as income dollar for dollar UNLESS it is totally excluded by statute (e.g. Food Stamps) or excluded under PASS.

Assistance Based On Need (ABON) is assistance provided under a program which uses income as a factor of eligibility and is funded wholly by a State. If a program uses income to determine payment amount but not eligibility, it is not ABON. Assistance Based on Need is EXCLUDED from income.

(Note that State supplementary payments made to refugees are considered to be ABON even if the Federal government reimburses the State.)

In short, ABON is excluded from income and IBON is counted as income dollar for dollar values excluded under PASS.

0364.15.10 FIP Under a PASS

REV:01/2002

Family Independence Program (FIP) payments under a PASS are excluded. However, FIP payments are based on need; and, unless excluded under a PASS, are counted dollar for dollar as income.

The $20 general income exclusion does not apply to this income.

The Family Independence Program makes a payment to family unit rather than to an individual. The payment is frequently referred to as a grant. An individual who meets the eligibility requirements for FIP and SSI may choose the program under which s/he prefers to receive benefits. However, if the individual receives SSI, s/he may no longer be included in the FIP grant.

0364.15.15 Foster Care Payment

REV:06/1994

An individual is considered to be in foster care when:

- A public or private (nonprofit) agency places an individual under a specific placement program; and,
- The placement is in a home or a facility which is licensed or otherwise approved by the State to provide care; and,
- The placing agency retains responsibility for continuing supervision of the need for such placement and the care provided.

Foster care payments made to the provider of foster care is not income to the provider.

0364.15.15.05 Effect of Foster Care Payment

REV:06/1994

Foster Care payments made under Title IV-E are federally funded income based on need (IBON) to the child in care. This income is not subject to the $20 general exclusion. The total payment is counted dollar for dollar.

Foster Care payments involving funds provided under Title IV-B or Title XX of the Social Security Act are social services and are excluded from the Foster Child's income.

0364.15.20 Adoption Assistance

REV:06/1994

Adoption Assistance Programs provide payments and/or services for children for whom unassisted adoption is unlikely because of age, ethnic background, physical, mental, or emotional disability etc.

The income of either the adopting parent, the adopted child or both may have been considered in determining the amount of the adoption assistance.

Adoption assistance provided by States under Title IV-E of the Social Security Act involves Federal funds and is needs-based.

Under IV-E there is no income test for the adopting parents. The law requires that the child, to be eligible for federally funded foster care must be AFDC or SSI eligible (but not necessarily receiving AFDC or SSI) at the time adoption proceedings are initiated, and meet the additional criterion of special needs.

Adoption assistance cash payments made to adoptive parents under Title IV-E are federally funded income based on need (IBON) to the adopted child. This income is not subject to the $20 general exclusion and is counted dollar for dollar.

0364.15.25 Support Payments

REV:06/1994

Alimony and support payments are cash or in-kind contributions to meet some or all of a person's need for food, clothing or shelter.

Support payments may be made voluntarily or because of a court order. Alimony is an allowance made by the court from the funds of one spouse to the other spouse in connection with a suit for legal separation or divorce.

Alimony, spousal and other adult support payments are unearned income to the parent.

Child support payments are unearned income to the child. However, one-third of a child support payment made to or for an eligible child by an absent parent is excluded.

A parent is considered absent if the parent and the child do not reside in the same household. If there are brief periods of living together, the parent is considered absent if the child remains independent or under the care and control of another person, agency or institution, or is living in the home of another unless the parent retains parental control and responsibility.

A parent is not considered absent if he is away due to employment (except for military service), intends to resume living with the child, and retains parental responsibility and control.

0364.15.30 Grants, Scholarships, Fellowship

REV:06/1994

Grants, scholarships, and fellowships are amounts paid by private, nonprofit agencies, the U.S. Government, instrumentalities or agencies of the U.S., State and local governments and private concerns to enable qualified individuals to further their education and training or research work.

Any portion of a grant, scholarship or fellowship used to pay tuition, fees or other necessary educational expenses is excluded from income. This exclusion does not apply to any portion set aside or actually used for food, clothing or shelter.

Allowable expenses include carfare, stationery supplies, and impairment related expenses necessary to attend school or perform schoolwork. Allowable fees include laboratory fees, student activity fees, etc.

0364.15.35 Student Loans

REV:06/1994

Federal funds or insurance are provided for educational programs at middle school, secondary school, undergraduate and graduate levels under Title IV of the Higher Education Act and student assistant programs of the Bureau of Indian Affairs.

Any grant, scholarship or loan to an undergraduate student for educational purposes made or insured under any program administered by the Commissioner of Education is excluded from income and resources.

Any portion of student financial assistance for attendance costs received from a program funded in whole or in part under Title IV of the Higher Education Act of 1965 or under BIA Student Assistance Programs is excluded from income and resources.

Attendance costs are:

- o Tuition and fees normally assessed a student carrying the same academic workload (as determined by the institution) required of all students in the same course of study;

- o Allowances for books, supplies, transportation and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution.

0364.15.40 Interest Earned on Burial Fund

REV:06/1994

Interest earned on the value of excluded burial funds is excluded from income (and resources) if left to accumulate in the burial fund.

Interest earned on agreements representing the purchase of an excluded burial space is excluded from income (and resources) if left to accumulate.

THIS INCOME EXCLUSION APPLIES ONLY IF THE BURIAL FUND OR SPACE PURCHASE AGREEMENT IS EXCLUDED AT THE TIME THE INTEREST IS PAID.

Appreciation in value and the interest must be left to accumulate to be excluded from income. If not left to accumulate (e.g. paid directly to the individual, spouse or parent), the receipt of the interest may result in countable income.

0364.15.45 Gifts of Domestic Travel Tckts

REV:06/1994

The value of a ticket for domestic travel received by an individual (or spouse) is excluded from income and, if retained, is not a resource if:

- o The ticket is received as a gift; and,

- o The ticket is not converted to cash.

0364.15.50 Death Benefits

REV:06/1994

A death benefit is something received as the result of another's death.

Examples of death benefits are:

- Proceeds of a life insurance policy received due to the death of the insured;
- Lump sum death benefit from SSA;
- Railroad Retirement burial benefits;
- VA burial benefits;
- Inheritances in cash or in-kind;
- Cash or in-kind gifts given by relatives, friends or a community group to "help out" with expenses related to the death.

NOTE: Recurring survivor benefits such as those received under Title II, private pension programs etc. are not death benefits.

Death benefits are excluded to the extent the beneficiary paid the expenses of the deceased's last illness and burial expenses.

Last illness and burial expenses include:

- Related hospital and medical expenses;
- Funeral, burial plot and internment expenses;
- Other related expenses.

0364.15.55 Home Energy Assistance Payment

REV:06/1994

Home energy or support and maintenance assistance is excluded if it is certified in writing by the appropriate State agency to be both based on need and:

- Provided in-kind by a private nonprofit agency; or,
- Provided in cash or in kind by a supplier of home heating oil or gas, a utility company providing home energy, or a municipal utility providing home energy.

State certification may be in the form of an individual certification of a particular case, or a "blanket" certification of a program or organization.

The exclusion applies to assistance provided for:

- An SSI applicant/recipient;
- A member of the SSI applicant/recipients household; or,
- An SSI applicant/recipient's spouse, parent(s), sponsor (sponsor's spouse) or essential person.

0364.15.60 Disaster Assistance

REV:06/1994

At the request of a State governor, the President may declare a major disaster when the disaster is of such severity and magnitude that effective response is beyond the capabilities of the State and local governments, and federal assistance is needed.

Assistance provided to the victims of a presidentially declared disaster area includes assistance from:

- Federal programs and agencies;
- Joint Federal and State programs;
- State or local government programs;
- Private organizations (e.g. the Red Cross).

The value of support and maintenance in cash or in-kind is excluded from countable income if:

- The individual lived in a household maintained as the home at the time the disaster occurred in the area; and,
- The President declared the area a Federal disaster area; and,
- The individual stopped living in the home because of the disaster and began to receive support and maintenance within 30 days after the catastrophe; and,
- The individual receives support and maintenance while living in a residential facility maintained by another person. A residential facility is to be interpreted broadly, to mean a private household, a shelter, or any other tempporary housing arrangement as a result of the disaster.

0364.15.65 Federal Housing Assistance

REV:06/1994

The Federal Government provides many forms of housing assistance through the Office of Housing and Urban Development (HUD) and the Farmers' Home Administration. The forms of housing assistance include:

- Subsidized housing (e.g. public housing, reduced rent, cash towards utilities etc.);
- Loans for renovations;
- Loans for construction, improvement, or replacement of farm homes and other buildings;

- Mortgage or investment insurance;
- Guaranteed loans and mortgages.

This assistance may be provided directly by the Federal Government or through other entities such as local housing authorities, nonprofit organizations etc.

The value of any assistance paid with respect to a dwelling unit is excluded from income and resources if paid under:

- The United States Housing Act of 1937;
- The National Housing Act;
- Section 101 of the Housing and Urban Development Act of 1965;
- Title V of the Housing Act of 1949; or,
- Section 202(h) of the Housing Act of 1959.

0364.15.70 Food Programs with Fed Involve

REV:06/1994

Food and assistance provided by the following Federal programs is excluded from income (and resources):

- Food Stamp Program;
- School Lunch program;
- Child Nutrition programs;
- Nutrition Programs for Older Americans.

The following may be assumed to have Federal involvement and to be excludable under Federal statutes:

- Meals and milk provided at reduced rates or free to children in schools and service facilities such as day care centers, recreational facilities or recreation centers;
- Meals provided for free or at reduced rates to senior citizens by a center or project under the auspices of a State or local government or nonprofit program for the aging;
- U.S.D.A. food commodities distributed by any program;
- Food stamps and cash which has been verified as the value of the food stamps provided in lieu of the stamps;
- WIC distributions to pregnant women and children.

0364.15.75 Refugee Cash Assistance

REV:06/1994

Refugee Cash Assistance, Cuban and Haitian Cash Assistance, and federally reimbursed general assistance payments to refugees may be excluded under a PASS.

If not excluded under a PASS, it is federally funded income based on need (IBON) and counted dollar for dollar as income. The $20 general income exclusion does not apply to this income.

0364.15.80 Relocation Assistance

REV:06/1994

Relocation assistance is provided to persons displaced by projects which acquire real property. Relocation assistance provided to persons displaced by any Federal, federally-assisted, State, State- assisted or locally assisted project is excluded.

The following types of relocation assistance may be provided:

- Moving expenses;
- Reimbursement for losses of tangible property;
- Expenses of looking for a business or farm;
- Displacement allowance;
- Amounts required to replace a dwelling over the acquisition cost for the prior dwelling to the project or agency;
- Compensation for increased interest cost and other debt service costs of a replacement dwelling (if encumbered by a mortgage);
- Expenses for closing costs (but not prepaid expenses) on replacement dwelling;
- Rental expenses for displaced tenants;
- Amounts for downpayments on replacement housing for tenants who decide to buy;
- Mortgage insurance through Federal Programs with waiver or requirements of age, physical condition, or personal characteristics etc., which borrowers must usually meet; and,
- Direct provision of replacement housing (as a last resort).

0364.15.85 Certain Reparation Payments

REV:06/1994

Reparation payments which are excluded from income are:

- Reparation payments received from the Federal Republic of Germany;

- Austrian social insurance payments based in whole or in part on wage credits granted under the Austrian General Social Insurance Act;

- Restitution payments made by the U.S. Government to individual Japanese Americans (or if deceased, their survivors) and Aleuts who were interned or relocated during World War II;

- Agent Orange settlement payments.

0364.15.90 Miscellaneous Exclusions

REV:06/1994

The following sources of unearned income are excluded from countable income when determining MA eligibility for individuals and couples:

- Victim Compensation Payment which is any payment received from a fund established by a State to aid victims of crime;

- Home Produce which is consumed by the individual or the individual's household; and,

- Refund of Taxes Paid on Real Property or Food.

0364.15.95 Non-SSA Statutory Exclusions

REV:06/1994

Many Federal statutes in addition to the Social Security Act provide assistance or benefits for individuals and specify that the assistance or benefit will not be considered in deciding eligibility for SSI. These statutes are listed and placed in categories according to the kind of income or assistance they provide. The list gives the name of the Federal statute (where possible), the public law number, and the citation. Each item briefly describes what the statute provides that will not reduce or eliminate an SSI payment.

FOOD

- Value of food coupons under the Food Stamp Act of 1977, section 1301 of Pub. L. 95-113 (91 Stat. 968, 7 U.S.C. 2017(b)).

- Value of federally donated foods distributed under section 32 of Pub. L. 74-320 (49 Stat. 774) or section 416 of the Agriculture Act of 1949 (63 Stat. 1058, 7 CFR 250.6(e)(9)).

- Value of free or reduce price food for women and children

under the

- (1) Child Nutrition Act of 1966, section 11(b) of Pub. L. 89-642 (80 Stat. 889, 42 U.S.C. 1780(b)) and section 17 of that Act as added by Pub. L. 92-433 (86 Stat. 729, 42 U.S. C. 1786); and,

- (2) National School Lunch Act, section 13(h)(3), as amended by section 3 of Pub. L. 90-302 (82 Stat. 119, 42 U.S.C. 1761(h)(3)).

HOUSING AND UTILITIES

- Assistance to prevent fuel cut-offs and to promote energy efficiency under the Emergency Energy Conservation Services Program or the Energy Crisis Assistance Program as authorized by section 222(a)(5) of the Economic Opportunity Act of 1964, as amended by section 5(d)(1) of Pub. L. No. 93-644 and section 5(a)(2) of Pub. L. 95-568 (88 Stat. 2294 as amended, 42 U.S.C. 2809(a)(5)).

- Fuel assistance payments and allowances under the Home Energy Assistance Act of 1980, section 313(c)(1) of Pub. L. 96-223 (94 Stat. 299, 42 U.S.C. 8612(c)(1)).

- Value of any assistance paid with respect to a dwelling unit under

  - (1) The United States Housing Act of 1937;

  - (2) The National Housing Act;

  - (3) Section 101 of the Housing and Urban Development Act of 1965; or,

  - (4) Title V of the Housing Act of 1949.

  Note: This exclusion applies to a sponsor's income only if the alien is living in the housing unit for which the sponsor receives the housing assistance.

- Payments for relocating, made to persons displaced by Federal or federally assisted programs which acquire real property, under section 216 of Pub. L. 91-646, the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (84 Stat. 1902, 42 U.S.C. 4636).

EDUCATION AND EMPLOYMENT

- Grants or loans to undergraduate students made or insured under programs administered by the Secretary of Education under section 507 of the Higher Education Amendments of 1968, Pub. L. 90-575 (82 Stat. 1063).

- Any wages, allowances, or reimbursement for transportation and attendant care costs, unless excepted on a case-by-case basis, when received by an eligible handicapped individual employed in a project under title VI of the Rehabilitation Act of 1973 as added by title II of Pub. L. 95-602 (92 Stat. 2992, 29 U.S.C. 795(b)(c)).

NATIVE AMERICANS

- Revenues from the Alaska Native Fund paid under section 21(a) of the Alaska Native Claims Settlement Act, Pub. L. No. 92-203 (85 Stat. 713, 43 U.S.C. 1620(a).

  Note: This exclusion does not apply in deeming income from sponsors to aliens.
- Indian tribes - Distribution of per capita judgment funds to members of

  - (1) The Blackfeet and Gros Ventre Tribes under section 4 of Pub. L. No. 92-254 (86 Stat. 265, 25 U.S.C. 1264) and under section 6 of Pub. L. No. 97-408(96 Stat. 2036);

  - (2) The Papago Tribe of Arizona Indians under section 8(d) of Pub. L. No. 97-408 (96 Stat. 2038);

  - (3) The Grand River Bank of Ottawa Indians in Indian Claims Commission docket numbered 40-K under section 6 of Pub. L. No. 94-540 (90 Stat. 2504);

    Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

  - (4) Tribes or groups under section 7 of Pub. L. No. 93-134 (87 Stat. 468, 25 U.S.C. 1407);

    Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

  - (5) The Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation as authorized by section 2 of Pub. L. No. 95-433 (92 State. 1047, 25 U.S.C. 609c-1);

  - (6) The Wyandot Tribe of Indians under section 6 of Pub. L. No. 97-371 (96 Stat. 1814, 42 U.S. C. 1305);

  - (7) The Shawnee Tribe of Indians under section 7 of Pub. L. No. 97-372 (96 Stat. 1816, 42 U.S.C. 1305);

  - (8) The Indians of the Miami Tribe of Oklahoma and Indiana under section 7 of Pub. L. 97-376 (96

Stat. 1829, 42 U.S. C. 1305);

- (9) The Clallam Tribe of Indians under section 6 of Pub. L. 97-402 (96 Stat. 2021);

- (10) The Pembina Chippewa Indians under section 9 of Pub. L. No. 97-403 (96 Stat. 2025);

- (11) The Confederated Tribes of the Warm Springs Reservation under section 4 of Pub. L. No. 97-436 (96 Stat. 2284);

Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

- (12) The Red Lake Band of Chippewa Indians under section 3 of Pub. L. No. 98-123 (97 Stat. 816); and

- (13) The Assiniboine Tribe of Fort Peck Montana under section 5 of Pub. L. No. 98-124 (97 Stat. 818, 42 U.S.C. 1305) and the Assiniboine Tribe of Fort Belknap under section 5 of Pub. L. No. 98-124 (97 Stat. 818, 42 U.S.C. (1305) and section 6 of Pub. L. No. 97-408 (96 Stat. 2036).

o Receipts from land held in trust by the Federal government and distributed to members of certain Indian tribes under section 6 of Pub. L. No. 94-114 (89 Stat. 579).

Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

- (1) The Pueblo of Santa Ana Indians of New Mexico under section 6 of Pub. L. No. 95-498 (92 Stat. 1677, 42 U.S.C. 1305);

- (2) The Pueblo of Zia Indians of New Mexico under section 6 of Pub. L. No. 95-499 (92 Stat. 1680, 42 U.S.C. 1305); and

- (3) The Shoshone and Arapahoe Tribes of the Wind River Reservation of Wyoming under section 2 of Pub. L. No. 98-64 (97 Stat. 365, 25 U.S.C. 117).

o Revenues from the Maine Indian Claims Settlement Fund and the Maine Indian Land Acquisition Fund paid under section 5 of the Maine Indian Claims Settlement Act of 1980, Pub. L. No. 96-420 (94 Stat. 1796, 25 U.S.C. 1728(c)).

Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

OTHER

- o Compensation provided volunteers in the foster grandparents program and other similar programs, unless determined by the Director of the Action Agency to constitute the minimum wage, under sections 404(g) and 418 of the Domestic Volunteer Service Act of 1973 (87 Stat. 409, 413), as amended by Pub. L. No. 96-143; (93 Stat. 1077); 42 U.S.C. 5044(g) and 5058).

  Note: This exclusion does not apply to the income of sponsors of aliens.

- o Any assistance to an individual (other than wages or salaries) under the Older Americans Act of 1965, as amended by section 102(h)(1) of Pub. L. 95-478 (92 Stat. 1515, 42 U.S.C. 3020a).

0364.20 RENTAL PROPERTY INCOME

REV:06/1994

If the applicant reports income from property, the AP-759 is completed and signed by the applicant. For individuals and couples (SSI-related), net income from rental property or roomer/boarders is normally unearned income. (In rare instances in which an individual makes his/her living in the real estate or boarding home business, the rental income may be earned income. Any questions regarding classification of rental income are referred by memorandum to the Regional Manager.)

0364.20.05 Rental Inc, Ind Lives in Prop

REV:06/1994

If the applicant/recipient owns and lives in a multiple family dwelling, the agency representative must pro-rate the allowable expenses based on the number of rental units.

Allowable expenses are:

- o Interest payment on the mortgage(s);
- o Insurance;
- o Taxes;
- o Water and sewer charges and assessments;
- o Utilities provided to the tenant as part of the rent and billed to the applicant for the building as a whole.

To determine the countable UNEARNED income from rental property which is also the home of the applicant:

- o Total the monthly rental income from all units;
- o Determine the expenses that the applicant incurs for the

building as a whole;

- Convert all expenses to a monthly amounts and total them. Pro-rate the allowable expenses on the basis of the number of rental units to the number of dwelling units in the building. An applicant renting one unit in a two-family house will therefore be able to deduct one-half of the allowable expenses. An applicant occupying a three-family house may deduct two-thirds of the allowable expenses;

- Determine the cost of the tenant's utilities billed to and paid by the applicant separately from the applicant's own utilities. Those expenses may be allowed as a deduction in full;

- Total the allowable deductions from the rental income to determine the countable unearned income.

0364.20.10 Rental Inc, Prop is Not Home

REV:06/1994

The property must first be evaluated as a resource. The value of the property combined with the value of other resources must not exceed the resource limit. If the resources are within the limit, all the allowable expenses are deducted from the gross rental income to determine the countable rental income of the applicant/recipient.

Allowable expenses are:

- Interest payments on the mortgage(s);

- Insurance;

- Taxes;

- Water and sewer charges and assessments.

0364.20.15 Roomer or Roomer/Boarder Inc

REV:06/1994

ROOMER INCOME

An individual may rent one or more rooms of his/her single family home or apartment. If the applicant/recipient has roomer income, pro-rate allowable expenses on the basis of the number of rented rooms to the total number of rooms in the house. Bathrooms, unfinished attics and basements do not count in determining total rooms. For example, if a house with six rooms has one room rented, one-sixth of the allowable expenses are deducted from the gross roomer income. The balance after deduction of the pro-rated expenses is countable unearned income.

ROOMER/BOARDER

The applicant/recipient may provide meals in addition to lodging.

If so, the allowable expenses which are deducted from the roomer/boarder income may include the cost of providing food. To reflect the added cost of providing food, the Food Stamp Program "Maximum Food Stamp Allotment" amount is deducted for the number of roomer/boarders. (See Food Stamp Manual, Sec. 1038).

0364.25 TREATMENT OF VA INCOME

REV:06/1994

The Department of Veterans Affairs (VA) has numerous programs which make payments to Supplemental Security Income (SSI) recipients and their families. For SSI purposes, treatment of those VA payments depends on the nature of the payments.

The most common types of payments and their treatment are the following:

- VA PENSION PAYMENTS are based on need and the $20 general income exclusion does not apply.

- VA COMPENSATION PAYMENTS, which are made on the basis of a service-connected disability or death, are unearned income subject to the $20 general income exclusion if made to the veteran, spouse, child or widow(er). VA compensation payments made to a surviving parent of a veteran are federally funded income based on need and the $20 general income exclusion does not apply.

- VA AID AND ATTENDANCE ALLOWANCES, which are paid to veterans, spouses of disabled veterans and surviving spouses in regular need of the aid and attendance of another person, or who are housebound, is excluded. This allowance is combined with the individual's pension or compensation payment.

- VA EDUCATIONAL BENEFITS are provided under a number of different programs, including vocational rehabilitation. Payments made as part of a VA program of vocational rehabilitation is excluded. Any VA educational benefit or portion of such a payment which is funded by the government, and is not part of a program of vocational education, is unearned income.

  Some VA educational assistance programs are "contributory". The money is contributed to an educational fund and the government matches the money when it is withdrawn while the veteran is pursuing an education. Any portion of a VA educational benefit which is a withdrawal of the veteran's own contributions is a conversion of a resource and is not income.

- VA CLOTHING ALLOWANCES related to the use of a prosthetic or orthopedic appliance, payable in August of each year to a veteran with a service connected disability, is excluded.

0366 SSI-RELATED DEEMING OF INCOME

0366.05 DEEMING DEFINED

REV:06/1994

The term "deeming" is used to identify the process of considering another person's income to be the income of the Medical Assistance applicant/recipient. When the deeming rules apply, it does not matter whether the income of the other person (deemor) is actually available; the deeming rules are applied anyway.

There are two categories of individuals whose income may be deemed to a Medical Assistance applicant/recipient: Ineligible Spouse and Ineligible Parent.

INCOME IS DEEMED FROM THE "INELIGIBLE" TO THE "ELIGIBLE." The terms "eligible" and "ineligible" in this context refer to the individual's position in the deeming process. "Ineligible" refers to the spouse or parent WHOSE INCOME will be considered as belonging to the "eligible" spouse or child. The deemed income is then considered to be income of the Medical Assistance applicant/recipient and is used in determining the individual's financial eligibility for Medical Assistance. Final eligibility for Medical Assistance is contingent upon all financial and non- financial criteria of the program being met.

0366.10 DEEM FROM INELIG TO ELIG SPOUS

REV:06/1994

When both members of a couple (spousal relationship and living together in the community) apply and both members of the couple have an SSI-related coverage group, the incomes of the couple are combined and tested against the Medical Assistance income standard for two. Each member's Medical Assistance eligibility is determined under his/her own particular coverage provision.

SPOUSE-TO-SPOUSE DEEMING OF INCOME IS INVOLVED IN THE ELIGIBILITY DETERMINATION WHEN ONLY ONE MEMBER OF A COUPLE APPLIES OR WHEN ONLY ONE MEMBER OF THE COUPLE IS POTENTIALLY ELIGIBLE FOR MEDICAL ASSISTANCE UNDER AN SSI-RELATED COVERAGE GROUP.

The applicant/recipient member of the couple is termed the "ELIGIBLE INDIVIDUAL". The "INELIGIBLE SPOUSE" means someone who lives with the eligible individual as that person's husband or wife, either through a ceremonial marriage or through a common-law marriage, and who is not eligible for Medical Assistance.

0366.10.05 Income Deeming Spous

REV:06/1994

When an ineligible spouse lives in the same household as the eligible individual, these deeming rules are applied in the following order:

FIRST: Determine the amount of the ineligible spouse's earned and unearned income, applying the appropriate income exclusions, in the computation month.

SECOND: Deduct an allocation for each ineligible child who lives in the household. "Ineligible child" means the ineligible individual's natural or adopted child who is under the age of 21, lives in the same household, and is not eligible for Medical Assistance. EXCEPTION: No allocation is given for any children who are receiving cash assistance (AFDC, SSI, GPA):

- The allocation for each ineligible child is the difference between the Federal Benefit Rate (FBR) for an eligible couple and the FBR for an eligible individual;

- Each ineligible child's allocation is reduced by the amount of his or her own income (appropriate income exclusions applied); and,

- The allocations for ineligible children are first deducted from the ineligible spouse's unearned income. If the ineligible spouse does not have enough unearned income to cover the allocations, the balance is deducted from the ineligible spouse's earned income.

THIRD: If the remaining income (both earned and unearned) of the ineligible spouse is EQUAL TO OR LESS THAN the difference between the FBR for an eligible couple and the FBR for an eligible individual, there is no income to deem to the eligible individual. IN THIS SITUATION, THE ELIGIBLE INDIVIDUAL'S OWN COUNTABLE INCOME IS SUBTRACTED FROM THE MA STANDARD FOR ONE TO DETERMINE ELIGIBILITY.

FOURTH: If the remaining income (both earned and unearned income) of the ineligible spouse is MORE THAN the difference between the FBR for an eligible couple and the FBR for an eligible individual, THE ELIGIBLE INDIVIDUAL AND THE INELIGIBLE SPOUSE ARE TREATED AS AN ELIGIBLE COUPLE:

- The eligible individual and the ineligible spouse are treated as an eligible couple by combining the remainder (after allowable allocations) of the ineligible spouse's unearned income with the eligible individual's own unearned income, and the remainder of the ineligible spouse's earned income with the individual's earned income;

- Apply all appropriate income exclusions, including the first $20 of unearned income (if less than $20 of unearned income in a month, any remaining portion of the $20 exclusion is applied to any earned income in the month), $65 of any earned income in the month, and one-half of remaining earned income in the month;

- Subtract the couple's countable income from the MA STANDARD FOR TWO.

FIFTH: If the couple's countable income is EQUAL TO OR LESS THAN the MA STANDARD FOR TWO in the computation month, the INDIVIDUAL IS ELIGIBLE FOR MA UNDER THE DEEMING RULES.

0366.10.10 Spouse to Spouse Deeming Examples

REV:01/1995

EXAMPLE 1: Jim, an aged individual, lives with his ineligible spouse, Anna, and their ineligible daughter, Stephanie. Jim receives $439 unearned income per month. Anna receives $302 unearned income per month. She has no earned income and Stephanie has no income at all. From Anna's income, $229 is allocated to Stephanie (the difference between the FBR for an couple and the FBR for an individual). The $229 allocation is subtracted from Anna's unearned income, leaving $73. Since Anna's $73 remaining income is not more than $229, which is the difference between the FBR for a couple and the FBR for an individual, none of the income is deemed to Jim. Instead, Jim's own countable income of $419 ($439 minus the $20 general income exclusion) is compared to the Medical Assistance standard for one, $522.35. Jim is eligible for Medical Assistance.

EXAMPLE 2: Max, a disabled individual, lives with his ineligible spouse, Mimi, and their ineligible son, Matt. Max and Matt have no income. Mimi has earned income of $426 per month and unearned income of $278 per month. First, $229 is allocated to Matt from Mimi's $278 unearned income, leaving $49 in unearned income. Since Mimi's total remaining income of $475 ($49 unearned plus $426 earned) is more than $229, which is the difference between the FBR for a couple and the FBR for an individual, her income is deemed to be available to both members of the couple. Therefore, their combined countable income is computed as for a couple. The $20 general income exclusion is applied to Mimi's unearned income further reducing it to $29. The $65 plus one-half the balance earned income exclusion is applied to her earned income reducing it to $180.50. The $29 countable unearned income is added to the $180.50 countable earned income for a total countable income of $209.50, and compared to the Medical Assistance standard for a couple, $807.50. Max is eligible for Medical Assistance based on deeming.

EXAMPLE 3: Mr. Peirot, a disabled individual, lives with his ineligible spouse, Mrs. Peirot, who earns $260 per month. Mr. Peirot receives a pension (unearned income) of $150 per month. Since Mrs. Peirot's income is greater than $229, which is the difference between the FBR for a couple and the FBR for an individual, all of her income is deemed to be available to both Mr. and Mrs. Peirot. Compute the combined countable income for the couple as follows. Apply the $20 general income exclusion to Mr. Peirot's $150 unearned income, leaving $130. Apply the $65 and one-half the balance earned income exclusion to Mrs. Peirot's $260 earned income, leaving $97.50. This gives the couple total countable income of $227.50. This is less than $807.50, the Medical Assistance standard for a couple, so Mr. Peirot is eligible for Medical Assistance based on deeming.

0366.15 DEEM INELIG PARENT TO ELIG CHILD

REV:06/1994

"Ineligible parent" means a natural or adoptive parent, who lives in the same household and who is not eligible for Medical Assistance. The income of the ineligible parent is deemed to a natural or adopted Medical Assistance eligible child through the month in which the SSI-related eligible child reaches age 18.

Step-parent deeming is prohibited in Medical Assistance.

0366.15.05 Income Deeming Process

REV:01/2002

When an ineligible parent(s) live(s) in the same household as the eligible child, these deeming rules are applied in the following order:

FIRST: Determine the amount of each ineligible parent's earned and unearned income, applying the appropriate income exclusions, in the computation month.

SECOND: Deduct an allocation for each ineligible child who lives in the household. "Ineligible child" means the INELIGIBLE INDIVIDUAL'S NATURAL OR ADOPTED CHILD who is under the age of 21, lives in the same household, and is not eligible for SSI-related Medical Assistance. EXCEPTION: No allocation is given for any children who are receiving cash assistance (FIP, SSI, GPA):

- o The allocation for each ineligible child is the difference between the Federal Benefit Rate (FBR) for an eligible couple and the FBR for an eligible individual;
- o Each ineligible child's allocation is reduced by the amount of his or her own income (appropriate income exclusions applied);

- o The allocations for ineligible children are first deducted from the ineligible parent's unearned income. If the ineligible parent does not have enough unearned income to cover the allocations, the balance is deducted from the ineligible parent's earned income.

THIRD: Deduct an allocation for each ineligible parent. This allocation varies depending on the type of income the ineligible parent has.

- o IF ALL PARENTAL INCOME IS EARNED, allocate $85 (the sum of the $20 general income exclusion and the $65 earned income exclusion) plus
  - double the Federal Benefit Rate (FBR) for a month for a COUPLE if both parents live in the household; or,
  - double the FBR for a month for an INDIVIDUAL if only one parent lives in the household.
- o IF ALL PARENTAL INCOME IS UNEARNED, allocate $20 (the amount of the general income exclusion) plus
  - the FBR for a month for a COUPLE if both parents live in the household; or,
  - the FBR for the month for an INDIVIDUAL if only one parent lives in the household.
- o IF PARENTAL INCOME IS BOTH EARNED AND UNEARNED, allocate $20 from their combined unearned income. If there is less than $20 in unearned income, subtract the balance of the $20 from their combined earned income. Next subtract $65 plus one-half the balance of their earned income. Total the remaining earned and unearned income, and subtract:
  - the FBR for a month for a COUPLE if both parents live in the household; or,
  - the FBR for a month for an INDIVIDUAL if only one parent lives in the household.

FOURTH: Deem any remaining parental income to the eligible child(ren):

- o IF THERE IS ONLY ONE ELIGIBLE CHILD IN THE HOUSEHOLD, deem any parental income that remains to the eligible child as unearned income. Combine it with the eligible child's own unearned income, apply appropriate exclusions, i.e., a $20 general income exclusion, to determine the countable unearned income in the month. Add this amount to any COUNTABLE earned income the eligible child may

have. (Note: application of the earned income disregard of $65 and one-half the balance to the child's OWN EARNED INCOME, if any, results in child's countable earned income.) Subtract the total from the Medical Assistance standard for an individual to determine eligibility for Medical Assistance.

- IF THERE IS MORE THAN ONE ELIGIBLE CHILD IN THE HOUSEHOLD (under age 18), divide the parental income to be deemed equally among the eligible children. Combine it with the eligible child's own unearned income, apply appropriate exclusions, i.e., a $20 general income exclusion, to determine the countable unearned income in the month. Add this amount to any COUNTABLE earned income the eligible child may have. (Note: application of the earned income disregard of $65 and one-half the balance to the child's OWN EARNED INCOME, if any, results in child's countable earned income.) Subtract the total from the Medical Assistance standard for an individual to determine eligibility for Medical Assistance.

0366.15.10 Parent to Child Deeming_Examples

REV:01/1995

EXAMPLE 1: Mrs. Lind is the ineligible parent of Jennie, a disabled child. Jennie has no income; Mrs. Lind has earned income of $1,250 per month. Reduce her income by an allocation of $85 (the sum of the $20 general income exclusion and the $65 earned income exclusion) plus $916 (double the FBR for an individual). This is a total allocation of $1001 for her needs. The balance of $249 ($1,250 minus $1001) is deemed to Jennie. Jennie now has unearned income of $249 from which the $20 general income exclusion is deducted leaving countable income of $229. Since this is less than $522.35, the Medical Assistance standard for an individual, Jennie is eligible for Medical Assistance.

EXAMPLE 2: Hank, a disabled child, lives with his mother and father and a 12-year-old ineligible brother. His mother receives a pension (unearned income) of $335 per month, and his father earns $1,755 per month. Hank and his brother have no income. First, $229 is allocated to Hank's brother from the unearned income. This leaves $106 in unearned income. Since the remaining parental income is both earned and unearned, the unearned income is further reduced by $20, general income exclusion, leaving $86. The $1,755 earned income is reduced by $65 plus one-half the balance, leaving $845. The countable unearned and countable earned income is totaled, $931. The FBR for a couple, $687, is

deducted as the allocation for the parents, leaving $244 to be deemed as Hank's unearned income. Hank's $244 deemed income is reduced by the $20 general income exclusion, which leaves Hank with countable income of $224. Since this is less than $522.35, the Medical Assistance standard for an individual, Hank is eligible for Medical Assistance.

EXAMPLE 3: Jesse and Frank are disabled children who live with their mother. The children have no income but their mother receives $616 in unearned income. Since all the mother's income is unearned, $478 is allocated for her needs (the FBR for an individual, plus the $20 general income exclusion). After subtracting this allocation from her $616, divide the remaining $138 equally between the two children ($69 each) as unearned income. Deduct the $20 general income exclusion from each child's unearned income leaving each child with $49 countable income. The $49 is less than $522.35, the Medical Assistance standard for an individual (one) so each child is eligible for Medical Assistance.

EXAMPLE 4: Mrs. Parker is the ineligible parent of two disabled children, Bonnie and Lori. Bonnie and Lori have no income; Mrs. Parker has unearned income of $1,250 per month. Reduce her income by an allocation of $478 for her needs. The amount of her allocation is the $20 general income exclusion plus $458, the FBR for an individual. The balance of $772 ($1,250 minus $478) to be deemed is divided equally between Bonnie and Lori. Each now has unearned income of $386 from which the $20 general income exclusion is deducted leaving countable income of $366 for each child. Since this is less than $522.35, the Medical Assistance standard for an individual, the girls are eligible for Medical Assistance.

NOTE: If an eligible child later becomes ineligible, only that amount of income is deemed to the child which, when combined with the child's own income if any, causes the child's countable income to exceed the Medical Assistance standard (i.e., deem only an amount which causes the child to become ineligible). Equally divide that amount of the ineligible child's deemed income which exceeds the standard and redistribute it to the remaining eligible child(ren) in the household.

0366.20 INELIG SPOUS TO ELIG SPOUS, CHI

REV:06/1994

When an eligible spouse and an eligible natural or adopted child live in the same household as an ineligible individual, who is both a spouse and a natural/adoptive

parent, the ineligible spouse/parent's income is deemed first to the eligible spouse with any remainder income then deemed to the eligible child.

Step-parent deeming is prohibited in SSI-related Medical Assistance.

0366.20.05 Income Deeming Process

REV:01/2002

To deem income from an ineligible spouse to an eligible spouse and eligible child, these deeming rules are applied in the following order:

FIRST: Determine the amount of the ineligible spouse/parent's earned and unearned income, applying the appropriate income exclusions, in the computation month.

SECOND: Deduct an allocation for each ineligible child who lives in the household. "Ineligible child" means the INELIGIBLE INDIVIDUAL'S NATURAL OR ADOPTED CHILD who is under the age of 21, lives in the same household, and is not eligible for SSI-related Medical Assistance. EXCEPTION: No allocation is given for any children who are receiving cash assistance (FIP, SSI, GPA):

- o The allocation for each ineligible child is the difference between the Federal Benefit Rate (FBR) for an eligible couple and the FBR for an eligible individual;
- o Each ineligible child's allocation is reduced by the amount of his or her own income (appropriate income exclusions applied); and,
- o The allocations for ineligible children are first deducted from the ineligible parent's unearned income. If the ineligible parent does not have enough unearned income to cover the allocations, the balance is deducted from the ineligible parent's earned income.

THIRD: If the remaining income (both earned and unearned) of the ineligible spouse is EQUAL TO OR LESS THAN the difference between the FBR for an eligible couple and the FBR for an eligible individual, there is no income to deem to the eligible individual. IN THIS SITUATION, THE ELIGIBLE INDIVIDUAL'S OWN COUNTABLE INCOME IS SUBTRACTED FROM THE MA STANDARD FOR ONE TO DETERMINE ELIGIBILITY.

FOURTH: IF THERE IS NO INCOME DEEMED TO THE SPOUSE AS IN THE PREVIOUS STEP, NO INCOME IS DEEMED TO THE CHILD.

FIFTH: However, if the remaining income (both earned and unearned income) of the ineligible spouse is MORE THAN the difference between the FBR for an eligible couple and the FBR for an eligible individual, THE ELIGIBLE INDIVIDUAL AND THE INELIGIBLE SPOUSE ARE TREATED AS AN ELIGIBLE COUPLE:

- The eligible individual and the ineligible spouse are treated as an eligible couple by combining the remainder (after allowable allocations) of the ineligible spouse's unearned income with the eligible individual's own unearned income, and the remainder of the ineligible spouse's earned income with the individual's earned income;

- Apply all appropriate income exclusions, including the first $20 of unearned income (if less than $20 of unearned income in a month, any remaining portion of the $20 exclusion is applied to any earned income in the month), $65 of any earned income in the month, and one-half of remaining earned income in the month;

- Subtract the couple's countable income from the MA STANDARD FOR TWO.

SIXTH: If the couple's countable income is EQUAL TO OR LESS THAN the MA STANDARD FOR TWO in the computation month, the INDIVIDUAL IS ELIGIBLE FOR MA UNDER THE DEEMING RULES.

SEVENTH: IF THE SPOUSE IS ELIGIBLE for Medical Assistance after income has been deemed from the ineligible spouse/parent, NO INCOME IS DEEMED TO THE CHILD.

- To determine the child's eligibility, subtract the CHILD'S OWN COUNTABLE INCOME WITHOUT DEEMING from the Medical Assistance standard for one.

EIGHTH: IF THE SPOUSE IS NOT ELIGIBLE for Medical Assistance after the ineligible spouse/parent's income has been deemed, INCOME IS DEEMED TO THE CHILD in the following manner.

- Deem to the eligible child any of the spouse-to-spouse deemed income which EXCEEDS THE MEDICAL ASSISTANCE STANDARD FOR TWO (the MA standard used to determine eligibility for the spouse).

0366.20.10 Spouse to Spouse and Child Deeming

REV:01/1995

EXAMPLE 1: Mary, a blind individual, lives with her husband, John, and their disabled child, Peter. Mary and Peter have no income, but John is employed and earns $1,450 per month. Mary's eligibility is determined first. Since John's income is more than $229, which is the difference between the FBR for an eligible couple and the FBR for an eligible individual, the entire $1,450 is treated as earned income available to John and Mary as a couple.

Because they have no unearned income, the $1,450 is reduced by the $20 general income exclusion, and then by the earned income exclusion of $65 plus one-half the remainder. This leaves John and Mary with $682.50 in countable income. The $682.50 countable income is less than the Medical Assistance Standard for a couple ($807.50), so Mary is eligible for Medical Assistance; therefore no income is deemed to Peter. Peter's eligibility is determined based on his own income. Since he has no income of his own, Peter is eligible for Medical Assistance.

EXAMPLE 2: Al, a disabled individual, resides with his ineligible spouse, Dora, and their disabled son, Jeff. Al and Jeff have no income, but Dora is employed and earns $2,450 per month. Since Dora's income is more than $229, which is the difference between the FBR for an eligible couple and the FBR for an eligible individual, the entire $2,450 is treated as earned income available to Al and Dora as a couple. The $2,450 is reduced by the $20 general income exclusion and then by the $65 plus one-half the remainder earned income exclusion, leaving $1,182.50 in countable income. Al is ineligible for Medical Assistance because $1,182.50 in countable income exceeds $807.50, the Medical Assistance standard for a couple. Since Al is ineligible, $375 is deemed to Jeff. This is the amount of income over and above the amount which caused Al to be ineligible (the countable income minus the Medical Assistance standard for a couple). The $375 deemed to Jeff is unearned income. After the $20 general income exclusion is deducted, Jeff's countable income is $355. It is below $522.35, the Medical Assistance Standard for one. Jeff is eligible for Medical Assistance.

0366.25 TEMPORARY ABSENCES AND DEEM

REV:06/1994

TEMPORARY ABSENCE

FOR THE PURPOSE OF DEEMING, a temporary absence such as for visiting or for another reason, occurs when the Medical Assistance applicant/recipient, the ineligible spouse or ineligible parent or an ineligible child leaves the household but intends to, and does, return in the same month or the month immediately following. If the absence is temporary, the person is considered to be a member of the household.

CHILD AWAY AT SCHOOL

An eligible child who is away at school, but who comes home on some weekends or lengthy holidays and who is subject to the control of his/her parent(s), is considered to be temporarily absent from the household and income deeming rules apply. However, if the child is not subject to parental control, the absence is not

considered to be temporary and the deeming rules do not apply. Being subject to parental control affects deeming only if the child is away at school.

0366.30 INC EXCL, INELIG SPOUS/PAREN

REV:06/1994

Income is anything received in cash or in-kind that can be used to meet the needs for food, clothing, or shelter. In-kind income is not cash, but is actually food, clothing or shelter, or something that can be used to get one of these. SOME TYPES OF INCOME ARE EXCLUDED FROM THE DEEMING PROCESS. When determining how much income to deem, do not include the following types of income when deeming FROM an INELIGIBLE SPOUSE OR PARENT:

- Income excluded by Federal laws other than the Social Security Act;
- Any public income-maintenance payments received by the ineligible spouse or parent, and any income which was counted or excluded in figuring the amount of that payment;
- Any income of the ineligible spouse or parent used by a public income-maintenance program to determine the amount of that program's benefit to someone else;
- Any portion of a grant, scholarship, or fellowship used to pay tuition or fees;
- Money received for providing foster care to an ineligible child;
- The value of food stamps and the value of Department of Agriculture donated foods;
- Food raised by the ineligible spouse or parent and consumed by members of the household in which you live;
- Tax refunds on income, real property, food purchased by the family;
- Income used to fulfill an approved plan for achieving self-support;
- Income used to comply with the terms of court-ordered support, or support payments enforced under title IV-D of the Social Security Act;
- The value of in-kind support and maintenance;
- Periodic payments made by a State under a program established before July 1, 1973, and based solely on duration of residence and attainment of age 65;

- Disaster assistance as described under the Disaster Relief Act of 1974 and other Federal statutes enacted to provide relief to victims of major disasters (payments received to repair or replace lost, stolen, or damaged resources as a result of a catastrophe which the President declares to be a major disaster);
- Income received infrequently or irregularly;
- Work expense if the ineligible spouse or ineligible parent is blind;
- Income of the ineligible spouse or ineligible parent which was paid under a Federal, State, or local government program to provide the Medical Assistance applicant/recipient with chore, attendant or homemaker services;
- Certain support and maintenance assistance, i.e., home energy assistance related to meeting the costs of heating or cooling a home through payments for utility service or bulk fuels, or items which help to reduce the costs of heating or cooling such as conservation or weatherization materials and services.

0366.30.05 Spous/Paren to Inelig Spous

REV:06/1994

The allocation to an INELIGIBLE CHILD is reduced if the ineligible child has income. While considered to be income, in the deeming process do not include any of the following types of income, as the child's income, when allocating FROM an INELIGIBLE SPOUSE OR PARENT TO AN INELIGIBLE CHILD:

- All the types of income listed in 0366.30;
- If the ineligible child is a student, exclude any of the child's earned income up to $400 a month but not more than $1,620 per year;

0366.35 CHANGE IN DEEM STATUS-COUPLES

REV:06/1994

There are several events which can change deeming status. All such changes affect deeming the month after the month the change occurs, unless otherwise noted. Examples of a change in status are:

- Ineligible Spouse Becomes Eligible;
- Spouses Separate or Divorce;
- Eligible Spouse Begins Living With An Ineligible Spouse;

- o Ineligible Spouse Dies;
- o Eligible Individual Becomes Institutionalized.

0366.35.05 Ineligible Spouse becomes Elig

REV:06/1994

If an ineligible spouse becomes eligible, the individual and spouse are treated as an eligible couple effective with the month the spouse becomes eligible. MA eligibility and payment amount are based on the couple's income for that month.

0366.35.10 Spouses Separate or Divorce

REV:06/1994

If an ineligible spouse and eligible spouse separate, or their marraige ends in divorce, the ineligible spouse's income is no longer deemed effective with the month following the month of separation or divorce.

0366.35.15 Elig Ind and Inelig Spouse

REV:06/1994

If an eligible individual begins living with an ineligible spouse, deeming of the ineligible spouse's income begins effective with the month after the month they begin living together.

0366.35.20 Ineligible Spouse Dies

REV:06/1994

If an ineligible spouse dies, deeming stops for purposes of determining eligibility with the month following the month of death.

0366.35.25 Elig Ind Becomes Institut

REV:06/1994

If an eligible individual moves into a medical facility, deeming stops for purposes of determining MA eligibility effective with the month following the month of separation.

0366.40 CHANGE IN DEEM STAT-PAREN/CHIL

REV:06/1994

Deeming of an ineligible parent's income to an eligible child can begin or end when there has been a change in the family's situation. Except where noted, all changes in status are effective in the month following the month the change occurs.

Changes in status may include:

- o Ineligible Parent Becomes Eligible;
- o Eligible Parent becomes Ineligible;
- o Ineligible Parent Dies;
- o Ineligible Parent and Eligible Child No Longer Living In Same Household;
- o Ineligible Parent and Eligible Child Begin Living In Same Household;
- o Eligible Child Moves Into Medical Care Facility;
- o Child Attains Age 18.

0366.40.05 Inelig Parent Becomes Elig

REV:06/1994

If an ineligible parent becomes eligible for MA, deeming from that parent to an eligible child to determine the child's eligibility for MA stops beginning with the month the parent becomes eligible.

0366.40.10 Eligible Parent Becomes Inelig

REV:06/1994

If an eligible parent becomes ineligible, deeming of the parent's income begins with the first month of the parent's ineligibility.

0366.40.15 Ineligible Parent Dies

REV:06/1994

If an ineligible parent dies, deeming stops from that parent for purposes of determining the child's eligibility for MA beginning with the month following the month of death.

If the child lives with two ineligible parents, and one dies, deeming continues from the surviving parent to determine the child's MA eligibility.

0366.40.20 Paren, Chil Not In Same Househo

REV:06/1994

If an ineligible parent and eligible child no longer live in the same household, deeming of that parent's income stops effective the month after the month the parent (or child) leaves the household for purposes of determining eligibility.

0366.40.25 Parent/Child in Same Household

REV:06/1994

If an ineligible parent and an eligible child begin living in the same household, the parent's income is deemed to the child for purposes of determining MA eligibility beginning the month after the month they begin living together.

0366.40.30 Elig Child in Med Care Fac

REV:06/1994

If an eligible child becomes institutionalized, then the deeming stops for purposes of determining MA eligibility in the month following the month of institutionalization.

0366.40.35 Child Attains Age 18

REV:06/1994

Deeming stops effective the month following the month the individual turns 18.

0368 FLEXIBLE TEST OF INCOME

0368.05 USE OF EXCESS INCOME

REV:06/1994

An individual who meets the other eligibility requirements, but has income in excess of the Medically Needy income limits may be eligible for Medical Assistance in accordance with the Flexible Test of Income.

Flexible Test cases are determined for a six (6) month period beginning with the first day of the month in which application is received. Eligibility as Medically Needy is not established, however, until the applicant has presented 1) RECEIPTS FOR MEDICAL SERVICES INCURRED DURING THE PERIOD OF DETERMINATION and/or 2) UNPAID BILLS incurred either during the CURRENT PERIOD of determination AND/OR PRIOR TO APPLICATION for which the individual is STILL LIABLE equal to the amount of such excess income. The only exception is in the case of medical expenses which are paid by or are the liability of other medical care programs that are funded 100% with State funds. For example, a applicant's medical expenses that have been paid (or are to be paid) by the RIPAE or RIte-Care programs are considered to be the liability of the applicant, and if otherwise allowable, are deducted from the spenddown liability. Medical expenses that are subject to payment by any other third party payer are not considered the liability of the applicant and are not deducted from the excess income.

In some cases, current payments ON THE PRINCIPAL BALANCES of loans to pay off old medical bills (i.e., bills incurred prior to the current budget period) are incurred health care expenses if certain conditions are met.

If the applicant is determined eligible under a flexible test of income, the applicant is certified for SIX (6) MONTHS OR FOR THE BALANCE OF THE SIX (6) MONTH PERIOD remaining when the excess income is absorbed.

0368.05.05 When Eligibility Begins

REV:06/1994

The date of eligibility is the actual day of the month on which the applicant incurs a medical expense which reduces income to the income standard. THEREFORE, THE DATE OF ELIGIBILITY IS THE DAY THAT THE MEDICAL SERVICE IS PROVIDED AND NOT THE DATE OF THE BILLING, which may be a later date. The expense is incurred on the day of the service.

When an incurred medical expense is a hospital bill, the date of eligibility is the first day of hospitalization. An AP-758 is required to establish the amount of the hospital bill for which the individual is liable. The individual's liability is his/her excess income on the first day of hospitalization, providing there is no expense subsequently incurred which reduces such excess income to a lesser amount.

If the applicant has excess income and there is no indication of medical expenses by which the excess can be absorbed, the case is rejected. However, if the applicant should present medical expenses within the same six (6) month period, the original application is used in determining whether the excess income for this same six-month period has been reduced to the income standard.

0368.05.10 Whose Expenses are Used

REV:06/1994

Where income of the ineligible spouse (or ineligible parent(s)) is deemed available to the applicant, such individual(s) is included in determining the appropriate family size for the Medically Needy income standard. (This is to ensure that the ineligible party's income will be protected for their maintenance needs.) Medical expenses incurred by such spouse or parent(s) (or family) are counted toward the applicant's spenddown liability (excess income).

However, once the excess income has been absorbed, only the eligible applicant(s) shall be entitled to MA coverage.

0368.10 RECOGNIZED MED/REMEDIAL CARE

REV:01/2002

Expenses which may be used to offset excess income include:

- Adult Day Care;
- Respite Care; and,
- Home Health Aide/Homemaker Services.

0368.10.05 Adult Day Care

REV:06/1994

The cost of adult day care services may be used to offset a flexible-test spenddown liability. In order to be considered a cost of "medical or remedial care", these conditions must be met:

- o The service must have been rendered by a provider agency approved by the Department of Elderly Affairs (DEA); and,
- o The service was required to assist an individual, who because of severe disability related to age or chronic illness, encountered special problems resulting in physical and/or social isolation detrimental to his/her well- being, or required close monitoring and supervision for health reasons.

0368.10.10 Respite Care

REV:06/1994

The cost of respite care may be used to offset a flexible-test spenddown liability if the applicant receives overnight respite care at a licensed nursing/convalescent facility or in-home respite care as provided by the Department of Elderly Affairs (DEA).

0368.10.15 Home Health Aide/Homemaker Ser

REV:01/2002

The cost of Home Health Aide services or Homemaker services may be used to offset a flexible-test spenddown liability under certain circumstances. In order to be considered a cost of "medical or remedial care", the following three conditions must be met:

- o The service must have been rendered by an agency licensed by the Rhode Island Department of Health, and recognized as a service provider by DHS under the Homemaker Program (see Section 0530.35 for list); and,
- o At least a portion of the service provided each month MUST be for personal care services (assistance with bathing, dressing, grooming, etc.). If the applicant does not (or did not) receive assistance with personal care during a month, no part of that month's cost of service may be used to offset the flexible-test spenddown liability; and,
- o A physician must certify the applicant's need for personal care services, in writing, at least once in each flexible-test period (six (6) months). The certification must indicate the patient's diagnosis(es), and the type of services required.

If the foregoing three criteria are met, eligibility staff may recognize, without further review, the cost of up to 65 hours per month in Home Health Aide/Homemaker services to offset a flexible-test spenddown liability. Deductions in excess of this amount must be approved in writing by the Nurse/Consultant for Homemaker Services located at 600 New London Avenue, Cranston.

The referral to the Nurse/Consultant is comprised of a brief cover memo prepared by the Eligibility Technician, a copy of the individual's Plan of Service obtained from the provider agency, and a copy of the physician's certification of need for services.

The Nurse/Consultant reviews the material to determine the extent to which the costs of service in excess of 65 hours per month may be recognized as a deduction from excess income. Only the cost of substantive services may be allowed as a deduction from excess income.

0368.15 DEDUCT LOANS TO PAY MED BILLS

REV:06/1994

A loan can be an incurred health care expense and, in some circumstances, may be applied against the CURRENT spenddown liability when the applicant has a CURRENT obligation under the loan. The objective of the policy is to allow the recipient to use his or her liability to the lender in place of his or her liability to the provider. However, since the applicant may apply only the amount that would have been deducted had the provider's bill been used, the deduction of interest paid or payable on the loan is precluded.

A loan that is taken out in the current eligibility period to pay a health care provider for services rendered in the same period (or, in the case of a new application, for services rendered in the month of application or within the 3 preceding months) may be applied against the spenddown liability for the current period IN PLACE of the provider's bill. (The loan expense and the provider's bill may not BOTH be applied against the spenddown liability.)

A loan taken out in the current period or a preceding period to pay a provider's bill incurred in a PRECEDING PERIOD may be applied against current spenddown liability to the extent of any unpaid balance in certain cases. Current principal payments and any remaining unpaid principal balance on the loan may be applied against the spenddown liability to the extent that:

- o The proceeds from the loan WERE actually used to pay the provider's bill (i.e., the loan payments are not deductible until after the proceeds have been paid to the provider); and,
- o Neither the provider's charges nor the loan payments and the unpaid balance were previously applied against spenddown liability or deducted form income.

Loan proceeds that will not be used until after the current eligibility period may not be applied against the spenddown liability in the current period because only loan proceeds THAT HAVE BEEN USED to pay for health care expenses may be applied.

However, such proceeds could be used against any spenddown liability for the subsequent period in which they actually are used.

This policy gives the recipient the relief intended by the spenddown (i.e., application of the remaining liability for old medical expenses against the person's spenddown liability). The policy does not change the treatment of old bills that remain unpaid -- i.e., they are still deductible in the spenddown to the extent that a current liability continues to exist and the bills have not been previously deducted.

0368.20 DEDUCTING RECOGNIZED MED EXP

REV:06/1994

In establishing financial eligibility, excess income is applied toward reasonable incurred medical expenses that are not subject to payment by a third party (other than those medical expenses which are the liability of or paid by 100% State funded medical care programs).

Determine the available excess income for the six (6) month period beginning with the month of application. Excess income can then be applied to recognized medical expenses incurred PRIOR to application and unpaid. If a medical expense is more than one (1) year old, it is necessary to ensure that the applicant is still liable for the payment. This can be done by presentation of a current billing. Apply the excess income to the medical expenses in the appropriate order.

Recognized medical expenses include medical insurance premiums, co- payments, deductibles and certain medical and remedial care expenses recognized under state law. Incurred medical expenses may also include current payments on the principal of loans used to pay off old medical bills.

Excess income is applied to the medical expenses in the following order:

FIRST: Deduct incurred medical insurance premiums, including any enrollment fee, Medicare premiums, capitation fees for enrollment in prepaid health care programs, and premiums for any other health insurance program which is primarily established for payment of medical costs. With the exception of Medicare premiums, the cost of such medical insurance must be actually incurred and MAY NOT BE PROJECTED over the six (6) months of the application period; Deduct any co-payments, co-insurance or deductibles under any health insurance program as they are incurred.

SECOND: Deduct necessary medical or remedial care recognized under state law but not provided within the Medical Assistance scope of services, such as chiropractic services, adult day care, respite care, or Home Health Aide/Homemaker services.

THIRD: Deduct necessary medical or remedial care provided within the Medical Assistance scope of services.

FOURTH: Deduct current payments on the principal balances of loans used to pay off medical bills incurred prior to the current budget period.

0368.25 EXAMPLES

REV:07/1999

EXAMPLE: The applicant has verified unpaid medical expenses for which the applicant is liable that were incurred prior to application but are still unpaid at the time of application. If the medical expenses absorb all the excess income, the applicant is eligible and is certified for a six (6) month period beginning with the month of application. The case must be redetermined at the end of the six (6) month period.

When the excess income is not absorbed by applying it to medical expenses incurred prior to the application and unpaid, the applicant must present receipts or bills for medical expenses incurred during the six (6) month period beginning with the month of application. The excess is then applied to those expenses.

When the excess income is absorbed, ELIGIBILITY BEGINS ON THAT DAY WHICH IS THE DAY THE MEDICAL SERVICE WAS PROVIDED. The case is certified for the balance of that six (6) month period. At the end of this period, a new application must be submitted.

EXAMPLE: An applicant applies in July with countable income which exceeds the medically needy income limit by $500 per year or $250 for six (6) months). The applicant cannot be certified as eligible until bills or receipts for incurred medical expenses totalling $250 are presented. If a receipt of $50 is presented in July, and a bill for $200 is presented in August, the applicant is then certified from the day in August that the medical service was provided, through December, the end of that six (6) month period.

If on the final day of the six (6) month period, the applicant has (1) no receipts or bills for incurred medical expenses; or (2) if the receipts and/or bills presented do not absorb the excess income; or (3) if the absorption of excess income in the exact amount of the excess income occurs on that final day, there is no eligibility and the application is rejected.

EXAMPLE: An applicant applies in July with income which exceeds the medically needy income limit by $500 per year or $250 for six (6) months. The applicant cannot be certified as eligible until bills and/or receipts for incurred medical expenses totalling $250 are presented. No bills or receipts for incurred medical expenses are presented and the case is rejected as of December 31.

EXAMPLE: An applicant applies in July with income which exceeds the medically needy income limit by $500 per year or $250 excess for six months. A receipt for $50 is presented in July, $100 in September, and $50 in November - total $200. No further bills or receipts are presented. Application is rejected as of December 31.

EXAMPLE: An applicant applies in July with income which exceeds the medically needy income limit by $500 per year or $250 for six months). A receipt for $50 is presented in July, $100 in September, $50 in November, and $50 on December 31 - total $250.

However, the excess income is absorbed on the final day of the six (6) month period. There is no eligibility for that period since there is no medical coverage to be met. Application is rejected as of December 31.

Had the receipts and/or bills totaled more than $250, eligibility would have existed for MA coverage of the amount of any unpaid bills over $250. Also, had the applicant been hospitalized on December 31, eligibility would have existed for any expenses on December 31 which exceed $250.

0368.30 CERTIFICAT OF FLEX TEST CASES

REV:06/1994

Each individual determined to be ineligible for MA will receive notice of the basis of ineligibility. Those individuals ineligible on the basis of excess income will be informed of the amount of his/her spenddown liability.

When a recipient's case is discontinued on the basis of income exceeding the Medically Needy income standard, a review of the recipient's situation is completed under the Flex Test policy.

Such recipient is advised of the amount of excess income and the eligibility period during which such excess must be absorbed.

When such applicant/recipient presents unpaid bills (for which the individual remains liable) incurred at any time through the final day of the six (6) month period and/or receipts for bills incurred during the period for which eligibility is being determined which total or exceed the amount of the excess income, eligibility exists for the balance of the six (6) month period. A new application is not needed for that six (6) month period.

Any case certified, whether for a full six (6) month period or a balance of even only one (1) month, needs a new application at the end of each six (6) month period. The InRHODES system will trigger the mailing of a redetermination packet by sending a notice to the field office. Each six (6) month period is determined separately.

Medical bills recognized in a previous Flexible Test period to reduce excess income must not be applied to reduce the excess income for the new application period. However, if the bills did not establish eligibility, then they were not used for spenddown and can be considered in a subsequent six (6) month period.

To certify a case where the recipient and Medical Assistance must share the expense, the InRHODES eligibility system will notify MMIS of the bills that were used to meet the spenddown. These bills will not be paid by MMIS and are the applicant's responsibility.

0368.30.05 Method of Control Flex Cases

REV:06/1994

The InRHODES on-line redetermination report lists all cases due for redetermination with flex-test cases highlighted. The system notifies workers two months before the month that certification ends that re-determination packets need to be sent out.

Flex-test cases by their nature are ineligible at the end of the certification period and eligibility must be redetermined. The redetermination activities should be completed by the end of the six-month (or less) flex-test period.

0369-PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

0369.05 OVERVIEW OF PROGRAM
EFF:12/01/2005

The Program for All-Inclusive Care for the Elderly (PACE) is a Medical Assistance program administered by DHS which provides an integrated model of medical and long term care services to qualified persons age fifty-five (55) and above. To qualify as a Medicaid eligible PACE participant, an individual must:

- Meet the Medical Assistance requirement for disability and be at least fifty-five (55) years of age, or meet the Medical Assistance requirement for age (65 or older);
- Require the level of care provided in a nursing facility (unlike home and community-based waivers, level of care can be determined to be permanent when improvement is unlikely);
- Meet all other financial and non-financial requirements for Medical Assistance long term care services, such as, but not limited to, citizenship, residency, resources, income, and transfer of assets.

CMS and the Center for Adult Health approved PACE providers are responsible for providing the full scope of Medicaid State Plan categorical and medically needy services and the following additional services:

- Multidisciplinary assessment and treatment planning;
- Case Management services;
- Personal Care;
- Homemaking;
- Rehabilitation;
- Social Work;
- Transportation;
- Nutritional Counseling;
- Recreational Therapy;
- Minor Home Modifications;
- Specialized Medical Equipment and Supplies.

The PACE program is voluntary for any eligible person, but if an individual selects this program, he/she must get all medical and support services through the PACE organization. There are no benefits outside of the PACE program.

DHS long term care/adult services staff is responsible for:

- All determinations and redeterminations of Medical Assistance Long Term Care categorical or medically needy eligibility and post-eligibility as described in Sections 0396.10 through 0396.10.20, and Sections 0396.15 through 0396.15.10.10;

- Determination of income to be allocated to cost of care (share);

- Maintenance of the DHS InRhodes and paper case file;

- Assisting disenrolled clients in application for alternate Medicaid Long Term Care programs, as needed.

The approved PACE provider is responsible for:

- Point of entry identification;

- Submitting all necessary documentation for level of care initial determinations and redeterminations and referral to DHS long term care/adult services offices for financial determinations;

- Checking Medical Assistance eligibility status and required share amount (if any) prior to enrolling the client in PACE as a Medicaid eligible individual, and at each reassessment;

- Providing and coordinating all needed services;

- Adhering to all PACE Provider requirements as outlined in the PACE Program Agreement between DHS and CMS, and to all credentialing standards required by the DHS Center for Adult Health including data submission.

The DHS Center for Adult Health is responsible for:

- Oversight and monitoring of all aspects of the PACE program;

- Conducting initial Level of Care Determinations and determining whether a permanent Level of Care should be assigned;

- Identifying clients for whom there is unlikely to be an improvement in functional/medical status.

0369.10 INVOLUNTARY DISENROLLMENT

EFF:12/01/2005

The PACE Organization may not request disenrollment because of a change in the enrollee's health status or because the enrollee's utilization of medical and/or social services, diminished mental capacity or uncooperative behavior is resulting from his or her special needs (except as specified below). Involuntary disenrollment conditions described in 42 CFR Section 460.164 will be used in Rhode Island. A person may be disenrolled for any of the following reasons:

- Non-payment of premiums on a timely basis: failure to pay or make satisfactory arrangements to pay any premium or co-payment due the PACE organization after a 30 day grace period.
- The participant moves out of the PACE program service area or is out of the service area for more than thirty (30) days unless the PACE organization agrees to a longer absence due to extenuating circumstances.
- The PACE organization is unable to offer health care services due to the loss of State licenses.
- The PACE organization's agreement with CMS and the State-administering agency is not renewed or terminated.
- The participant is defined as a person who engages in disruptive or threatening behavior, including times when the participant physically attacked, verbally threatened, or exhibited harassing behavior toward a PACE program staff member, contractor, or other PACE program participant.
- A person whose behavior is jeopardizing his/her health or safety or that of others.
- A person with decision-making capacity who consistently refuses to comply with his/her individual plan of care or the terms of the Enrollment Agreement.
- A participant may lose eligibility for the PACE program and be disenrolled because they no longer meet level of care requirements.

0369.15 DEPARTMENT APPROVAL FOR INVOLUNTARY DISENROLLMENT EFF:12/01/2005

Involuntary disenrollment from PACE requires DHS Center for Adult Health approval. A proposed involuntary disenrollment for any of the above reasons shall be subject to timely review and prior authorization by the Department, pursuant to the Involuntary Disenrollment procedure below:

- Disenrollment request: The PACE Organization (PO) shall submit to the DHS Center for Adult Health a written request to process all involuntary disenrollments. With each request, the PACE Organization shall submit to DHS evidence attesting to the above situations.

- Department's Approval: The Department will notify the PACE Organization about its decision to approve or disapprove the involuntary disenrollment request within fifteen (15) days from the date DHS has received all information needed for a decision.

- Upon DHS approval of the disenrollment request, the PACE Organization must, within three (3) business days, forward copies of a completed Disenrollment Request Form to the DHS Long Term Care Office and to the Medicare enrollment agency (when appropriate).

0369.20 NOTIFICATION TO THE MEMBER: EFF:12/01/2005

If and when DHS approves the PACE Organization's request for disenrollment, the PACE Organization must send written notification to the member that includes:

- A statement that the PACE Organization intends to disenroll the member;

- The reason(s) for the intended disenrollment; and

- A statement about the member's right to challenge the decision to disenroll and how to grieve or appeal such decision.

0369.25 DISENROLLMENT APPEAL:

EFF:12/01/2005

If the member files a written appeal of the disenrollment within ten (10) days of the decision to disenroll, the disenrollment shall be delayed until the appeal is resolved.

0369.30 LOSS OF PACE ENROLLMENT:
EFF:12/01/2005

When a member loses PACE enrollment, the effective dates of disenrollment from the PACE Organization will be determined as follows:

- Loss of Functional Level of Care:

  No longer requires the level of care provided in a nursing facility as defined in DHS Policy Section 0378.10.

- Out of Area Residence: The PACE Organization will notify the appropriate agencies, Medicare and/or Medicaid, if the member moves permanently out of the designated PACE catchment area. If the member moves permanently out of the catchment area, the date of disenrollment for Medicaid shall be the date when the move occurs. DHS will recoup Medicaid capitation payments made for any months after the month an out of area move occurs.

- Death: If the participant dies, the date of disenrollment shall be the date of death. DHS will recoup any whole capitation payments for months subsequent to the month a participant dies.

0369.35 NOTIFICATION TO THE PARTICIPANT:
EFF:12/01/2005

When the PACE Organization notifies the Center for Adult Health and Medicare enrollment agencies of the loss of PACE enrollment, the PACE Organization shall also send written notification to the member. This written notification shall include:

- A statement that the participant is no longer enrolled in the PACE program;

- The reason(s) for the loss of PACE enrollment.

0369.40 RE-ENROLLMENT AND TRANSITION OUT OF PACE
EFF:12/01/2005

- All re-enrollments will be treated as new enrollees except when a participant re-enrolls within two months after losing Medicaid eligibility. In this situation, the participant’s re-enrollment will not be treated as a new enrollment.

The PACE Organization shall assist participants whose enrollment ceased for any reason in obtaining necessary transitional care through appropriate referrals, by making medical records available to the participant’s new service providers; and (if applicable), by working with DHS to reinstate participant’s benefits in the Medical Assistance Program.

0369.45 VOLUNTARY DISENROLLMENT
EFF:12/01/2005

Participants in the PACE Program may voluntarily disenroll from the PACE Organization at any time. A voluntary disenrollment from the PACE Organization will become effective at midnight of the last day of the month in which the disenrollment is requested.

0370 SSI-RELATED COVERAGE GROUPS

0370.05 SSI-RELATED RECIPIENTS

REV:09/2003

This coverage group consists of aged, blind, or disabled individuals receiving SSI and/or the State Supplement. These Individuals are automatically entitled to Medical Assistance as Categorically Needy.

SSI recipients under age twenty one (21) may be enrolled in RIte Care Health Plans in accordance with provisions contained in Section 0348.

0370.05.05 SSI Assisted Living Applicant/Recipient

REV:12/1998

SSI eligible individuals residing in residential care and assisted living (RC/AL) facilities receive an SSI benefit based on the community federal benefit rate (FBR) plus an increased state supplementary payment for individuals living in such facilities.

RC/AL facilities provide housing, supervision, and personal care services in a residential setting to persons who need some assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs). Such individuals are able to remain in the community because of the supportive services provided through assisted living.

By adjusting the SSI benefit level for persons living in RC/AL facilities to more adequately reflect the cost of providing the services, increased access is available to low income persons whose needs are appropriate to the level of services provided by such facilities.

Individuals who receive this increased SSI benefit are allowed to retain a minimum personal needs allowance of fifty-five dollars ($55) per month from their SSI monthly benefit prior to payment of the RC/AL facility monthly fee.

In addition, individuals applying for SSI (either living in or who will be living in an RC/AL facility if determined eligible for SSI) are required to undergo a screening, assessment, and verification process for SSI individuals living in state licensed residential care and assisted living facilities.

0370.10 DEEMED SSI-RECIP UNDER 1619 (B)

REV:01/2002

This coverage group is individuals considered to be SSI recipients under 1619(b) of the Social Security Act. Persons in this group are "Qualified Severely Impaired" who are employed and individuals who no longer receive SSI payments and/or the State Supplement due to excess earned income. The Social Security Act allows them to remain Medicaid eligible.

0370.15 PICKLE AMENDMENT ELIGIBLES

REV:01/2002

This coverage group originated in a 1977 amendment to the Social Security Act introduced by Representative Pickle of Texas. The objective of the amendment is to prevent SSI recipients from losing their automatic medical coverage because of the yearly cost-of-living adjustments (COLAS) in their Social Security benefits. Since the Pickle amendment was enacted, the Federal court has extended its protection to all current RSDI recipients who, in any month after April, 1977, received RSDI and SSI concurrently and who subsequently lost SSI eligibility FOR ANY REASON (NOT SOLELY THE COLA) and who would still be eligible "but for" the COLAS which they had received since they were last eligible for and received SSI.

0370.15.05 Eligibility Requirements

REV:06/1994

Under the Pickle Amendment, categorical eligibility for Medical Assistance is protected for individuals who received SSI (Title XVI) and RSDI (Title II) concurrently (in the same month) in at least one month after April, 1977 and subsequently lost SSI for any reason (not solely the COLA), provided:

- o Such individuals currently receive RSDI; and,
- o Such individuals would currently be eligible for SSI but for the RSDI COLAS they received since the last month in which such individuals were eligible for and received SSI.

The following definitions apply to Pickle eligibility.

- o "Protecting" categorical eligibility means that such individuals are still eligible for MA as Categorically Needy. (They are still eligible for the full scope of medical services.);

- o "Still" eligible for MA as Categorically Needy means that there is no interruption in categorical eligibility. Such individuals retain the characteristic of aged, blind or disabled and remain within the resource limit. Income only has affected their SSI eligibility;

- o "Individuals" means that only SSI-related individuals/couples (who are aged, blind or disabled) and who are not residents of long-term care facilities are eligible to be considered under the Pickle Amendment. AFDC-related families (where a child is deprived of parental support or care) are not eligible to be considered under the Pickle Amendment because SSI eligibility is determined on an individual and not on a family basis. There is no SSI standard of payment for a family.

- o "Concurrently receiving SSI and RSDI" means that some individuals receive an RSDI benefit low enough to be eligible for an SSI payment, supplementing their RSDI up to the appropriate SSI standard;

- o "For any reason (not solely the COLA)" means that the cause of the loss of SSI need not necessarily be a COLA:

  Example: The individual started to receive a monthly pension from a former employer. This additional income caused the individual's total countable income to exceed the appropriate SSI standard of payment.

  Example: The individual was living alone and subsequently moved in with her daughter. The income remained the same but the SSI standard now applicable is lower ("individual in another's home"). Her income is now too high. She loses her SSI.

- o "Currently receiving RSDI" means that to be eligible for SSI and MA such individuals must be aged, blind or disabled. (Early retirement does not apply.);

- o "Would currently be eligible for SSI" means that such individuals (a) must be either aged, blind, or disabled; (b) must have resources within the appropriate resource limit; and, (c) must have met countable income less than the SSI standard of payment, according to living arrangement;

- o "But for the RSDI COLAS" (the "but for" test) means that in computing the net countable income, the RSDI COLAS received since the last month in which the individual was eligible

for and received SSI are disregarded. Therefore, eligibility is determined without the COLAS. If the individual is Pickle-eligible, such individual is treated as though still receiving SSI;

- Both "RSDI COLAS" and SSI COLAS are usually effective every year on January 1st;

- "Eligible for and received SSI" means that the receipt of an SSI check(s) is not sufficient in and of itself. The individual must have been eligible to receive the SSI check(s).

  Example: If initial receipt of RSDI raises the countable income equal to or above the SSI standard making the individual ineligible for SSI for that month (e.g. June), the SSI payment, already made, is considered an overpayment subject to recovery. The individual received the SSI check in June but was not eligible to receive it. Therefore, June is not a month of concurrent eligibility for and receipt of RSDI and SSI.

0370.15.10 Potentially Eligible Cases

REV:06/1994

A potentially eligible individual is one who is receiving RSDI and was eligible to receive (and received) RSDI and SSI concurrently in at least one month after April, 1977.

Once an individual has been identified as potentially eligible under the Pickle Amendment, that individual remains potentially eligible throughout his/her lifetime although actual Pickle eligibility can change as the individual's circumstances change.

0370.15.15 SSA Protected Amount

REV:06/1994

For individuals identified as potentially Pickle eligible, the RSDI COLAS which they and their financially responsible family member(s) received after such individuals were last eligible for and received SSI and RSDI concurrently are deducted from their countable income in determining their Categorically Needy eligibility for MA.

The Eligibility Technician will specify an SSA protected amount and status code "P" on the InRHODES Unearned Income (UNEA) panel. This protected amount will represent the amount of benefits received prior to the increase. When the Medical Assistance income is computed, this protected amount will be used in place of the actual SSA amount the applicant is receiving.

0370.15.20 Id Potential Pickle Cases

REV:06/1994

Every SSI-related applicant or recipient who currently receives RSDI and who received SSI cash assistance in any month after April, 1977 must be considered for possible eligibility under the Pickle Amendment at each application and redetermination.

- o At application, APPLICATION SUPPLEMENT FOR PICKLE ELIGIBILITY (ASPIC) is included in the application packet for such individuals/couples to gather the information and supporting documents necessary to ascertain Pickle-eligibility.

- o At redetermination, an APPLICATION SUPPLEMENT FOR PICKLE ELIGIBILITY (ASPIC) is included in the recertification packet for such individuals/couples to determine whether there has been a change in Pickle-eligibility. A change in either the recipient's circumstances or in the SSI standards can affect Pickle status.

Many cases not originally considered eligible under the Pickle Amendment because the termination from SSI resulted from a change in living arrangement or receipt of other benefits (such as Veterans' benefits or private pensions) should have been eligible, or may still become eligible for Pickle status in the future. This is because the countable amount of Social Security benefit for these cases is fixed (frozen) at the amount received for the last month of the individual and/or spouse's eligibility, while the SSI standards are increased each year.

0370.15.25 Determining Pickle Elig

REV:06/1994

In determining eligibility, all eligibility requirements for Categorically Needy individuals/couples must currently exist. The only difference between the Pickle cases and other cases is the special disregard of the RSDI COLAS; i.e., the frozen amount of RSDI.

Using the WORKSHEET FOR PICKLE ELIGIBILITY (WOPIC), the Eligibility Technician establishes the following requirements:

- o The characteristic of aged, blind, or disabled must exist. If the individual is active as Medical Needy, the characteristic has already been established. If the individual is an applicant receiving RSDI, the technician establishes that receipt of that benefit is based on a characteristic and not on early retirement;

- o Resources cannot be transferred for the purpose of attaining eligibility. Resources must be within the appropriate resource limits. If the individual is a recipient, the technician determines if there has been an increase in resources since application or the last recertification;

- o The technician establishes the date that the SSI case was closed, and that RSDI and SSI were received concurrently in any month since April, 1977.

- o If RSDI has been the only source of income since the loss

of SSI and there has been no change in the type of benefit (such as a change from spouse to widow), the amount of the RSDI benefit received in the month prior to the RSDI COLA which was coincident with the loss of SSI is the current amount of countable income, the frozen COLA to be used in future redeterminations. If there is insufficient information available, the frozen COLA must be manually calculated according to the formula on the reverse of the WOPIC. (The COLAS by date and percentage of increase are shown as Section 0370.15.45);

- o The unearned income disregard of $20 is applied;
- o If there has been a change in RSDI other than the COLA, add the amount of the difference between the old and new RSDI at the time of the change is added;
- o If non-RSDI income is currently received, it is countable income. (If such income is earned, the $65 + 1/2 disregard is applied);
- o The current countable income (all of the subsequent COLAS have now been disregarded) is compared to the current SSI standard for the individual's current living arrangement to determine if a deficit in income exists;
- o The WOPIC is signed by the Eligibility Technician and reviewed/signed by the Supervisor.

If this determination, at any point, results in Pickle- ineligibility, the Eligibility Technician determines current eligibility for MA using the actual RSDI currently received; the COLAS cannot be disregarded.

0370.15.25.05 Example of Pickle Elig

REV:06/1994

Mr. Q was terminated from SSI in 1/84 when he began to receive VA benefits in addition to his RSDI. In computing net countable income, the RSDI amount Mr. Q was receiving in 12/83 must be used to determine his Pickle eligibility.

Mr. Q's Pickle eligibility is determined as follows:

Amount	Description
$ 220.00	Current VA amount
+ 211.00	12/83 RSDI amount
$ 431.00	Countable unearned income
-20.00	Income disregard
$ 411.00	Total countable Pickle income

This is compared to the current SSI Standard. If the figure is below the SSI Standard, Mr. Q is categorically eligible for Medical Assistance under the Pickle Amendment.

0370.15.30 Verifying Pickle Eligibility

REV:06/1994

Verification of resources and income as well as any other verifications necessary to establish eligibility must be provided in accordance with procedures established for regular SSI-related MA cases (individuals/couples). Pickle eligibility is established upon verification of:

- Date of termination of eligibility for SSI payments;
- Present receipt of Social Security Disability or Aged benefits (not early retirement);
- Amount and type of RSDI benefit for the last month in which the individual (and/or spouse) was eligible for and received an SSI payment; and,
- All current income other than RSDI. Except for cases appearing on the Annual Review System, documents from the Social Security Administration (SSA) such as award letters, 1610 termination notices, confirmation on SSA letterhead, must show that receipt of SSI and RSDI were concurrent. Such documents must show dates coincident with the appropriate timeframes; e.g., an award letter for RSDI dated 1982 is outdated by COLAS accumulated since that year.

Copies of verifying documents must be retained in the case record.

0370.15.30.05 Change in Pickle Status

REV:06/1994

A Pickle-eligible case can become Pickle-ineligible for any of the following reasons:

- A subsequent increase in income (other than the RSDI COLA) which negates the effect of disregarding the RSDI COLAS, causing countable income to exceed the appropriate SSI standard;
- An increase in RSDI attributable to a change in the type of RSDI entitlement (for example, going from a spouse's to a widow's benefit) causes the countable income to exceed the appropriate SSI standard;
- A change in living arrangement introduces a lower SSI standard (for example, going from "living alone" to "living in another's home") causing the countable income to exceed the lower SSI standard;
- Accumulated resources exceed the resource limit.

A Pickle-ineligible case can become Pickle-eligible for any of the following reasons:

- A subsequent decrease in income (for example, loss of

rental income) which causes countable income to fall below the appropriate SSI standard;

- o A return to the community from a long-term care facility which makes an otherwise ineligible or Medically Needy individual Pickle-eligible;

- o A change in community living-arrangement which introduces a higher SSI standard (for example, going from "another's home" to "living alone") and causes countable income to be below the higher SSI standard;

- o An annual increase in SSI standards which causes countable income which has been above the SSI standard to fall below the new standard;

- o Resources decrease to within the resource limit.

It is reasonable to assume that almost any individual terminated from SSI by reason of excess income will eventually become eligible for MA as a Pickle case.

0370.15.35 Annual Review System

REV:06/1994

To implement the court's interpretation of the Pickle Amendment on an ongoing basis, an Annual Review System has been mandated under Federal regulations.

The Annual Review System does not preclude the requirement of a regular full redetermination because the Annual Review System is an income test at the time of the annual RSDI and SSI COLAS. The Annual Review System is conducted only for those individuals who meet the essential criterion, that is, they were eligible for and received RSDI and SSI concurrently after April, 1977.

The Annual Review System is designed to review the effect of only two income variables on Pickle eligibility. They are the

- o annual SSI COLA; and,

- o annual RSDI COLA.

Therefore, there are two populations to be identified by the Annual Review System:

- o Individuals who become Pickle eligible due to the SSI COLA; and,

- o Concurrent RSDI and SSI who lose SSI due to RSDI COLA.

0370.15.35.05 Pickle-Elig Due to SSI COLA

REV:06/1994

These are generally "Potential Pickle" Medically Needy recipients who receive RSDI, and who may become Pickle-eligible due to the increased SSI standard resulting from the SSI COLA. These individuals had countable income (calculated using a frozen RSDI amount) which exceeded the SSI standard in effect prior to the SSI standard because

the Frozen RSDI amount remained the same, while the SSI standard increased as a result of the SSI COLA. An individual, otherwise eligible for SSI, who has countaable income (because of the frozen RSDI) less than the new SSI standard, becomes Categorically Needy under the Pickle Amendment.

0370.15.35.07 Summ of Annual Review of SSI COLA Effect

REV:06/1994

MEDICALLY NEEDY RECEIVING RSDI

- o January, 1985

  Frozen RSDI
  + Other Income

  Total Countable Income = Equal to or more than 1985 SSI Standard

  Result = Pickle-ineligible as Categorically Needy. Redetermination Medically Needy Eligibility now using actual RSDI.

- o January, 1986

  Frozen RSDI (same as in 1/85)
  + Other Income

  Total countable Income = Less than 1986 SSI Standard

  Result = Becomes Pickle-Eligible as Categorically Needy.

  Redetermination Categorically Needy Eligibility at next Recertification or Annual REview Using Frozen RSDI.

0370.15.35.10 RSDI/SSI Who Lose SSI by COLA

REV:06/1994

These individuals may remain Categorically Needy under the Pickle Amendment. The RSDI amount received in the month prior to the RSDI COLA is frozen, and used in the calculation of countable income to determine Pickle eligibility. The actual RSDI benefit amount is used by SSA to calculate the SSI payment, and such individuals have too much actual income to receive all SSI payment. However, because the amount of the RSDI COLA is disregarded in calculating countalbe income for Pickle eligibility, total countable income for Pickle eligibility may be less than the new SSI standard. If so, and if otherwise eligible for SSI, the individual remains Categorically Needy under the Pickle Amendment.

0370.15.35.15 Summ of Annual Review of RSDI COLA Effect

REV:06/1994

CATEGORICALLY NEEDY RECEIVING RSDI AND SSI

- January, 1986

  Frozen RSDI
+ Other Countable Income

Total Countable Income = Equal to or more than 1986 SSI Standard

Result = Ineligible SSI
Remains Pickle-Eligible as Categorically Needy.

Note: An individual who continues to be eligible for SSI despite the RSDI COLA and is subsequently terminated from SSI for another reason is potential Pickle. The essential criterion of concurrent eligibility for and receipt of RSDI and SSI is met. The individual cannot become Pickle eligible until the next RSDI COLA at the earliest. This is because the frozen RSDI amount and the actual RSDI amount are the same. The actual RSDI benefit will not be greater than the frozen RSDI amount until the next RSDI COLA.

0370.15.35.17 Identifying the ARS Population

REV:01/2002

Annual Pickle lists are generated in two different ways:

- Each year SSA sends to Central Office a list of cases terminated on SSI because of the RSDI COLA. From C.O., an AP-206, a new DHS-2 Statement of Need, and an ASPIC are mailed to the individual. When the application is filed in the District Office, eligibility is determined in accordance with the provisions of the Pickle Amendment. A notice of eligibility or ineligibility is mailed to the individual.

- Prior to the implementation of the RSDI and SSI COLAS, which have lately been effective every year on January 1st, a computer interface with InRHODES will identify those Pickle-eligible and potential Pickle cases. Eligibility Technicians assigned to cases affected by the update will be notified. Eligibility will need to be redetermined, in accordance with the provisions of the Pickle Amendment.

These cases are identified by a special coding entered on the Unearned Income Panel of the Statement of Need.

0370.15.40 Authorization

REV:06/1994

Once an individual is identified as having been concurrently eligible for and receiving RSDI and SSI in at least one month since 4/77, s/he always carries an

eligibility factor code which identifies him/her as either Pickle eligible or potential Pickle.

Pickle eligible and potential Pickle cases must always be redetermined for Pickle eligibility using the special COLA disregards. The Eligibility Technician enters the protected amount and the protected income type on the Unearned Income Panel of the InRHODES Statement of Need.

Each Pickle eligible and potential Pickle case must be coded with the special eligibility factor code to insure the individual's lifetime inclusion as a member of the special class.

0370.15.45 Chart of RSDI COLA

REV:01/2006

0370.15.45 Chart of RSDI COLA REV:01/2006

RSDI COST-OF-LIVING ADJUSTMENTS (COLAs)

DATE	PERCENTAGE OF INCREASE
July 1, 1977	5.9%
July 1, 1978	6.5%
July 1, 1979	9.9%
July 1, 1980	14.3%
July 1, 1981	11.2%
July 1, 1982	7.4%
*	
January 1, 1984	3.5%
January 1, 1985	3.5%
January 1, 1986	3.1%
January 1, 1987	1.3%
January 1, 1988	4.2%
January 1, 1989	4.0%
January 1, 1990	4.7%
January 1, 1991**	5.4%
January 1, 1992	3.7%
January 1, 1993***	3.0%
January 1, 1994**	2.6%
January 1, 1995**	2.8%
January 1, 1996**	2.6%
January 1, 1997**	2.9%
January 1, 1998**	2.1%
January 1, 1999**	1.3%
January 1, 2000**	2.5%
January 1, 2001**	3.5%
January 1, 2002**	2.6%
January 1, 2003****	1.4%
January 1, 2004	2.1%
January 1, 2005	2.7%
Januray 1, 2006	4.1%

* No COLA in 1983
** Federal payment level only.
*** State share reduced to 1990 level.
**** Federal share increased; State share reduced, resulting in no change to combined SSI payment levels.

0370.20 DISABLED CHILD-KATIE BECKETT

REV:01/2002

This coverage group consists of certain disabled children under the age of eighteen (18) who are living at home and who would qualify for Medical Assistance if in a medical institution.

"Katie Beckett" coverage requires that the child meet special eligibility conditions in addition to financial eligibility.

A child under 18 years of age who is living at home but who is in need of the level of care provided in a hospital, Nursing Facility, or Intermediate Care Facility for Mental Retardation, has his/her Medical Assistance financial eligibility determined as if s/he were actually institutionalized. ONLY THE CHILD'S OWN INCOME AND RESOURCES ARE USED IN THE DETERMINATION OF FINANCIAL ELIGIBILITY. THE INCOME AND RESOURCES OF THE CHILD'S PARENTS ARE NOT DEEMED TO BE AVAILABLE TO THE CHILD. A "Katie Beckett" child is deemed Categorically Needy for the full scope of medical services. The purpose of "Katie Beckett" coverage is to make Medical Assistance for home care available to children who might otherwise be disqualified due to the parents' income.

0370.20.05 Special Elig Conditions

REV:09/2003

To be eligible for Katie Beckett coverage, it must be determined that:

- o The child requires the level of care provided in a hospital, a Nursing Facility, or an ICF-MR. The LTC/AS worker must assure that a completed assessment of the child's needs is sent to the Center for Child and Family Health (CCFH). This unit has the responsibility of determining the level of care and disability status for the child and the specific time frame for re-evaluation.

- o The level of care provided at home is appropriate for the child;

- o The estimated cost to Medical Assistance for providing the appropriate level of care at home does not exceed the cost to Medical Assistance for providing care in an institutional setting.

If the child meets these special eligibility conditions and is otherwise eligible, the Long Term Care worker authorizes medical coverage. Children eligible for MA under this coverage group may be enrolled in a RIte Care health Plan in accordance with provisions contained in Section 0348, if they are not otherwise covered by a third party health insurance plan.

0370.20.10 Instit, Home Cost Comparison

REV:01/2002

The estimated cost to MA of providing care for the child at home cannot exceed the estimated cost to MA of providing care in an institution.

To make this determination, the LTC/AS worker compares the gross monthly cost for the required level of care (hospital, NF, or ICF-MR, as appropriate) to the total gross monthly cost for allowed home care services.

0370.20.10.05 Allowed Home Care Services

REV:09/2003

Allowed home care services are:

- o Certified home health agency services, including skilled nursing; physical speech and occupational therapy and home health aid services; and,
- o Purchase or rental of durable medical equipment;
- o Home based therapeutic services; and,
- o Minor assistive devices, minor home modifications, and other special equipment.

Certain services may be provided by school systems for school age children, by family members and/or by volunteers and are not to be considered in estimating the cost of care at home. It should be noted, however, that for school age children these services are the legal responsibility of the school system.

0370.20.10.10 Determ Costs of Instit Care

REV:06/1994

The LTC worker enters the applicable type of institutional care on the Waivered Services (SERV) Panel and refers to the table of institutional costs maintained by the InRHODES system. The worker uses the SERV Panel which determines if the costs of services required to provide an appropriate level of care in the home are within the costs of care in the appropriate institution.

If eligible, there is no income applied to the cost of services.

The child is allowed to retain all income for community living expenses.

If the total estimated cost of care in the home is less than the total estimated cost of care in the appropriate institution, the child meets this special condition and, if otherwise eligible, is eligible for the full scope of MA benefits.

If the total estimated cost of services required to allow the child to be cared for at home exceeds the cost of institutional care, the child is ineligible, even if the child meets all other eligibility requirements.

0370.20.15 Financial Eligibility Requirements

REV:01/2000

To establish financial eligibility for "Katie Beckett" coverage, the LTC/AS worker determines if the child would be eligible for Medical Assistance, as either Categorically Needy or Medically Needy, if the child were institutionalized.

Only the income and resources of the child are considered. Any payment provided under Title XX or other federal, state or local government programs for in-home supportive services is excluded from income.

The LTC/AS worker determines if the child would be financially eligible for Medical Assistance if institutionalized. An institutionalized child is financially eligible for Medical Assistance if s/he is in one of the following groups:

- o If s/he would be eligible for SSI if institutionalized, i.e., has resources within the SSI limit of $2,000, and income LESS THAN $70.00 MONTHLY. These individuals receive cash SSI payments even when they are institutionalized and are therefore Categorically Needy;

- o If s/he had resources within the $2,000 limit and income of at least $70.00 but NOT MORE THAN THE FEDERAL CAP set forth in Section 0386.05. These individuals lose their SSI cash payment when they are institutionalized because their gross personal income is $70 or more per month. However, because their income is less than the Federal Cap they remain eligible for Medical Assistance as Categorically Needy;

- o If s/he has with resources less than the Medically Needy resource level of $4,000 and income less than the cost of care in the institution. These individuals are eligible as Medically Needy.

The income and resources of the parents are not considered in the determination of eligibility, and are not used to reduce the cost of Medical Assistance services.

Under the law, a child who meets the "Katie Beckett" requirement, is for Medical Assistance purposes only, deemed to be receiving an SSI cash payment and, therefore, Categorically Needy.

0370.25 DISABLED ADULT CHILDREN

REV:01/2002

The Employment Opportunities for Disabled Americans Act provides a special income disregard for this group of individuals, effective July, 1987. The intent of Congress in authorizing this coverage group is to protect the Categorically Needy status of certain individuals who lose SSI benefits SOLELY due to the receipt of the disabled adult child's Social Security benefits.

To become a member of this group and thus be eligible for a special income disregard, an individual must meet all of the following criteria:

- Be at least age eighteen (18); and,
- Have become blind or disabled before reaching age twenty-two (22); and,
- Have been receiving SSI benefits on the basis of blindness or disability; and,
- Have lost SSI benefits after July, 1987 as a result of entitlement to, or increase in, RSDI Child's benefits (Title II-d).

For persons in this coverage group, the amount of the increase in disability benefits or the new entitlement (whichever caused SSI ineligibility) is disregarded when determining MA financial eligibility as Categorically Needy.

0370.25.05 Identif of the Coverage Group

REV:06/1994

Individuals who are members of this group are identified by the SDX interface at the time they are closed on SSI. They are sent an Application (DHS-1) and Statement of Need (DHS-2) and instructed to contact the appropriate district office to make an appointment to apply.

0370.25.10 Determination of Eligibility

REV:06/1994

To be eligible as Categorically Needy under this coverage, it must be established that the individual would be eligible for SSI except for the RSDI benefit. The Eligibility Technician determines if the individual meets the normal eligibility requirements (residency, enumeration, resources, citizenship/alienage). Receipt of the RSDI benefit establishes the characteristic of disability for MA.

Using the interface function BENDEX panel, the Eligibility Technician documents that:

- SSI benefits were terminated due to the receipt or increase in the disabled adult child's benefits under Sec. 202(d); and,
- The individual currently receives such benefits; and,
- The amount of benefit increase which caused SSI ineligibility, if the loss of SSI was caused by an increase.

If otherwise eligible for SSI, the individual's countable income is determined, disregarding the RSDI and any subsequent COLAs which caused eligibility. The Eligibility Technician enters a zero protected income amount and the adult disabled child type code on the InRHODES Unearned Income panel.

0370.25.15 Redetermination of Eligibility

REV:06/1994

The normal redetermination process is followed. In addition, the Eligibility Technician must confirm that the applicant is still receiving RSDI benefits, using the InRHODES interface function, BENDEX panel.

If all other eligibility criteria are met, the individual's countable income is computed by disregarding the RSDI benefit which caused SSI ineligibility and all subsequent COLAS. If the individual would be eligible for SSI, but not for the RSDI benefit, eligibility as Categorically Needy would still exist.

If Categorically Needy eligibility no longer exists, eligibility for Medically Needy coverage is determined with no special disregard for the individual's RSDI benefit.

0370.30 SSI-ELIG NON CASH RECIPIENTS

REV:01/2002

This coverage group consists of individuals who would be eligible for a cash payment under the SSI program but who have not applied yet, or who are eligible for SSI and choose not to accept cash payment.

0370.35 SSI-ELIG EXCEPT FOR MA RULES

REV:01/2002

This coverage group consists of individuals who would be eligible for SSI or the State Supplement except for an eligibility requirement that is prohibited in Medical Assistance.

0370.40 STATE SUPP RECIP, 12/73 AABD

REV:01/2002

This coverage group consists of AABD recipients of December, 1973 and their essential spouses who continue to live with and be essential to the well-being of the cash recipient. The essential spouse continues as long as his/her cash recipient spouse remains eligible under the December, 1973 eligibility requirements.

0370.45 SSI INELIG BY ACTUAR CHANGES

REV:01/2002

The Social Security Amendments of 1983 eliminated an actuarial reduction formula applied to the RSDI benefits of disabled widow(er)s who become entitled to RSDI benefits before age 60.

The resulting Title II (RSDI) benefit increase disadvantaged some SSI recipients because the RSDI increase was enough to raise their income above the SSI standard, thus causing the loss of SSI and eligibility for Categorically Needy Medical Assistance (MA).

This coverage group consists of disabled widow(ers) who lost SSI benefits because of 1983 changes in the actuarial reduction formula and filed a written application for MA prior to July 1, 1988.

The Consolidated Omnibus Budget Reconciliation (COBRA) of 1985 restored Categorically Needy eligibility for these individuals who filed a written application for MA before July 1, 1988 and meet the specific requirements of this coverage.

0370.45.05 Eligibility Requirements

REV:06/1994

Categorically Needy MA is provided to any disabled widow(er) who:

- o Was entitled to a disabled widow(er)'s benefit under Title II (RSDI) for December, 1983;
- o Was entitled to and received a widow(er)'s benefit based on a disability, as defined by SSA, for January, 1984;
- o Because of the increase in the amount of his/her disabled widow(er)'s benefit which resulted from the elimination of the reduction factor for disabled widow(er)s entitled before age 60, became ineligible for SSI in the first month in which that increase was paid to him/her (and in which a retroactive payment of that increase for prior months was not made);
- o Has been continuously entitled to a disabled widow(er)'s benefit under Title II (RSDI) from the first month that an increase in his/her disabled widow(er)'s benefit was received;
- o Filed an application for Medical Assistance prior to July 1, 1988; and,
- o Would be eligible for SSI if the amount of that increase and any subsequent COLAS in disabled widow(er)'s benefits were disregarded in determining countable income.

0370.45.10 Determination of Eligibility

REV:06/1994

An application for MA must have been filed prior to July 1, 1988.

Eligibility as Categorically Needy under this coverage requires eligibility for SSI except for the RSDI benefit. The Eligibility Technician determines if the individual meets the normal eligibility requirements, including residency, enumeration, citizenship/alienage and resources within Categorically Needy limits.

Receipt of disabled widow(er)'s benefits establishes the disability factor for MA. No separate disability review need be done.

If otherwise eligible for SSI, the individual's countable income is determined disregarding the RSDI and any subsequent COLAs which caused ineligibility.

The Eligibility Technician documents, via the interface function, BENDEX panel that:

- o SSI benefits were terminated due to the increase in the individual's Title II benefits;

- The individual currently receives such benefits; and,
- The amount of benefit increase which caused SSI ineligibility, if the loss of SSI was caused by an increase.

0370.45.15 Redetermination of Elig

REV:06/1994

The normal redetermination process is followed. In addition, the Eligibility Technician confirms that the applicant is still receiving RSDI benefits using the InRHODES interface function, BENDEX panel.

If all other eligibility criteria are met, the individual's countable income is computed by disregarding the RSDI benefit which caused SSI ineligibility and all subsequent COLAs. If the individual would be eligible for SSI, Categorically Needy eligibility continues.

If Categorically Needy eligibility no longer exists, eligibility for Medically Needy coverage is determined with no special disregard of the applicant's RSDI benefit.

0370.50 PROTECTED WIDOW (ERS) AGE 60-65

REV:01/2002

This coverage group consists of disabled widow(ers) between the ages of sixty (60) and sixty-five (65) who:

- Lost SSI benefits solely as a result of entitlement to Widow(er)'s benefits under Section 202 (e) or (f) of the Social Security Act, or a combination of widow(er)'s benefits with other RSDI benefits;
- Are currently entitled to Title II benefits; and,
- Are not yet entitled to Medicare.

For persons in this coverage group, the Title II benefit is disregarded in determining countable income.

0370.50.05 Determination of Eligibility

REV:06/1994

To be eligible as Categorically Needy, the individual must be eligible for SSI except for the RSDI benefit. Eligibility is determined in the usual manner, except that the amount of the RSDI benefit is disregarded in counting income. The Eligibility Technician enters a zero protected income amount and the protected widower code on the InRHODES Unearned Income panel.

The applicant must meet the normal characteristic and resource requirements for Categorically Needy (SSI) eligibility. Certain types of widow(er)'s benefits under Section 202 (e) or (f) of Title II of the SSA do not confer disability status on the recipient.

Therefore, staff must ascertain if a disability determination must be done (See Section 0352.15). The individual's countable income, disregarding the RSDI benefit, must be within the limit for a Categorically Needy individual.

The individual's RSDI benefit is disregarded only until s/he reaches 65 or becomes entitled to Medicare. Individuals generally become entitled to Medicare benefits when they reach 65 years of age, or in the twenty-fifth (25th) month of entitlement to RSDI disability benefits. At the month of the 65th birthday, or the month of entitlement to Medicare, the individuals's membership in this special class terminates, and eligibility must be redetermined using all of the individual's income.

Consequently, if the Eligibility Technician is aware that an individual will become Medicare-eligible or reach age 65 prior to the normal redetermination date, the redetermination is scheduled in that earlier month. The Eligibility Technician must verify the fact that SSI benefits were terminated solely due to the receipt of Sec. 202 (e) or (f) benefits, or a combination of Sec. 202 (e) or (f) and other RSDI benefits via the BENDEX Panel in the InRHODES Interface function. The BENDEX file is used to determine if a disability benefit is being paid. (The SDX file will indicate closure from SSI due to income; however, it does not indicate under which section the benefits were received).

If the individual is not Categorically Needy using the above procedure, eligibility for Medically Needy coverage is determined using normal procedure. NO SPECIAL TREATMENT OF INCOME IS ALLOWED IN THE Medically Needy DETERMINATION.

0370.50.10 Redetermination of Elig

REV:06/1994

At each redetermination of eligibility, the Eligibility Technician must, in addition to the normal requirements, ascertain that individual is not in receipt of Medicare, and has not reached age 65.

Cost of living (COLA) increases in the RSDI benefit received subsequent to the initial RSDI entitlement (which caused the ineligibility for SSI benefits) are disregarded in the determination of eligibility as long as the individual remains a member of this special class. This is because the intent of Congress is to protect these individuals from becoming ineligible for Categorically Needy coverage as a result of their RSDI benefit, until they are eligible for Medicare.

0370.55 DIS WIDOW (ERS), DIVORCED SPOUS

REV:01/2002

This coverage group consists of disabled widow(ers) and disabled surviving divorced spouses who lose SSI or the State Supplement due to the receipt of Title II Disabled

Widow(ers) Benefits (DWB). For Medical Assistance purposes, these individuals are deemed to be SSI recipients until they are entitled to receive Medicare.

0370.60 DIS CHIL RECEIV IV-E ADOPT SUB

REV:01/2002

This coverage group consists of disabled children who are receiving Title IV-E Adoption Assistance. The Adoption Assistance Program provides Federal funding for continuing payments for hard to place children with special needs. The special needs adoptive children must be SSI-recipients or FIP eligible at the time of adoption. A cash payment is not an MA eligibility requirement for Title IV adoption assistance children. These children continue to be eligible for Medical Assistance as long as a Title IV-E adoption assistance agreement is in effect. An interlocutory order or final adoption decree need not exist.

0370.65 REFUGEE MEDICAL ASSISTANCE

REV:01/2002

This coverage group is refugees who have resided in the United States for eight (8) months or less, and who are ineligible for one of the categorical programs due to lack of a characteristic.

0370.65.05 Eligibility Requirements

REV:06/1994

To be eligible for Refugee Medical Assistance (RMA), a refugee must:

- o Meet the refugee immigration and identification requirements or be dependent the child of such refugees;
- o Meet the non-financial requirements and conditions of eligibility for Refugee Cash Assistance (RCA). (Receipt of RCA is not an RMA eligibility requirement);
- o Not have been denied or terminated from RCA due to voluntary termination from a job or a refusal or employment;
- o Not be full-time students except as allowed in Section 0906.20;
- o Be recipients of RCA or, for certain refugees prohibited from receiving a cash payment for a limited period of time, be eligible for some form of RCA;
- o Have income and resources within the Categorically Needy limits.

0370.65.10 Treatment of Income

REV:06/1994

In-kind services and shelter provided by a sponsor or resettlement agency are not considered as income to the refugee when determining financial eligibility for RMA.

Direct cash payments to the refugee from a sponsor or resettlement agency are counted as unearned income.

0370.65.15 Eight Month Limit for RMA

REV:06/1994

Receipt of RMA under the characteristic of "refugee" is limited to the first eight (8) months in the United States, beginning with the month the refugee initially entered the United States, or the entrant was issued documentation of eligible status by the Immigration and Naturalization Service.

0370.65.20 Extended RMA Coverage

REV:06/1994

If a refugee receiving Refugee Cash Assistance becomes ineligible solely due to increased earnings from employment, the refugee's RMA is extended, at the same level of care, for four months or until the end of the eight month limitation, whichever comes first.

0370.65.25 Termination of Elig for RMA

REV:06/1994

A refugee who is terminated from RCA because of failure or refusal to participate in the employment-related requirements (Sections 0906.10 and 0906.20) is also terminated from RMA. The RMA termination applies only to the sanctioned individual.

0370.70 LOW INCOME AGED AND DISABLED

REV:08/2000

This coverage group consists of individuals and members of couples who:

* are over the age of sixty five (65) or disabled. (An individual whose eligibility is based solely on blindness is not eligible under this coverage group. However, a blind individual who also meets the criteria for disability may be eligible).

* have countable income which is less than or equal to one hundred percent (100%) of the federal poverty income level guidelines;

* have countable resources within the medically needy resource limit; and,

* meet all other technical and cooperation requirements for Medical Assistance.

Under this coverage group:

* Income limits are rigid. There is no flexible test of income.

* Cost of living increases in Title II benefits (COLAs) effective in January each year are disregarded in determining income eligibility through the month following the month in which the annual federal poverty guidelines are published in the Federal Register.

* Eligible individuals and couples receive the full scope of categorically needy services.

* As with other SSI related coverage groups, retroactive coverage for the three (3) months prior to application is available to eligible individuals. However, in no case may coverage begin before 7/1/00.

0370.75 MEDICALLY NEEDY COVERAGE

REV:08/2000

Eligibility for Medically Needy coverage is based on the same characteristics as the Categorically Needy, but on the resource/income limits established for the Medically Needy.

0370.75.05 Med Needy Aged, Blind or Disabled

REV:08/2000

This coverage group consists of aged, blind and disabled individuals who have income and resources established for the Medically Needy.

0370.75.10 12/73 Blind or Disabled Ind

REV:08/2000

This coverage group consists of individuals who, whether or not they received cash for the month of December, 1973, were eligible by reason of their having been previously determined to meet the criteria for disability or blindness, established under the state's approved plan for AABD, and who, for each month after December 1973, continue to meet the definition of disability or blindness.

0372 SPECIAL TREATMENT COVER GROUPS

0372.05 MEDICARE PREMIUM PAYMENT PROGRAM

REV:01/2006

0372.05 MEDICARE PREMIUM PAYMENT PROGRAM REV:01/2006

In accordance with federal law, limited Medical Assistance is provided to low income Medicare beneficiaries. This limited coverage helps eligible individuals pay for some or all of their out-of-pocket Medicare expenses.

There are four categories Medicare Premium Payment Program Benefits:

1. Qualified Medicare Beneficiary (QMB)
   QMBs were established under the legal authority of the Medicare Catastrophic Coverage Act (MCCA) of 1988. States are required to pay Medicare Part A and Part B premiums, deductibles, and co-payments on behalf of eligible individuals. For eligible QMBs, Medical Assistance makes a direct payment to the federal government for the Part A premium (if any), the Part B premium, and provides payments for Medicare co-insurance and deductibles as long as the total amount paid by the Medicare Program does not exceed the Medical Assistance Program allowed amount(s) for the service(s). An individual may qualify for and receive QMB and full Medical Assistance at the same time.

2. Specified Low Income Medicare Beneficiary (SLMB)
   SLMBs were established under the legal authority of the Omnibus Budget Reconciliation Act (OBRA) of 1990. States are required to pay the Medicare Part B premium on behalf of eligible individuals. Medical Assistance makes a direct payment to the federal government for the Medicare Part B premium for an eligible SLMB. An individual may qualify for and receive SLMB and full Medical Assistance at the same time.

3. Qualifying Individual-1 (QI-1);

   Qualifying Individuals were established under the legal authority of the Balanced Budget Act (BBA) of 1997. States are required to help pay certain Medicare costs through a capped allocation of funds for Qualifying Individuals-1 (QI-1). Medical Assistance makes a direct payment to the federal government for the Medicare Part B premium for an eligible QI-1. Qualifying Individuals (QI 1) are not otherwise eligible for Medical Assistance. QI benefits are subject to federal appropriations.

4. Qualified Disabled Working Individual (QDWI).

   QDWIs were established under the legal authority of the Omnibus Budget Reconciliation Act (OBRA) of 1989 which allows disabled individuals who lose or have lost Medicare coverage solely because of work to buy it back. These individuals are called "Disabled Working Individuals."

   OBRA further requires states to pay the Part A

Medicare premium for certain Disabled Working Individuals, called Qualified Disabled Working Individuals. The single benefit of this coverage is MA payment of the Medicare Part A premium. Qualified Disabled Working Individuals (QDWIs) are not otherwise eligible for Medical Assistance.

Medicare is the federal health insurance to which individuals who are insured under the Social Security system are entitled once they attain 65 years of age or reach the 25th month of a permanent and total disability. Medicare is also available to individuals who have permanent kidney failure and individuals who received a kidney transplant. Medicare has two parts:

- Part A Medicare Insurance
  - pays for hospital services and limited Skilled Nursing facility services;
  - is available without charge to individuals who are insured under Social Security or Railroad Retirement systems and who have attained 65 years of age or have reached the 25th month of a permanent and total disability;
  - is available without charge to certain individuals who receive continuing dialysis for permanent kidney failure and certain individuals who have had a kidney transplant; and,
  - is also available to aged or disabled individuals who are not insured under the Social Security System for a premium amount determined by the Social Security Administration.
- Part B Medicare Insurance
  - pays for physician services, durable medical equipment and other outpatient services; and,
  - is available to both "insured" and "uninsured" individuals who have attained 65 years of age or have reached the 25th month of a permanent and total disability upon payment of a monthly premium. The Part B premium as of January 1, 2006 is $88.50 for timely enrollees.

Individuals who receive Social Security or Railroad Retirement benefit payments are automatically enrolled in Medicare when they turn 65 or reach their 25th month of disability.

Individuals who may need to apply for enrollment in Medicare are those who: 1) have not applied for Social Security or Railroad Retirement Benefits; 2) were involved in certain Government employment; or 3) have kidney failure/kidney transplant. The initial enrollment period is a seven-month period that starts three months before the individual first meets the requirements for Medicare. Individuals who do not enroll

in the initial enrollment period may enroll in the general enrollment period, held each year from January 1 through March 31.

0372.05.05 Qualified Medicare Beneficiary (QMB)

REV:10/1999

A Qualified Medicare Beneficiary (QMB) is an individual or member of a couple who:

- o Is enrolled in or entitled to Medicare Part A;
- o Has countable resources within twice the SSI limit;
- o Has countable income less than or equal to one hundred (100%) percent of the Federal Poverty (FPL) Guidelines; and
- o Meets the citizenship/alienage, residency, enumeration, and third party resource requirements of the Medical Assistance Program.

Under this coverage group:

- o Medical Assistance makes a direct payment to the federal government for Medicare premiums (Part A, if any, and Part B) and provides payments for Medicare deductibles and coinsurance as long as the total amount paid by the Medicare Program does not exceed the Medical Assistance Program allowed amount(s) for the service(s). Individuals cannot be reimbursed directly by Medical Assistance;
- o An individual may be eligible for QMB and Medical Assistance at the same time;
- o Eligibility begins on the first day of the month after the application is filed and all eligibility requirements are met. There is no provision for retroactive eligibility.
- O Eligibility is certified for a twelve (12) month period;
- o Countable income and resources are determined using SSI related methodology (DHS Manual Sections 0356 and 0364);
- o Income limits are rigid. There is no flexible test of income;
- o Cost-of-living increases in Title II benefits (COLAs), effective in January each year are disregarded in determining income eligibility through the month following the month in which the annual Federal Poverty (FPL) Guidelines update is published.

0372.05.10 Specified Low Income Medicare Benef (SLMB)

REV:10/1999

A Specified Low-Income Medicare Beneficiary (SLMB) is an individual or member of a couple who:

- Is enrolled in or entitled to Medicare Part A;
- Has countable resources within twice the SSI resource limit;
- Has countable income in an amount greater than one hundred (100%) percent of the Federal Poverty (FPL) Guidelines and less than or equal to one hundred twenty (120%) percent of FPL; and
- Meets the citizenship/alienage, residency, enumeration, and third party resource requirements of the Medical Assistance Program.

Under this coverage group:

- Medical Assistance makes a direct payment to the federal government for Part B Medicare premiums. Individuals cannot be reimbursed directly by Medical Assistance;
- An individual may be eligible for SLMB and Medical Assistance at the same time;
- Eligibility begins on the first day of the month in which the application is filed and all eligibility requirements are met;
- Eligibility is certified for a twelve (12) month period;
- Retroactive eligibility may be determined and benefits granted for the three months prior to the month of application;
- Countable income and resources are determined using SSI-related methodology (DHS Manual Section 0356 and 0364);
- Cost-of-living increases in Title II benefits (COLAs) effective in January each year are disregarded in determining income eligibility through the month following the month in which the annual Federal Poverty (FPL) Guidelines update is published.
- Income limits are rigid. There is no flexible test of income.

0372.05.15 Qualifying Individual-1 (QI-1)

REV:01/2003

A Qualifying Individual-1, QI-1, is an individual who:

- o is enrolled in or entitled to Medicare Part A;
- o has countable income greater than one hundred twenty (120%) percent of the Federal Poverty (FPL) Guidelines and less than one hundred thirty five (135%) of FPL;
- o has countable resources within twice the SSI resource limit;
- o meets the citizenship/alienage, residency, enumeration, and third party resource requirements of the Medical Assistance Program; and,
- o is not eligible for Medical Assistance under any other coverage provision.

Under this coverage group:

- o Medical Assistance makes a direct payment to the federal government for Medicare Part B premiums. The individual cannot be reimbursed directly by Medical Assistance;
- o Countable income and resources are determined using SSI-related methodology (See DHS Manual Sections 0354 and 0362);
- o Cost-of-living increases in Title II benefits (COLAs), effective in January each year, are disregarded in determining income eligibility through the month following the month in which the annual Federal Poverty (FPL) Guideline update is published;
- o Eligibility begins the month in which the application is filed and all eligibility requirements are met;
- o Eligibility may be established and benefits granted up to three months prior to application, but not prior to the beginning of the calendar year;
- o Eligibility is certified until the end of the calendar year in which the application was filed.

Eligibility for QI-1 benefits is subject to federal appropriations.

0372.05.20 Qualifying Individual-2 (QI-2)

REV:01/2003

A Qualifying Individual 2, QI-2, is an individual who:

- is enrolled in or entitled to Medicare Part A;
- has countable income greater than or equal to one hundred thirty five percent (135%) of the Federal Poverty (FPL) Guidelines and less than one hundred seventy five percent (175%) of FPL;
- has countable resources within twice the SSI resource limit;
- meets the citizenship/alienage, residency, enumeration, and third party resource requirements of the Medical Assistance Program; and
- is not eligible for Medical Assistance under any other coverage provision.

Under this coverage group:

- Medical Assistance provides reimbursement to an eligible individual for the portion of the Medicare Part B premium that is attributable to the shift of some home health benefits from Part A to Part B;
- Eligibility begins the month in which the application is filed and all eligibility requirements are met;
- Eligibility may be established for up to three (3) months prior to the date of application, but not prior to the beginning of the calendar year in which the application is filed;
- Eligibility is certified from the month of application until the end of the calendar year in which the application is filed.

The QI-2 program ended on December 31, 2002. Individuals may apply for retroactive QI-2 benefits through March 31, 2003 for the three (3) month period prior to application. However, QI-2 benefits cannot be paid for any month after December 2002.

0372.05.25 Qualified Disabled & Working Indiv (QDWI)

REV:10/1999

A Qualified Disabled and Working Individual (QDWI) is an individual or member of a couple who:

- Is entitled and able to enroll, as determined by the Social Security Administration, in Medicare Part A as a disabled working individual;
- Lost original entitlement to Medicare Part A through the loss of Title II benefits due to substantial gainful activity;
- Has countable income of less than or equal to 200% of the

Federal Poverty Level;

- o Has countable resources within twice the SSI limit;
- o Meets the citizenship/alienage, residency, enumeration, and third party resource requirements of the Medical Assistance Program; and,
- o Is NOT eligible for Medical Assistance under any other coverage provision.

Under this coverage group:

- o Medical Assistance makes a direct payment to the federal government for Part A Medicare premiums. An individual cannot be reimbursed directly by Medical Assistance;
- o Eligibility begins the month in which the application is filed and all eligibility requirements, including enrollment in Medicare Part A, are met;
- o Eligibility may be determined and benefits granted for up to three (3) months prior to the month of application;
- o Countable income and resources are determined using SSI-related methodology (See DHS Manual Sections 0356 and 0364),
- o Income limits are rigid. There is no flexible test of income.

0372.05.30 Eligibility Determination

REV:01/2003

For eligibility under the Medicare Premium Payment Program to exist, an individual or member of a couple must file an application and meet the non-financial requirements of citizenship, alienage, residency, enumeration and third party resources requirements that all other Medical Assistance applicants must meet, as well as the specific requirements of the Medicare Premium Payment Program: Enrollment in Medicare Part A, income and resources limits.

An individual or member of a couple may qualify for Medicare Premium Payment Program benefits regardless of living arrangement. Income and resource limits are uniform, and do not vary depending on living arrangement or institutional status.

An individual may apply for the Medicare Premium Payment Program only, Medical Assistance only, or both Medical Assistance and Medicare Premium Payment Program benefits. If eligible, the applicant is certified at his/her option for:

* Medicare Premium Payment Program Benefits only;
* Medical Assistance only; or
* Medical Assistance with QMB/SLMB. (QIs and QDWIs are not eligible for Medical Assistance.)

Notices of agency action to applicants for Medicare Premium Payment Program benefits parallel the notices sent regarding actions on Medical Assistance applications. Applicants for Medicare Premium Payment Program benefits must receive adequate notice of agency action to accept or reject an application for such coverage.

The agency must send timely and adequate notice of benefit termination. The notice must be mailed at least ten (10) days prior to the effective date of the action.

Applicants/recipients requesting or receiving Medicare Premium Payment Program benefits are entitled to the same due process protection afforded other Medical Assistance applicants and recipients. However, there are no rights to appeal a decision made to discontinue benefits for QI-2s effective December 31, 2002 because termination is as a result of federal law.

0372.05.35 Application Process

REV:10/1999

DHS provides two distinct application processes for individuals and members of couples who are requesting Medicare Premium Payment Program benefits. They are:

- o Combined Application (Forms DHS-1 and DHS-2)

  Individuals and couples applying for all covered Medical Assistance benefits complete the DHS-1 (Application) and DHS-2 (Statement of Need) forms. Such applicant is entitled to have eligibility determined under any and all coverage groups for which he/she may qualify, including Medicare Premium Payment Program benefits. Information about the benefits available under each appropriate coverage group must be provided to the individual at the time of application. If an applicant does not specifically and voluntarily choose to have his/her eligibility determined under a specific coverage group only, eligibility is determined for all potential coverage groups.

- O Streamlined Application (Form MPP-1)

  Individuals and couples applying only for Medicare Premium Payment Program benefits may complete the MPP-1 application form and mail it to the DHS office. The application date is the date the signed form is received in the DHS office.

To reduce barriers to eligibility for Medicare Premium Payment Program applicants, required verification is obtained from the individual's Social Security record. The State Verification and Exchange System (SVES) is used whenever possible to verify the applicant's date of birth, residency, social security number, social security income, Medicare Claim Number and Medicare Enrollment. Citizenship/alienage is pre-determined by the Social Security Administration and that requirement is met with Medicare enrollment. This verification must be obtained before eligibility is approved.

Initial eligibility is not delayed while verification of income other than Social Security and resources is pending, providing that the information contained in the

application does not conflict with other information provided by the applicant, information contained in other DHS applications, or other documented information known to DHS. Income other than Social Security and resources are verified with the applicant's consent by DHS Health Care Quality, Financing and Purchasing personnel at Central Office. As a condition of continued eligibility, the applicant/recipient must cooperate in the verification process by either a) providing verification of income and resources or b) giving consent to DHS to obtain such verification. Information and/or documentation obtained in verification process is referred to the appropriate DHS field office for any necessary action.

A decision on an application for Medicare Premium Payment Program benefits must be made within thirty (30) days of the receipt of the signed application form in the DHS office.

0372.05.40 Financial Requirements

REV:10/1999

The resource and income evaluation methods described in Sections 0356 and 0364 for SSI-related individuals are used to determine countable income and countable resources for Medicare Premium Payment Program applicants.

0372.05.40.05 Resource Limits

REV:10/1999

The basic resource limits for QMB/SLMB/QDWI/QI-1&2 status are set by law at twice the SSI resource limits. The basic limits are:

- $4,000 for an individual;
- $6,000 for a couple;

Resource exclusions, including those for life insurance, automobile, tangible personal property/household goods, burial contracts, and funds set aside for burial are identical to those of the SSI program. Refer to Section 0354.35 for Exclusions for Categorically Needy SSI-related individuals and couples.

0372.05.40.10 Income Limits

REV:01/2003

The income limits for the Medicare Premium Payment Program benefits, based on the Federal Poverty (FPL) Guidelines for the appropriate family size, are listed below.

- QMB - less than or equal to one hundred (100%) percent of FPL;
- SLMB - greater than one hundred (100%) percent FPL and less than or equal to one hundred twenty (120%) percent of FPL;
- QI-1 - greater than one hundred twenty (120%) FPL and less than one hundred thirty five (135%) percent FPL;
- QI-2 - greater than or equal to one hundred thirty five (135%) of FPL and less than one hundred seventy five

(175%) of FPL. The QI-2 program ended on December 31, 2002;

- o QWDI - less than or equal to two hundred (200%) percent of FPL.

0372.05.40.15 Title II COLA Disregard

REV:01/2003

For QMBs, SLMBs, and QIs, the cost-of-living increases in Title II benefits (COLAs), effective in January each year, are disregarded in determining income eligibility through the month following the month in which the annual Federal Poverty Level update is published.

Only Title II COLAs are disregarded in this manner. This exclusion does not apply to cost-of-living adjustments in other types of income, such as government or private retirement pensions.

0372.20 LIST & DEFINITIONS OF LIMITED BENEFIT GROUPS

REV:01/2003

The following information describes the various categories of individuals who are entitled to Medicare and eligible for some category of Medical Assistance limited benefits.

1. Qualified Medicare Beneficiaries (QMBs) - Individuals entitled to Part A of Medicare, with income not exceeding 100% of the Federal poverty level, and resources not exceeding twice the SSI limit (currently $4,000 for an individual and $6,000 for a couple). QMBs may be eligible for full Medical Assistance or may have MA eligibility limited to payment of Medicare Part A and Part B premiums and Medicare cost-sharing (deductibles and coinsurance) for Medicare services provided by Medicare providers.

   A. QMBs without other Medical Assistance (QMB Only) - Individuals entitled to Part A of Medicare, with income not exceeding 100% FPL, and resources not exceeding $4,000 ($6,000 for a couple). Eligibility for MA is limited to payment of Medicare Part A and Part B premiums and Medicare deductibles and coinsurance for Medicare services provided by Medicare providers.

   B. QMBs with Medical Assistance (QMB Plus MA) - Individuals entitled to Part A of Medicare, with income not exceeding 100% FPL, and resources not exceeding $4,000 ($6,000 for a couple). Eligibility for Medical Assistance includes payment of Medicare Part A and Part B premiums and Medicare deductibles and coinsurance for Medicare services provided by Medicare providers.

   C. Non-QMBs - In addition, there are individuals who are eligible for Medicare and Medical Assistance, but who are not eligible under any of the special Medicare categories. Typically, these are Medicare eligible

individuals whose income exceeds the income limits of any of the special categories and who spend down income to become eligible for MA. MA benefits are for MA services provided by MA providers, but only to the extent that the MA payment rate exceeds any Medicare payment for the service covered by both Medicare and MA.

2. Specified Low-income Medicare Beneficiaries (SLMBs) - Individuals entitled to Part A of Medicare, with income above 100%, but not exceeding 120% FPL, and resources not exceeding $4,000 ($6,000 for a couple). Eligibility for MA benefits is limited to payment of Medicare Part B premiums.

3. Qualified Disabled and Working Individuals (QDWIs) - Individuals entitled to purchase Part A of Medicare (Medicare benefits lost because of return to work), with income below 200% FPL, and resources not exceeding $4,000 ($6,000 for a couple), and not otherwise eligible for MA. Eligibility for MA benefits is limited to payment of Medicare Part A premiums.

4. Qualifying Individuals-1 (QI-1s) - Individuals entitled to Part A of Medicare, with income above 120%, but less than 135% FPL, resources not exceeding $4,000 ($6,000 for a couple), and not otherwise eligible for Medical Assistance. Eligibility for MA benefits is limited to full payment of Medicare Part B premiums. The QI-1 program is subject to federal appropriations.

5. Qualifying Individuals-2 (QI-2s) - Individuals entitled to Part A of Medicare, with income at least 135%, but not exceeding 175% FPL, resources not exceeding $4,000 ($6,000 for a couple), and not otherwise eligible for Medical Assistance. Eligibility for MA benefits is limited to partial payment of Medicare Part B premiums. The eligible individual is reimbursed directly for the overpayment. The QI-2 program ended on December 31, 2002.

0372.30 Title XV Coverage Group

REV:04/2001

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (P.L. 106-354), amended Title XIX to include an optional Medicaid coverage group for uninsured women under age sixty-five (65) who are screened under the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program and found to need treatment for breast or cervical cancer or for precancerous conditions of the breast or cervix. Effective April 2001 and retroactive to January 1, 2001, Medical Assistance is provided to women who meet the specific eligibility requirements for this coverage group.

0372.30.05 Definitions

REV:04/2001

For purposes of this policy, the following definitions apply:

CREDITABLE COVERAGE means the term as it is defined in section 2701 of the Public Health Service Act, known as the Health Insurance Portability and Accountability Act of 1996, or HIPAA.

Creditable coverage includes, for example, most health insurance coverage (including insurance that may have high deductibles or limits), a group health plan, Medicare, Medicaid, Armed forces insurance, a medical program of the Indian Health Service (IHS) or of a tribal organization, and a state health risk pool.

However, for purposes of this policy, creditable coverage does not include plans which do not provide coverage for the treatment of breast or cervical cancer, or plans which provide only dental, vision, or long term care coverage, or plans which provide coverage only for a specified disease or illness. Further, if a woman is in period of exclusion (such as a preexisting condition exclusion or an HMO affiliation period) for treatment of breast or cervical cancer or if she has exhausted her lifetime limit on all benefits under her health plan, she is not considered to have creditable coverage for purposes of this policy.

SCREENED FOR BREAST OR CERVICAL CANCER UNDER THE CDC BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM ESTABLISHED UNDER TITLE XV OF THE PUBLIC HEALTH SERVICE ACT means: a)A woman's clinical services were funded all or in part by CDC Title XV funds; b) she was screened under the RI Department of Health (HEALTH) Women's Cancer Screening Program (even if their particular clinical service was not paid for by CDC Title XV funds); or c) she was screened by a HEALTH designated provider and subsequently enrolled in the HEALTH Women's Cancer Screening Program.

NEED TREATMENT means that the diagnostic test following a breast or cervical cancer screen indicates that the woman is in need of cancer treatment services as verified by the RI Department of Health Women's Cancer Screening Program. These services include diagnostic services that may be necessary to determine the extent and proper course of treatment, as well as definitive cancer treatment itself. Based on the physicians plan-of-care, women who are determined to require only routine monitoring services for a precancerous condition of the breast or cervix (e.g., breast exams and mammograms) are not considered to need treatment.

COURSE OF TREATMENT means the period of time a woman requires treatment for breast or cervical cancer, or a precancerous condition of the breast or cervix, as specified in writing by the woman's treating physician or nurse practitioner.

0372.30.10 Scope of Services

REV:04/2001

Eligible members of this coverage group receive the full scope of services provided to categorically needy individuals. (Section 0300.20)

0372.30.15 Eligibility Requirements

REV:04/2001

Under this coverage group, Medical Assistance is provided to a woman who:

1. Is under age sixty-five (65); and

2. Was screened for breast or cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service (PHS) Act and found to need treatment for either breast or cervical cancer, or a precancerous condition of the breast or cervix; and

4. Does not otherwise have creditable coverage; and

5. Is not otherwise eligible for Medical Assistance as categorically needy; and

5. Meets the technical MA requirements of residence, citizenship/immigration status, and provision of a social security number (Section 0300.25.05) and the cooperation MA requirements relating to provision of information needed for an eligibility determination and assignment of rights to third party payments for medical care (Section 0300.25.15).

0372.30.15.05 No Income or Resource Test

REV:04/2001

A woman must meet certain financial criteria in order to qualify for screening under the Centers for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program and the Rhode Island Department of Health Women's Cancer Screening Program. The Department of Health Women's Cancer Screening Program, or its designees, are responsible for determining eligibility for screening under these programs.

However, there are no separate Medical Assistance Income or Resource Limits for this group.

0372.30.20 Presumptive Eligibility

REV:04/2001

Presumptive eligibility is a Title XIX option that permits states to enroll women in Medical Assistance (MA) for a limited period of time before a full application is processed, based on a determination of a qualified entity of likely MA eligibility.

This allows early access to health care for women found through screening to need cancer treatment.

Presumptive eligibility is granted if, based on information contained on the MA/Title XV Application Form (MA/BCC-1) and information provided by the health care provider conducting the screening, the RI Department of Health (HEALTH) Women's Cancer Screening Program determines that the woman: a) is under age sixty-five (65); b) has no other form of individual or group health insurance (including Medical Assistance);

c)needs treatment for breast or cervical cancer or a precancerous condition of the breast or cervix; and d) resides in RI.

Presumptive eligibility begins on the date Department of Health determines that the woman appears to meet above criteria.

Presumptive eligibility ends on the date a formal determination is made on the woman's application for MA, or if she does not file an MA application, on the last day of the month following the month in which presumptive eligibility begins.

DHS is responsible for providing the Department of Health Women's Cancer Screening Program with MA application forms and information on how to assist applicants in completing and filing such forms. The Department of Health Women's Cancer Screening Program, or its designees are responsible for providing the woman with assistance in completing and filing an MA application form (MA/BCC-1). The Department of Health Women's Cancer Screening Program is further responsible for:

- making determinations of presumptive eligibility based on information provided on the MA/BCC-1;
- providing the woman with written notification of presumptive eligibility; and
- notifying DHS within five (5) days of determinations of presumptive eligibility.

If a woman is determined not to be presumptively eligible, the Department of Health Women's Cancer Screening Program provides the applicant with written notification of the following:

- the reason for the determination;
- that she may file a formal application for Medical Assistance and where she may apply for Medical Assistance;
- that a formal determination of MA eligibility will be issued by DHS based on her completed MA application; or
- if she does not file an MA application, her presumptive eligibility ends on the last day of the month following the month presumptive eligibility began.

There are no appeal rights associated with determinations of presumptive eligibility. However, appeal rights do apply to the application for Medical Assistance.

0372.30.25 Application Process

REV:04/2001

The MA/BCC-1, a streamlined mail-in application form, is used to determine eligibility for MA under this coverage group.

Verification of immigration status must be provided by the applicant before MA eligibility is established. In addition, verification of the woman's eligibility for screening under the CDC Breast and Cervical Cancer Early Detection Program and her need for treatment is required before MA eligibility is established. However, up-front verification of other information on the application form is not required unless it is inconsistent with that provided on previous DHS applications or with other documented information known to DHS.

Applications for Medical Assistance are available at the Department of Health Women's Cancer Screening Program, DHS offices, and at other DHS designated locations.

The Center for Adult Health is responsible for determinations of MA eligibility for this coverage group. Individuals identified by the Center for Adult Health as potentially eligibility for MA under another categorically needy coverage group must cooperate in filing a full MA application (DHS-1/DHS-2 or MARC-1 as appropriate) as a condition of maintaining MA eligibility.

Eligibility decisions are made in accordance with provisions contained in Section 0302.15. If the applicant indicates that an unpaid medical bill was incurred in the three (3) month period preceding application, eligibility for retroactive coverage is determined. To qualify for retroactive coverage, the applicant must meet all eligibility requirements during the retroactive period.

0372.30.30 Redeterminations

REV:04/2001

A redetermination of MA eligibility must be made periodically to determine that the recipient continues to meet all eligibility requirements. The redetermination of eligibility is based on information provided on a new application form and documentation from the woman's treating physician regarding her course of treatment. If a woman's course of treatment for breast or cervical cancer (or for a precancerous condition of the breast or cervix) has ended, or if verification of the need for continuing treatment is not provided within the time frame specified, eligibility is discontinued.

A full redetermination of eligibility must be made at least every twelve (12) months, or whenever a change in circumstances occurs, or is expected to occur, that may affect eligibility.

Interim verification of continuing treatment, based on the reasonable expectation of the length of a woman's course of treatment, is also required. Unless otherwise specified by the woman's treating physician or nurse practitioner, the expected length of time for treatment of a pre-cancerous condition is four (4) months.

0372.30.35 When Eligibility Ends

REV:04/2001

Eligibility for MA under this coverage group ends if:

- the woman attains age sixty-five (65); or
- she acquires creditable coverage; or

- her course of treatment for breast or cervical cancer ends; or
- she fails to complete a scheduled redetermination; or
- she is no longer a RI resident; or
- she otherwise does not meet the eligibility requirements for the program.

MA notification and appeal rights apply to individuals losing eligibility under this coverage group.